Delicious NUTRITIOUS
NUTRITION THERAPY FOR VIBRANT HEALTH

WELCOME! NEW CLIENT INTAKE QUESTIONNAIRE

Name: _____ Date: _____

Address: _____

City: _____ State: _____ Zip: _____

Best phone # to reach you: _____ OK to leave a message? Y N

Email address: _____ Gender: _____

Birthday: _____ Current age: _____ How old do you feel? _____

Where did you grow up? _____

Describe the types of foods you ate:_____

_____

How would you describe your current relationship with food? _____

_____

Do you live alone or with others? _____

Do you care for dependent children, parents or others? _____

_____

Do you prepare food for others? Do you mainly eat with others, or alone? _____

_____

How many hours pass between finishing dinner and eating breakfast? _____

How often do you eat breakfast? Describe a typical meal: _____

_____

Describe your typical lunch: _____

_____

Your typical dinner: _____

_____

Where do you eat most of your meals? *please mark boxes as applicable, mark %"s if relevant*

	Home, Sitting Down	Home, Standing Up	Car	Desk	Restaurant
Breakfast					
Lunch					
Dinner					

Do you snack often? If so, what, when and where? _____

_____

Where do you buy groceries?_____

What are your favorite restaurants? _____

_____

What % of meals are pre-packaged or fast foods? _____ % of meals microwaved? _____

What foods do you love? _____

_____

If you ever feel like binging, what foods, substances or circumstances are triggers?

_____

_____

What foods do you despise? _____

_____

How much water do you drink a day? # of ounces or 8-oz glasses: _____

Do you feel thirsty or quenched? _____

Please circle which type(s) of water: Tap Glass bottles Small plastic bottles Filtered

Do you drink soda? Regular or diet? How much per day? _____

Do you drink tea? Black, green, or herbal? How much per day? _____

Do you drink coffee? Regular or decaf? How much per day? _____

Do you drink alcohol? What kind, how much, how often? _____

Do you smoke cigarettes or chew tobacco? Please describe current or previous use:

_____

Do you currently use / have previously used recreational drugs? _____

What is the highest level of education that you have completed? _____

Occupation: _____

How many hours per day? _____ Hours per week? _____

Do you find your work fulfilling, challenging, stressful? _____

_____

On a scale of 1-10, rate your overall stress level and describe stressors: _____

_____

Time you go to sleep: _____ Wake up: _____ Do you wake feeling rested? _____

Do you have trouble falling asleep? _____

Do you wake during the night? If so, at what time? _____

Describe your level of physical activity and exercise: _____

_____

_____

How would you describe your digestion? _____

_____

_____

Do you experience digestive troubles? *please circle*

Bloating	Burping	Cramps	Constipation	Diarrhea	Gas
Heartburn	Nausea	Nausea after taking vitamins	Painful BM's	Phlegm in throat	Tonsil stones

How frequently do you have BM's? Restroom visits per day_____ or per week: _____

Do you have / have you had any of the following medical conditions? *please circle*

Acne	ADD/ADHD	Addictions	Anemia	Anxiety	Appendicitis
Arthritis	Asthma	Candida	Cancer	Celiac	Colitis
Crohn's	Depression	Diabetes I/II	Disordered eating	Emotional eating	Eczema
Fatigue	Fibromyalgia	Fibroids, uterine	Gallstones	Gallbladder out	Heart attack
H. Pylori	Hypertension	Hyperthyroid or Graves'	Hypothyroid or Hashimoto's	IBS	Kidney disease or stones
Liver disease	Parasites	Psoriasis or psoriatic arthritis	Seizures	SIBO	Sinus infections, recurrent
Stroke	Tonsillitis	Virus, chronic	Ulcers	Other:	

Please indicate immediate relatives who have or have had the preceding medical conditions:

_____

_____

Have you been hospitalized for a serious condition or had major surgery? If applicable, how many times have you been under total anesthesia? _____

_____

_____

When you get sick, what do you typically come down with? How do you treat it and how long does it take to recover? _____

_____

Have you been tested for airborne or food allergies/sensitivities? If so, what do you react to?

_____

Please circle your blood type, if known: O A B AB not known

Do you know if you were fed breast milk or formula as an infant? _____

Do you know if you were delivered by natural childbirth or C-section? _____

Do you know if you were jaundiced or colicky as baby?_____

Do you have your tonsils? _____ Appendix?_____ Gallbladder? _____

Do have metal dental fillings? How many and for how long? _____

_____

Are you or have you been exposed to agricultural or industrial chemicals near home/at work?

_____

Do you take or use any of the following, or have you taken them in the past? *please circle*

Allergy medications	Antacids	Antibiotics
Antidepressants	Anti-fungals	Anti-inflammatories or NSAIDs
Birth control	Cortisone shots or Prednisone	Diet pills
Diuretics	Enzymes for digestion	HCL -Hydrochloric acid for digestion
HGH	Hormone replacement	Laxatives
Probiotics	Sleeping pills	Statins
Stool softener	Thyroid medication	Other:

...more on this topic on the next page

Please list any medications, vitamins or supplements you're taking. Include dose and brand.
Indicate how often you take them, and for how many years/months.
Please also list medications you have taken in significant amounts or for long past duration
for example, "birth control pills from age 19-34" or "acid blockers 3x/day for 5 years"

1. _____

2. _____

3. _____

4. _____

5. _____

6. _____

7. _____

8. _____

9. _____

10. _____

11. _____

12. _____

13. _____

14. _____

15. _____

Have you strongly positive or negative / worrisome reactions to any medications or supplements?

_____

_____

_____

_____

What are your current health concerns? Please list in order of importance:

1. _____

2. _____

3. _____

4. _____

5. _____

On a scale of 1-10, rank the importance of improving your health: _____

On a scale of 1-10, how willing are you to change food habits to meet your health goals? _____

Are there factors that may make change difficult? _____

_____

Your current weight: _____ How long at this weight? _____ Your height: _____

Have you ever gained or lost a significant amount of weight or had bariatric surgery? If so,

please explain: _____

_____

Are you comfortable with your current size and shape? What if anything might you like to change?

_____

_____

Is there anything else you'd like to mention? _____

_____

_____

_____

Thank you for your time and input! We will discuss more in person.