



## Nutritional Consultation Intake

### PATIENT INFORMATION

Full Name: \_\_\_\_\_ Date: \_\_\_\_\_

Day/Month/Year

Date of Birth: \_\_\_\_\_  
Day/Month/Year

Gender: Male Female

Ethnicity: \_\_\_\_\_

### CONTACT INFORMATION

Full Address: \_\_\_\_\_  
\_\_\_\_\_

Telephone: (home) \_\_\_\_\_ (work) \_\_\_\_\_

(mobile) \_\_\_\_\_

Email: \_\_\_\_\_

Marital Status (circle):    Single    Married    Divorced    Separated    Living with Partner    Widowed

Do you have any children?    Y    N

If yes, list age and gender. \_\_\_\_\_

**Emergency Contact:** \_\_\_\_\_

Relationship to you: \_\_\_\_\_

(\_\_\_\_\_) \_\_\_\_\_ (\_\_\_\_\_) \_\_\_\_\_ (\_\_\_\_\_) \_\_\_\_\_  
Telephone (home)                      Work                      Mobile / Pager

**Name of Medical Doctor:** \_\_\_\_\_ Tel: (\_\_\_\_\_) \_\_\_\_\_

Address: \_\_\_\_\_ Fax: (\_\_\_\_\_) \_\_\_\_\_

Date of last visit to Medical Doctor: \_\_\_\_\_ Date last physical: \_\_\_\_\_

Are you under the care of any other health care providers (Please list names, specialty, phone number)?

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

How did you hear of this clinic/who were you referred by? \_\_\_\_\_

Occupation? \_\_\_\_\_

Any occupational hazards? \_\_\_\_\_

## CONTEXT OF CARE

1. Why did you choose to come to this clinic?

2. Why are you interested in a nutritional consultation and/or menu plan?

3. What expectations or desired outcomes do you have from working with me?

4. What is your present level of commitment to changing your diet and lifestyle to a healthier one? (Rate from 1 to 10, 10 being 100% committed)

1 2 3 4 5 6 7 8 9 10

5. Please describe your current approach to diet and nutrition (i.e. junk food junkie, committed vegetarian, eat out most meals, love to cook, ready to learn...etc):

6. Please list the behaviors or lifestyle habits that you believe are obstacles to achieving your health and nutrition goals:

6. Who do you know that will *sincerely and consistently* support you in the beneficial dietary and lifestyle changes you will be making?

7. What do you LOVE to do?

**MEDICAL HISTORY**

Please list your chief health concerns and/or any conditions you currently suffer from:

<b>Concern</b>	<b>Since</b>
1.	
2.	
3.	
4.	
5.	

What effect have these issues had on your life?

How would you describe your general state of health?

Please list any major trauma, injury, surgery, illness or accident (mental, emotional or physical) you have sustained.

<b>Incident</b>	<b>Date</b>	<b>Long-term effects</b>

**MEDICATIONS / SUPPLEMENTS / DRUGS**

Please list all **current** medications and supplements you take including prescription drugs, over the counter drugs, herbs, vitamins, minerals, homeopathics, etc.

<b>Drug / Supplement (Company &amp; Brand Name)</b>	<b>Used For</b>	<b>Date Started</b>	<b>Dosage / Frequency</b>

In the last 5 years, about how many courses of antibiotics have you taken?  
Most recent course?



**DIET & DIGESTION**

Are there any foods you avoid or exclude from your diet? If so, for what reason?

Are there any foods that you crave specifically? (chocolate, sweets, salty, sour, rich/fatty, breads, spicy)

What are your favourite foods?

**Check all of the following items that you currently eat:**

- lentils & beans
- soy
- fish
- seafood/shellfish
- poultry
- pork
- beef
- dairy
- eggs
- avoid gluten
- nuts
- seeds
- at least 2 servings fresh fruits per day
- brown rice, barley, quinoa, other whole grains
- at least 4 servings (1 cup raw/1/2 cup cooked) veggies per day
- bread, baked goods, pasta, cereal or crackers daily

**Which of the following do you like most?**

- spicy
- sweet
- salty/savoury
- sour flavour
- bitter flavour
- crunchy foods
- soft foods
- creamy foods
- chewy foods
- fresh salads
- soups & stews
- pasta
- meat & potatoes
- sandwich
- variety of ethnic foods
- continental/North American fare
- fast food / fried food

Do you regularly eat breakfast?

Do you prepare your own lunch or eat out?

How many nights per week do you cook dinner?

How many nights per week do you eat out/order in?

What is your current skill level and interest level in cooking and food preparation?

**Is there any more information you'd like to provide me with to better customize your meal plan?**

How much water do you drink daily?

What is the primary source of your drinking water (bottled, filtered, tap, well, etc)?

What other beverages do you drink, and how much?

How often do you urinate? Every \_\_\_\_ hr(s)

How often do you have a bowel movement (per day or week)?

**LIFESTYLE FACTORS**

Please fill out the schedule below. For a highly variable schedule enter in the parts that recur and enter “variable” in the other sections. For events that recur weekly, enter as “yoga class Mon & Fri”.

	Typical Weekday	Typical Weekend Day
5:00-5:30 am		
5:30-6:00 am		
6:00-6:30 am		
6:30-7:00 am		
7:00-7:30 am		
7:30-8:00 am		
8:00-8:30 am		
8:30-9:00 am		
9:00-9:30 am		
9:30-10:00 am		
10:00-10:30 am		
10:30-11:00 am		
11:00-11:30 am		
11:30am-12:00pm		
12:00-12:30 pm		
12:30-1:00 pm		
1:00-1:30 pm		
1:30-2:00 pm		
2:00-2:30 pm		
2:30-3:00 pm		
3:00-3:30 pm		
3:30-4:00 pm		
4:00-4:30 pm		
4:30-5:00 pm		
5:00-5:30 pm		
5:30-6:00 pm		
6:00-6:30 pm		
6:30-7:00 pm		
7:00-7:30 pm		
7:30-8:00 pm		
8:00-8:30 pm		
8:30-9:00 pm		
9:00-9:30 pm		
9:30-10:00 pm		
10:00-10:30 pm		
10:30-11:00 pm		
11:00-11:30 pm		
11:30pm –12am		
12:00-12:30 am		
12:30-1:00 am		
1:00-1:30 am		
1:30-2:00 am		
2:00-2:30 am		
2:30-3:00 am		
3:00-3:30 am		
3:30-4:00 am		
4:00-4:30 am		
4:30-5:00 am		

On a scale of 1-10, (10 = highest)

Rate your energy: \_\_\_\_\_ /10

Rate your stress level: \_\_\_\_\_ /10

What time of the day is your energy best? \_\_\_\_\_ worst? \_\_\_\_\_

What affects your energy? (increases or decreases)

Do you exercise regularly? Y N

If so, What forms of exercise?

What duration/intensity/frequency?

### **SLEEP**

What time do you typically get into bed?

What time do you typically wake in the morning?

Do you experience difficulty in waking up?

How would you rate your overall quality of sleep, on average out of 10?

(0 = total insomnia/almost no sleep, 10 = deep, undisturbed sleep, wake naturally & easily) \_\_\_\_\_/10

Do you use any sleep aids (over-the-counter, or prescribed)?

If so, what type/amount/frequency?

### **FEMALE (if applicable)**

Age at menarche (first menses)? \_\_\_\_\_ Age at menopause (if reached)? \_\_\_\_\_

Number of days for typical menstrual flow (include spotting and bleeding)? \_\_\_\_\_

Number of days in menstrual cycle (from first day to the following first day)? \_\_\_\_\_

Date of last menses? \_\_\_\_\_

Number of pregnancies? \_\_\_\_\_ Number of live births? \_\_\_\_\_

**Is there any chance you are pregnant now?** Y N

**Are you currently lactating?** Y N

Date of last PAP test?

Any history of irregular PAP test (please explain)?

Date of last physical exam?

Date of last screening lab work?

### **MALE (if applicable)**

Do you go to a doctor or ND for an annual physical exam? Y N

Date of last physical exam?

Date of last screening lab work?

Last DRE (digital rectal exam)? \_\_\_\_\_ Any irregularities found?

### **ADDITIONAL**

Is there any other information relevant to your health that has not been addressed?

**Thank you for taking the time to complete this intake form. It's completion will help me to understand your whole health picture, and your nutritional needs and goals. Please complete the diet diary on the following page.**

# Diet Diary

Name: \_\_\_\_\_

Please provide a **detailed** account of all food, beverages, condiments and snacks consumed, including **portion sizes** and **times** consumed. Provide 2-3 typical weekdays and 1 typical weekend days. Also note whether food was **purchased, eaten out or prepared at home**.

	Weekday 1	Weekday 2	Weekday 3	Weekend 1
<b>Date:</b>				
<b>Breakfast</b>				
<b>Lunch</b>				
<b>Dinner</b>				
<b>Snacks Water Beverages Medications Supplements</b>				
<b>Comments: Symptoms Energy level Mood Digestion Bowel Movements Headache</b>				