

Nutrition Intake Form

Name: _____

Date: _____

List top 3 health goals: _____

| Personal and Family History. Check all that apply to you and your blood relatives | Self | Mother | Father | Grandma (mom's) | Grandpa (mom's) | Grandma (dad's) | Grandpa (dad's) | Sibling | Sibling | Child | Other |
|---|------|--------|--------|-----------------|-----------------|-----------------|-----------------|---------|---------|-------|-------|
| High Blood Pressure | | | | | | | | | | | |
| Heart Attack, Disease | | | | | | | | | | | |
| High Cholesterol | | | | | | | | | | | |
| Stroke | | | | | | | | | | | |
| Asthma, respiratory condition | | | | | | | | | | | |
| Allergies, Hayfever | | | | | | | | | | | |
| Food Allergies | | | | | | | | | | | |
| Chemical sensitivities | | | | | | | | | | | |
| Frequent Infections | | | | | | | | | | | |
| HIV, AIDS | | | | | | | | | | | |
| Digestive disease or disorder | | | | | | | | | | | |
| Liver Disease, Hepatitis | | | | | | | | | | | |
| Kidney Disease | | | | | | | | | | | |
| Cancer or Tumors | | | | | | | | | | | |
| Type: | | | | | | | | | | | |
| Arthritis, Rheumatism | | | | | | | | | | | |
| Fibromyalgia/Chronic Fatigue | | | | | | | | | | | |
| Mental Illness | | | | | | | | | | | |
| Depression or anxiety | | | | | | | | | | | |
| Alcoholism, Drug Use | | | | | | | | | | | |
| Eating Disorder | | | | | | | | | | | |
| Migraine Headache | | | | | | | | | | | |
| Epilepsy, Seizures | | | | | | | | | | | |
| Thyroid Disease | | | | | | | | | | | |
| Obesity | | | | | | | | | | | |
| Diabetes (type I / type II) | | | | | | | | | | | |
| Anemia | | | | | | | | | | | |
| Other: | | | | | | | | | | | |
| | | | | | | | | | | | |

List any allergies or sensitivities: _____

List all current supplements/medications/treatments: _____

How many times per day do you eat (including meals and snacks)? _____

Do you ever skip meals? Yes / No Which meal(s)? _____

How often do you skip that meal(s)? _____

Have you ever been on a modified diet (vegan/vegetarian; Atkins; weight watchers; raw food; etc)? List all: _____

| Food type | I eat these foods (check one): | daily | weekly | rarely |
|--|--------------------------------|-------|--------|--------|
| White flour products such as bread, pasta, pastry | | | | |
| Refined sugar products (soda, cereals, candies, etc.) | | | | |
| Artificial sweeteners (nutrasweet & others in beverages & foods) | | | | |
| Trans fats (lunch meats, margarine, fried foods, chips) | | | | |
| High salt foods (chips, canned soups, cheese, lunch meats) | | | | |
| Processed foods (instant meals, frozen dinners, packaged food, etc.) | | | | |
| Red meat or pork products | | | | |
| Eggs | | | | |
| Dairy | | | | |
| Poultry and/or Fish | | | | |
| Fresh fruit or natural fruit juice | | | | |
| Dried fruits and/or vegetables | | | | |
| Raw vegetables (leafy or crunchy) | | | | |
| Cooked vegetables (leafy or crunchy) | | | | |
| Cooked starchy vegetables (potato, yam, corn, squash, beets) | | | | |
| Whole grains (brown rice, whole wheat, oatmeal, etc.) or whole grain foods | | | | |
| Beans/legumes (soy, tofu, kidney beans, peas, lentils, garbanzos, etc.) | | | | |
| Nuts and/or seeds (flax, sesame, almonds, etc.) | | | | |
| Unprocessed/organic/virgin oils (olive, sesame, grapeseed, etc) | | | | |
| Water or herb (non-caffeinated) tea | | | | |

I exercise:

- Never
- 1-2 times per week
- 3-4 times per week
- Daily

My workouts last for _____ minutes.

I do the following types of exercise (list):

I engage in stress reducing or relaxing activities:

- Never/rarely
- Once or more per month
- Once or more per week
- At least once per day

I regularly (once per week or more):

- Smoke cigarettes
- Drink alcohol: drinks per week _____
- Use caffeine (coffee/soda): cups per week _____
- Take recreational drugs
- Get less than 7/more than 10 hours of sleep
- Have difficulty falling asleep at night
- Have difficulty staying asleep at night
- Have difficulty waking up in the morning

Usual bed time:

Usual waking time:

Pick one phrase that you most relate to:

- I am generally happy and enjoy my life.
- My life is somewhat stressful and varies from enjoyable to miserable
- I feel out of control and I dislike my life

Rate your overall stress level (circle one):

1 2 3 4 5 6 7 8 9 10
low med high

What do you do for a living? _____

Do you enjoy your work? Yes / No How many hours per week do you work? _____

Think about the following items. Mark which item you are willing to examine and make changes, which you might be willing to evaluate, and which you will not change.

| Item | Willing to change | Might evaluate | Won't change |
|---|-------------------|----------------|--------------|
| Food choices and eating habits | | | |
| Current stressors and stress level | | | |
| Addictive behaviors (drugs, alcohol, foods, etc.) | | | |
| Exercise habits | | | |
| Self defeating attitudes and beliefs | | | |
| Non-prescription medication use | | | |
| Physical comfort/pain level | | | |
| Toxins (food additives, cleaning & body products) | | | |