NORTHEAST NUTRITION
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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: