NORTHEAST NUTRITION
Diane Tryon, RD
P.O. Box 12
Danielson, CT 06239
(860) 617 – 0241 diane.tryon@sbcglobal.net

Client: Please complete this form using Microsoft Word. It is best to be completed prior to the first appointment. Email it to the address above so that your care can begin at our first meeting.

New Client Intake Form

Name: ______________________________ Date: ______________

Mailing Address: ______________________________

Email Address: ______________________________

Age: __________ Date of Birth: ______________ Gender: __________

Phone: Home: ______________ Cell: ______________ Work: ______________

Reason for Nutrition Counseling: ______________________________

If Referred ~ Name & Address: ______________________________

Medical History:

Height: ________ Current Weight: ________ Desired Weight: ________ Lowest Weight/Age: _________________

Highest Weight/Age: ________ Have you had any recent weight changes? _________________________________

Have you been diagnosed by a doctor for a nutrition-related problem such as diabetes, anemia, high cholesterol, gastrointestinal problem, Celiac Disease or a thyroid disorder, etc.? Yes ______ No ______

Please indicate whether you or a family member have/had any of the following conditions:

Disease/Condition	Self	Family	Relationship	Treatment
Asthma				
Cancer				
Celiac Disease				
Diabetes				
Eating Disorder				
Food Allergies				
Food Intolerances				
GERD/Heartburn				
Heart Health				
High Cholesterol				
Hypertension (HBP)				
Kidney Disease				
Menstrual Problems				

Other: ______________________________

Are you currently being treated for any medical condition(s)?______________ ___ Yes ___ No
Are you taking any medications? ___ Yes ___ No
Please list: ____

____

____

Are you taking any vitamin, mineral, food or herbal supplements? ___ Yes ___ No
Please list: ____

Recent Labs if Available: Cholesterol _____HDL ____LDL ____Triglycerides _____ Dated: ___________

Do you follow a special dietary plan such as low cholesterol, kosher, or vegetarian, etc.? ____ ___ Yes ___ No
Are there certain foods you do not eat? ____
Are there any specific foods you must include in your diet due to religion?_______________________

List weight loss attempts:

Diet | How Long? | Year | Outcome ~ Weight | Own Plan or MD
____

____

Exercise History:

Do you have any physical conditions that limit your ability to exercise? ___ Yes ___ No
Circle or Bold or Highlight One: Low=0-30 min/day Moderate=30-60 min/day Heavy = 1 hour+/day
List type, duration, frequency, and intensity of all exercise activities in the course of a month:

____

____

____

Meal Planning:

Who plans your meals?_______________________ Who cooks? _____________________________
Who shops? __________ Is a list used?_________ Do you use the food label? ___________________
Do you cook from scratch often? _______________Or prefer frozen entrees & starters? ___________
Do you use a food service? ________________ Access to a cafeteria daily?____________ Do you generally feed others or just yourself? ____

Eating Patterns:

How many days per week do you eat: Breakfast ______ Lunch ______ Dinner ______
What do you like to snack on?____________________ Time(s) of Day to snack?__________________
Do you buy or pack a lunch? How often?____
How often do you dine out or order out per week?____
List types of restaurants:____

____
Favorite entrée: ___________________________Favorite Beverage:______________________________
Describe your typical eating environment: (alone, spouse, roommate, in a car, at a desk, etc.)

Goals/Expectations
What change(s) would you like to make? What would you like to focus on from our 1:1 nutrition counseling? Use the space below to elaborate.

As well, please circle, bold, or highlight ALL that apply.

Weight Management * Portion Size * Disease Management * Meal Planning * Label Reading * Exercise Ideas * General Nutrition * Healthy Food Preparation * Carb Counting * Low Fat Cooking Ideas * Heart Health * Seasonings * Diabetes * Celiac Disease *
Food Safety * My Nutritional Needs * Dyslipidemia * Gastrointestinal Disorders
Hypertension (HBP) * Cancer Care * Bone and Osteoporosis * Salt Intake * Pregnancy * *
Constipation/Fiber * Disease Prevention * Heart Disease * Food Allergies *

OTHER / ADDITIONAL ISSUES: