Patient Intake Form

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Please fill in all the information as accurately as possible. The information you provide will assist in formulating a complete health profile. All answers are confidential.

PATIENT INFORMATION

First Name _____ Last Name _____ Current Date _____

Home Phone ( ) _____ Cell Phone ( ) _____ Date of Birth _____

Address _____

Email _____ Occupation _____

Referral Source _____

DOCTOR INFORMATION

Primary Care Physician

First Name _____ Last Name _____

Phone Number ( ) _____

Address _____

Therapist

First Name _____ Last Name _____

Phone Number ( ) _____

Address _____

HEALTH INFORMATION

Height _____ Weight _____ Goal Weight _____

Please list any present health concerns (symptoms, onset, diagnosis, duration, etc.).

_____

_____

Please list any medications or vitamin supplements taken.

_____

_____

Please list any known food allergies or intolerances.

_____

_____

NUTRITION QUESTIONNAIRE

What prompted you to seek nutrition counseling services at this time?

_____

_____

What eating habits do you believe need the most improvement?

_____

_____

If you have any disordered eating history, please describe.

_____

_____

Please check your current eating pattern (all that apply):

- Varies day to day ___
- Varies week to week ___
- Grazer ___
- Meal skipper ___
- Nighttime eater ___
- 3 meals per day ___
- Restrictive ___
- Binge eater ___
- 3 meals per day plus snacks ___
- No pattern ___

How would you describe your cooking skills, meal preparation, and general food organization?

_____

_____

How often do you travel and how does this affect your eating?

_____

_____

How often do you dine out and what are the restaurants you frequent?

How do family and friends affect your eating habits?

What life stress might contribute to food behaviors you would like to change?

Please describe any formal diets or weight loss programs you have participated in.

PHYSICAL ACTIVITY QUESTIONNAIRE

Please list the types and frequency of activity you participate in on a regular basis.

Do you have any current or future exercise goals?

Has your physician limited your activity for medical reasons?

Do you have any past or present injuries limiting your activity?

Have you been sedentary and inactive and feel that this is problematic?

FOOD QUESTIONNAIRE

What does a typical day of food consumption look like for you?

Breakfast

Lunch

Dinner

Snacks

Beverages

Please list the typical choices within each food group.

Proteins

Grains/Breads

Fruits

Vegetables

Fats

What foods do you dislike and/or avoid? Why?

What foods do you crave?

Are there any foods that you have the tendency to overeat?

Are there any foods that you eat which make you feel guilty?

What foods do you know make you feel good or energetic?