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INTAKE AND HEALTH GOALS

PERSONAL AND SOCIAL HISTORY

Name _____ Date _____
Address _____
_____

Phone _____
Email _____
Gender _____ Height _____ Weight _____ Date of Birth _____

Emergency Contact Name and Phone _____

How did you learn about our services? _____

What are your most important health problems? List them in order of importance.
1.

2.

3.

4.

5.

Are you currently receiving medical or health care? ☐ Yes ☐ No
If yes, from whom and for what?
_____
If no, when and where did you last receive medical or health care?
_____

What was the reason?
_____

What is your occupation? _____

What is your work schedule? Include yearly vacation time.
_____

Do you enjoy your work? ☐ Yes ☐ No _____

What educational degrees do you hold?

_____

Describe your household. Who do you live with?

_____

Main interests and hobbies. _____

_____

Do you exercise regularly? ☐ Yes ☐ No
What type of exercise do you do?

_____

How many days a week?
How long per session?

What is your typical bedtime? _____ waking time? _____
Do you wake up during the night? ☐ Yes ☐ No
Do you awake refreshed in the morning? ☐ Yes ☐ No

Rate your energy on a scale of 1-5 with 1=low, 5= high _____
What time of day is your energy the best? _____ worst? _____

Rate your stress level on a scale of 1-5 with 1 = low, 5 = high _____

MEDICAL HISTORY

List all medications (over the counter and prescription) and supplements (dietary and herbal) that you are currently taking. Include dose and time.

_____

_____

_____

_____

_____

_____

_____

Do you frequently use any of the following?
Antacids ☐ Yes ☐ No Antibiotics ☐ Yes ☐ No
Aspirin-Ibuprofen-Acetaminophen ☐ Yes ☐ No Laxatives or Stool Softeners ☐ Yes ☐ No

HOSPITALIZATIONS / SURGERY: Have you had hospitalizations or surgeries? List what and when. _____
_____
_____
_____
_____
_____

Have you had blood tests in the last 5 years? ☐ Yes ☐ No

ALLERGIES: Are you hypersensitive or allergic to:

Drugs/Chemicals? What type of reaction?

_____

Any foods? What type of reaction?

_____

Any environmental irritants? What type of reaction?

_____

Any seasonal or chronic complaints? When? What type of reaction?

_____

FAMILY HISTORY: Do you or anyone in your family have a history of any of the following? (Please check and name whom.)

☐ Cancer _____ ☐ Diabetes _____

☐ Kidney disease _____ ☐ Stroke _____

☐ Anemia _____ ☐ Arthritis _____

☐ Heart disease _____ ☐ High Blood Pressure _____

☐ Asthma _____ ☐ Hay Fever _____

Any other relevant family medical history?

_____

_____

FOOD AND NUTRITION

Do you follow a specific diet (vegetarian, vegan, gluten-free, etc...) ☐ Yes ☐ No

Please describe:_____

_____

Do you feel satisfied with your ability to prepare healthy foods?

_____

Do you need help with any of the following:

Losing weight: ☐ Yes ☐ No Gaining weight: ☐ Yes ☐ No

Maintaining weight: ☐ Yes ☐ No Healthy eating: ☐ Yes ☐ No

What foods do you love:

_____

What foods do you dislike:

_____

How much water do you drink a day? _____

Do you drink: Energy drinks? ☐ Yes ☐ No Soda? ☐ Yes ☐ No Coffee? ☐ Yes ☐ No
Alcohol? ☐ Yes ☐ No How many alcohol drinks per day? _____

Do you have any concerns about your relationship with food?

_____

How often do you have a bowel movement? _____ Any issues with bowel movements (constipation, diarrhea, undigested food, color)? _____

How many times a week do you

Eat while driving? _____ Eat while working? _____ Eat out, take-out ? _____
Shop for food? _____ Eat while watching TV? _____ Eat at home? _____

Check all that apply: Cigarette ☐ Cigar ☐ Pipe ☐ Chewing Tobacco ☐

Recreational Drug Use? ☐ Yes ☐ No

HEALTH GOALS

What do you hope to achieve through working with me? Please list in order of importance. Include anything you want to change about how you feel and anything you would like to change about your diet.

1.

2.

3.

4.

5.

Additional thoughts (brainstorm): _____
_____

Long term goals: What would you like to achieve in 1 year?

Mid-term goals: What would you like to achieve in 6 months?

Short term goals: What would you like to achieve in 3 months?

What are your challenges in reaching your goals? We can plan strategies to conquer these challenges. Examples: (1) I love to eat/drink _____, even though I feel it is not good for me; (2) My schedule leads to eating on the go; (3) I don't have time to prepare healthy meals; (4) It is hard to prepare something appropriate for my entire family; (5) My finances limit me; (6) I am confused about what to eat by all the diets/information out there; (7) I need accountability; (9) I lack support at home; (10) It's a struggle finding healthy foods I like.