

THE WELLNESS PACKAGE - Client Intake Form

All information received on this form will be treated as strictly confidential. Please fill out the form completely and accurately. This information is essential to helping the nutrition therapist to provide a comprehensive wellness package that is safe and effective to help meet your needs and achieve your goals.

Full Name:

Address:

Phone Number:

Date of Birth:

List 3 Nutrition Goals that you hope to achieve with the wellness package:

1)

2)

3)

List 3 Activity/Fitness Goals that you hope to achieve with the wellness package:

1)

2)

3)

List 3 Wellness of "Self" Goals that you hope to achieve with the wellness package:

1)

2)

3)

On a scale of 1-5 (5 is I'm ready Now!) How motivated are you to change your current eating habits? (Circle your choice)

1

2

3

4

5

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List any medications that you are taking:

List any supplements or vitamins that you are currently taking:

List any allergies you have and what sort of reaction you experience:

Food:

Medication:

Other:

How many hours on average do you sleep at night?

Do you or have you ever smoked? If so how much?

How many drinks per/week do you have?

Do you currently engage in physical activity or training?

If so, what does your current fitness plan consist of (types of exercise, frequency, duration)?

Are you working with a trainer or coach?

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When was the last time you had a physical?

What is the name of your Primary Care Physician?

Do you or have you ever been diagnosed with the following?

- Diabetes Type 1/Type 2
- Heart Attack
- Hypertension
- Thyroid Hyper/Hypo
- Stroke
- Food Allergies
- Oral Allergy Syndrome
- Celiac Disease
- Frequent UTI's
- Cancer
- Autoimmune disorder
- Irritable Bowel Syndrome
- Reflux/Gastric Ulcer
- Asthma
- Sleep Apnea
- Arthritis
- Chronic Pain
- Depression
- Anxiety Disorder

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Eating Disorder

Other:

Please elaborate on any items you have checked yes:

Have you ever been to a dietitian or nutritionist before?

If yes, what was the reason and describe your experience:

Describe any special diet or eating plan that currently follow:

Have you eliminated or do you avoid certain foods?

If yes, what are they and why:

How many meals do you eat a day?

How many snacks?

What is your height:

What is your weight:

Goal Weight:

Have you recently lost or gained any weight?

If yes, how much?

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Notes: