

# Intake Form:

Name:

Age:

Occupation (what are you doing in life and are how do you feel about it?):

Who do you live with?

---

Purpose of our Consult- Tell me about why we are meeting. What do you feel is the primary purpose?

Relevant Medical History- Please list/describe any medical diagnoses or procedures I should be aware of.

If applicable, have there been any inconsistencies with your menstrual cycle? If yes, please describe.

Please list your current medications & supplement dosages:

Please list/describe any mental health concerns should I be aware of (i.e. depression, anxiety, OCD, PTSD)?

Rate your current perceived level of stress on a scale of 1-10:

Have you ever worked with a dietitian/nutritionist? If yes, tell me about your experience.

# Intake Form:

## Digestive Health

Have you ever received a gastrointestinal (GI) diagnoses? If yes, please describe

Did you have any GI issues as child or adolescent? If yes, please describe

Do you have any food allergies or intolerances? If yes, please describe

## Gastrointestinal symptoms:

On a scale of 1-10 (10 = terrible, 0=non-existent) please state a number that identifies the level intensity of the following symptoms:

Gas 1 2 3 4 5 6 7 8 9 10

Nausea 1 2 3 4 5 6 7 8 9 10

Constipation 1 2 3 4 5 6 7 8 9 10

10

Reflux/ (GERD) 1 2 3 4 5 6 7 8 9 10

10

Bloating 1 2 3 4 5 6 7 8 9 10

Diarrhea 1 2 3 4 5 6 7 8 9 10

Abdominal Pain 1 2 3 4 5 6 7 8 9

Incomplete emptying 1 2 3 4 5 6 7 8 9

**Relevant Family History-** Share with me any family dynamics you feel are important for me to know/understand.

What was food like in your house growing up? What is it like now? Does anyone in your family have a history of dieting, disordered eating, or eating disorders? Other chronic illnesses?

# Intake Form:

## **Food & Nutrition**

Tell me about your dieting and/or your eating disorder history

## **Dieting Patterns**

How many meals a day do you eat?

Do you skip meals?

If yes, which ones do you skip and why?

What are your snacking habits (i.e. frequency, time of day, foods you choose)?

When you feel overwhelmed or life gets busy, do you neglect your eating habits? If yes, please describe.

Do you feel that your life/schedule conflicts with nourishing your body in the way you'd like to? If yes, please describe.

Do you eat and multi-task (i.e. read, watch TV, drive)? If yes, please describe:

Where do you eat your meals?

Do you feel you eat particularly fast or slow? Please describe:

Do you like to cook?

Who does the grocery shopping?

Who prepares the food at home?

# Intake Form:

**Please list the usual time and typical daily intake for each meal:**

Breakfast:

Lunch:

Dinner:

Snacks: What foods do you love?

What foods do you dislike?

Are there any foods that you fear or feel like binge foods for you?

Are there any foods that feel "safe" to you?

Do you eat your meals?

Do you feel you eat particularly fast or slow? Please describe:

Do you like to cook?

Who does the grocery shopping?

Who prepares the food at home?

# Intake Form:

## Exercise and Activity

Have you ever had a consistent exercise routine?

If yes, tell me about your past exercise habits/relationship to exercise:

Tell me about your current exercise habits/relationship to exercise:

**Weight- You can leave blank if you prefer or if it feels uncomfortable, we can discuss it in session together.**

Height:

Current weight:

Ave weight. for the past 2 to 3 years?

Weight you feel most comfortable

How much weight did you gain with pregnancy?

Have you lost or gained weight recently?

How much?

Time frame?

Do you weigh yourself currently? If yes, how frequently:

Please circle how you currently feel about your body.

Strongly dislike

dislike

slightly satisfied

satisfied

very satisfied

## Working together

What do you hope to accomplish through our visits together?

Please feel free to share any additional information here.