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 _____ Current Weight _____ Goal Weight _____ High Weight _____ Low 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? _____

_____

_____