Nutrition Therapy Intake Form

Interviewer: _____ Title: _____

Date: _____ Follow Up: _____

Name: _____

Address: _____

Email Address: _____ Phone: _____ Age: ___

Relationship Status: _____ How many children/their ages? _____

Occupation: _____

Preferred Form of Communication (Phone, Text, Email) _____

List medications you are currently taking:

List vitamins, minerals, herbs and nutritional supplements you are currently taking:

List your main wellness concerns:

What are your goals?

What foods do you generally eat for:
Breakfast?

Lunch?

Dinner?

Snacks?

Liquids?

What are your favorite snack foods?

What are your favorite meals?

What foods do you eat on a daily basis?

What foods would you like to eat less of? Why?

What foods/products would be the most difficult to give up and why?

What foods would be the easiest to eliminate?

What percentage of your food is home cooked? Are you the main cook in your household?

Do you consume a lot of packaged foods (granola bars, cereals, chips, etc.)? If so, what are your favorites? What are the items you can't live without?

Where do you grocery shop?

What is the most important thing you would like to should change in your diet?

Any food allergies/sensitivities?

Do you do the grocery shopping? Yes No Some

Do you do the cooking at home? Yes No Some

How often do you eat out during a typical week?

Where do you eat at?

Do you consume alcohol? Yes No

If yes, how often?

Are you allergic to any foods? Yes No
If yes, please list

Do you have any food intolerances/sensitivities? Yes No
If yes, please list

Are there certain foods that you avoid from your diet? Yes No
If yes, please explain

Have you ever been told by a doctor to follow a specific nutrition plan (weight loss, diabetic, low cholesterol, etc.)? Yes No

Are you currently following a nutrition plan (i.e. diabetic, gluten free, low lactose, etc.) ? Yes No
If yes, please describe

What have been some of your health challenges/obstacles that you encountered in the past?
□ Limiting sweets/desserts
□ Eating too large of quantities
□ Lack of motivation
□ Limiting high sugar beverages
□ Emotional eating (stress, upset, happy, etc.)
□ Problems with goal setting
□ Eating too fast
□ Feeling overly hungry
□ Lack of physical activity (not seeing results)
□ Eating when not hungry
□ Food cravings
□ Chewing/swallowing
□ Skipping meals
□ Unsure about what to eat
□ Lack of appetite
□ Difficulty with shopping
□ Difficulty with cooking
□ Financial challenges

What changes are you ready to make within the next 30-60 days to improve your overall health?

Do you think family and friends will be supportive of you making health and lifestyle changes to improve your quality of life? Explain, if no.

Who in your family or on your health care team will be most supportive of you making dietary change?

Anything else you would like to share? (Please use the back side if necessary)