Healing Whole NUTRITION

Client Intake Form

Please complete this form to the best of your ability. Such a long form may seem overwhelming, but it will help to optimize your health goals and results while we work together.

ABOUT YOU

Name

Email

Address	City	State	Zip

Occupation

Mobile Phone

Emergency Contact	Emergency Contact Phone/Email

Date of birth	Gender	Height	Weight	Nationality

Circle one: Single Married Divorced Widowed	Name of spouse/significant other:

Children's names and ages (if it applies):

Why are you here today? Briefly describe any problems you may be experiencing.

____

____

Interests in nutritional health (circle any that apply to or interest you):

Weight Loss	Hormone Imbalance	Family Nutrition
Fertility	Thyroid Health	Weight maintenance
Fatigue	Fitness	Paleo Diet
Adrenal Fatigue	Weight gain	Stress relief

PHYSICIAN

Have you seen a physician for your current health problems? YES _____ NO ______

Physician's name: ____

Contact Information: ____

If yes, what was their diagnosis? ____

____

Did your physician refer you to a nutrition therapist? ______________________________

Normal work hours:

Job-related stress level (1 being little stress, 10 being immense stress)
1 2 3 4 5 6 7 8 9 10

Normal commute time:

PERSONAL & LIFESTYLE	
	Does your job require you to be at a computer? Yes_______ No_________ How many hours spent sitting at a computer per day? _____________
	Please list major stressors in your life (work, family, finances, health, etc.) ____ ____ ____
	What do you do for fun/what are your hobbies? ____ ____
	How many hours of sleep do you normally get: ___________ Naps? Yes_____ No_______ Do you wake up during the night? Yes______ No _______ Sometimes _________ If yes, for what reason? ____ What time of night? ____ Do you smoke? Yes ______ No ________ If yes, how many per day? _________________ Do you drink? Yes ________ No ________ If yes, how many drinks per week? ___________ Have you ever had a substance abuse problem? Yes _______ No ________ If yes, when and for how long? ____ Did you seek treatment? ____ How many times do you go out to eat during the week? _____________________________ Do you exercise? Yes_________ No ___________ How many times do you exercise throughout the week? For how Long? ____

PERSONAL & LIFESTYLE

____

What types of exercise? Circle all that apply.

Running   Climbing   Yoga   Weight training   Pilates   Barre

Walking   Crossfit   Interval Training   Yard work   Sports   Other

Other: ____

Were you a high school or collegiate athlete? If yes, what sports and for how long?

____

Any injuries related to sports or any physical activities you now partake in?

____

Have you ever or are you currently struggling with your weight? Yes ______ No _______

Most you have ever weighed: ________ Least you have ever weighed: _________

When did you weight your most? ____________________ Least? _____________________

What grocery store do you normally like to go to? _________________________________

Favorite foods? ____

Least favorite foods? ____

Do you drink caffeine? If yes, how often and how much?

____

Who else are you working with to alleviate any issues you are having?

Acupuncturist   Fertility Specialist   Massage Therapist   Chiropractor   Dermatologist

Other: ____

]
Please list any surgery's or hospitalizations you have had:

Hospitalization/Surgery	Reason	Date

MEDICAL HISTORY

Please list any miscarriages or C-sections you have had:

Miscarriage/C-section	@ how many weeks	Date

Current medications and supplements:

Medication/Supplement/Prenatal	Dose	Taken for?

Allergies/Food Intolerances

Allergy/Intolerance	When did this begin?	Symptoms

Birth control:

Birth Control Type	How long have you been on it?	Symptoms

MEDICAL HISTORY

Childhood History:

Breastfed? Yes_________ No ___________ If yes, for how long? _______________________

Were you immunized? Yes__________ No ______________

Family History:

Has anyone in your family been diagnosed with any of the following? Please indicate M for mother's side and F for father's side.

Heart Disease	Obesity	Type 1 Diabetes	Type 2 Diabetes	Breast Cancer
Alzheimer's	Thyroid Issues	Fertility issues	Alcohol Abuse	Depression
Skin Cancer	High Blood Pressure	High Cholesterol	Mental Illness	Anxiety

Have any siblings suffered from any of the above?

____

____

____

How often do you have a bowel movement?

3x/day _________ 2x/day ___________ 1x/day ___________ 3-4/week ________

Health Goals

How committed are you to change (1 being not very committed, 10 being willing to do anything to feel better)

1 2 3 4 5 6 7 8 9 10

Explain: ____

____

What would you like to see yourself doing that you are currently unable to do?

____

____

____

H E A L T H G O A L S	What goals would you like to achieve in the next 3 months? ____ ____ ____ 6 months: ____ ____ 12 months: ____ ____ Anything else you would like to address that was not covered in these forms? ____ ____ ____ ***Lastly, a 24 hour recall. Please write down what you have eaten and drank in the last 24 hrs.*** Breakfast – Lunch – Dinner - Snacks - Beverages - I look forward to meeting you, working with you, and working together to achieve your health goals! Thank you for taking the time to fill out these forms.

Have a question?
Please contact me @
healingwholenutrition@gmail.com
614.397.6990