the NUTRITIOUS LIFE studio

CLIENT INTAKE FORM

Referred By: _____

Profile

Part I: Personal Information **Date:** / /

Name: _____

Age: _____

D.O.B: _____

Sex: **M** **F**

Home Address: _____

_____

Home #: _____

Work #: _____

Cell #: _____

Email: _____

Work Location: _____

Occupation: _____

Relationship Status: **Single** **Married** **Divorced** **In relationship**

Do you have children? **Y** **N** **If yes, how old?** _____

Do you have roommates? **Y** **N**

What are your reasons for coming to see me?

_____

_____

Part II: History

Anthropometrics

Height: ‘ “

Current Weight:

Usual Weight:

Does your weight fluctuate? **Y** **N** **If yes, please describe:**

_____

_____

_____

Do you menstruate regularly? **Y** **N**

_____

_____

When was your last physical/blood work?

_____

_____

Do you have any existing or previous medical conditions?

☐ High cholesterol/CVD ☐ Diabetes ☐ IBS ☐ Anxiety/Depression

☐ Hypertension ☐ Thyroid disease ☐ Cancer ☐ Eating Disorder

Other medical conditions or diagnoses:

_____

_____

Allergic conditions:

_____

_____

Medications:

_____

_____

Vitamins/Supplements/Herbs:

_____

_____

_____

Do you have regular bowel movements? Y N

☐ Diarrhea ☐ Gas ☐ Bloating ☐ Constipation

Do you take anything to help your bowels? _____

Family history:

Mom: _____

Dad: _____

Spouse: _____

Siblings: _____

Children: _____

Part III: Behaviors

Smoking:

Are you a smoker? **Y** **N**

If yes, how much? _____

What type? _____

If no, did you smoke in the past? **Y** **N**

Any weight change since you stopped? **Y** **N**

_____

Alcohol:

Do you drink alcohol? **Y** **N**

How many times per week? _____

How much each time? _____

What type? _____

Water: Please describe your water intake:

_____

_____

Caffeine:

Do you use caffeine: **Y** **N**

How much/often? _____

What type?

Coffee	Iced tea	Chai	Pills
Soda (diet or regular)	Tea	Energy Drinks	

If you drink coffee or tea, what do you put in it? _____

What other beverages do you consume?

_____

_____

Exercise:

Do you exercise? **Y** **N**

What type? _____

_____

Where do you workout? _____

How often? _____

How long do you workout at a time? _____

If no, do you have a history of exercise? **Y** **N**

Explain:

_____

_____

Reasonable Goal: _____

Travel:

Do you travel? (work, pleasure)

If yes, do you have difficulty eating healthy meals and snacks when away? **Y** **N**

Part IV: Quality of life

Please describe your energy level on a scale of 1-10.

Please describe your sleep patterns:

Please describe your stress level on a scale of 1-10: How do you manage it?

Please describe your organization style on a scale of 1-10:

Part V: Food history

What are your greatest weaknesses with food?

How often do your weaknesses affect your diet?

Do you think you eat emotionally?

Do you do any nighttime eating?

Do you consider yourself a "black and white" eater?

Food Preparation and Practices:

What was food like in your family growing up?

_____

_____

_____

What is food like in your household now?

_____

_____

Who does the shopping in your family? _____

Where do you shop? _____

How often do you shop? _____

Do you use grocery delivery? _____

Do you cook? _____

Do you plan a grocery list in advance? _____

Office:

Do you bring meals/snacks to work? **Y** **N**

If no, are you open to it? **Y** **N**

Do you have a kitchen-microwave, refrigerator, freezer, toaster? _____

Anything about the office you would want to share?

_____

_____

Do you order in, go out or bring from home?

_____

_____

Food intake:

Hunger quotient (HQ):

_____

_____

_____

How do you eat, fast, slow?

_____

_____

How many meals per day do you eat? _____

Do you snack? **Y** **N** **How often?** _____

Please describe a typical day.

_____

_____

_____

_____

_____

_____

Part VI: Diet History

Have you ever been on a diet or specific eating plan? **Y** **N**

If yes, please describe:

_____

_____

Have you tried:

Atkins

South Beach

Zone

Blood Type

Jenny Craig

Weight Watchers

LA Weight Loss

Cabbage Soup

Slim Fast

Paleo

Gluten Free

Vegetarian/Vegan

Cleanse: _____

Nutritionist: _____

Other: _____

What works for you?

_____

_____

_____

What does NOT work for you?

_____

_____

_____

Are you on a diet or specific eating plan currently? Y N

Please describe:

_____

_____

_____

What are your goals in coming to see me?

_____

_____

_____

Is there anything about lifestyle or food you want to share that we have not discussed?

_____

_____

_____

Client Food Preferences:

Favorite Foods:

_____

_____

_____

_____

Least Favorite Foods:

_____

_____

_____

_____

When you eat out, what do you usually order?

Italian: _____

Mexican: _____

Chinese: _____

Japanese: _____

American: _____

French: _____

Other: _____

STARCHES	VEGGIES	FRUITS	MEAT,FISH & POULTRY	DAIRY & ALTS.	FATS
Cereals	Artichokes	Apple	Bacon	Milk Low fat	Almonds
English Muffins	Asparagus	Apricot	Beans	Skim	Almond butter
Fiber crackers	Bok Choy	Banana	Beef	Whole	Avocado
Oatmeal	Broccoli	Blueberries	Chicken	Milk Alternatives Almond milk	Cheese
Pasta	Carrots	Cherries	Deli	Coconut milk	Chia seed
Quinoa	Cauliflower	Dates	Eggs/egg whites	Hemp milk	Coconut
Rice	Celery	Figs	Fish	Rice milk	Flax meal
Spelt	Cucumber	Grapes	Ground meat	Soy milk	Nuts
Tortillas	Fennel	Kiwi	Raw fish	Other Dairy Cheese	Nut butters
Waffles	Green beans	Mango	Sausage	Cottage cheese	Olive oil
Whole grains	Hearts of palm	Melon	Shellfish	Greek yogurt	Peanut butter
Whole-wheat bread	Jicama	Nectarine	Tofu	Yogurt	Salad dressing
	Lettuce	Orange	Turkey		Walnuts
	Mushrooms	Peach	Vegetable burger		
	Peppers	Pear			
	Spinach	Pineapple			
	Tomato	Plum			
		Raspberries			
		Strawberries			
		Watermelon			

24 Hour Food Recall

Please provide as much detail as possible regarding your food intake over the last 24 hours. For example: "½ cup Post Raisin Bran with 2% milk" versus "a bowl of cereal".

Meal:
Food:
Time:
Hunger Quotient:

Meal:
Food:
Time:
Hunger Quotient:

Meal:
Food:
Time:
Hunger Quotient:

Meal:
Food:
Time:
Hunger Quotient:

Meal:
Food:
Time:
Hunger Quotient:

Note: Hunger quotient refers to the level of hunger you felt at the beginning of the meal. The level is based on a scale of 1 to 10. 1 being equivalent to the feeling of fullness that you can't even think of food and 10 being equivalent to a feeling of such intense hunger that you could eat your shirt!