Restart Series: Nutrition Intake Form

Name____ Date________

Activity level at work (check all that apply):

- ❑ Sitting
- ❑ Driving
- ❑ Standing/walking
- ❑ Mixture of sitting/standing
- ❑ Computer work
- ❑ Heavy lifting
- ❑ Work outside
- ❑ Computer work
- ❑ Other _____________

When is your usual bedtime? ______ Rising time? ______ Do you use an alarm to wake up? ______

Do you have trouble falling asleep and/or staying asleep? ___________________________________

On a scale of 1-10, how would you rate your stress level? ______

Please list stressors: ____

Have you worked with a nutrition therapist before? ____

General Medical

How many times have you had dental work in the past five years? ____________________________

Do you have amalgam (silver) fillings? ______ If so, how many? ______

How many times have you taken antibiotics? ______ When were you first prescribed them? ______

What were they prescribed for? ____

When was the last time you took antibiotics? ____

What were they prescribed for? ____

Are you currently being treated for any medical conditions? Please list: _________________________

____

Enter and describe any past and/or present medical issues experienced by yourself or family members. Specify: 1=myself, 2=mother, 3=father, 4=grandparents.

Autoimmune Conditions: ____

Heart or Blood Vessels: ____

Bones or Skeletal: ____

Kidneys or Bladder: ____

Genital or Reproductive: ____

Lungs or Chest: ____

Head, Sinus, Ears: ____

Abdominal or Intestinal: ____

Digestive/Bowel Issues: ____

Brain or Neurological: ____

Cancer: ____

Diabetes: ____

Allergies: ____

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Arthritis: ____

Hepatitis: ____

HIV/AIDS: ____

Alcoholism and/or Drug Abuse: ____

Eyes: ____

Skin: ____

Psychological/Emotional: ____

Frequent colds or infections: ____

Other: ____

Blood type (if known): ______

Do you have any known food allergies? ______ Please specify: __________________________

How do they affect you? ____

Do you have seasonal allergies? ______ Please describe: _________________________________

Primary care physician: ___________________________________Phone: ________________

Nutrition and Eating Habits:

On average, how many times a week do you:

Cook full meals at home? ______ Eat at a restaurant? ______ Eat meat? ______ Eat alone? ______
Eat breakfast? ______ Eat three meals per day? ______ Shop for food? ______ Eat in the car? ______
Eat in front of the television? ______ Eat and work simultaneously? ______ Eat standing up? ______
Microwave your food? ______ Skip meals? ______

How often do you have a bowel movement? ____

Any problems with your bowel movements? Please specify: _______________________________

How often do you experience diarrhea and/or constipation? Provide details: _________________

Coffee per day? ______ Sodas per day? ______ Diet or regular? ______ Water per day? ______

List your favorite foods ____

List foods that you absolutely will not eat ____

Religious or Dietary Restrictions ____

Describe an average breakfast: ____

Describe an average lunch: ____

Describe an average dinner: ____

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Do you eat snacks? ______ What time(s) of the day?______________________________________

Describe an average snack ____

How would you describe your relationship with food? (Check all that apply):

- ❑ Emotional eater
- ❑ Eat out of boredom
- ❑ Often forget to eat
- ❑ Love to eat
- ❑ Eat only out of necessity
- ❑ No joy in eating
- ❑ Feel hungry all the time
- ❑ Overeat/don't know when to stop eating
- ❑ Healthy eating habits

Are you currently on a diet? _______ If so, please explain:
____

Do you weigh yourself? _______ If so, how often? ____

Highest weight: ______ Age ______ Lowest weight: ______ Age ______

Any recent weight loss/gain? ______ What would you like to weigh? ______

What food(s) are you not willing to give up? ____

How often do you dine out? ______What restaurants do you like? ____________________________

Do you eat fast food? ______ How often? ____________

What diets have you tried and what were your experiences with them? _________________________

____

Where do you usually shop for food? ____

Who does most of the grocery shopping in your family? _____________________________________

What is your weekly budget for food? ____________

Who does most of the cooking at home? ____________ Do you enjoy cooking? ______

How many members in household? ______

On a scale of 1(least) to 10 (most) how willing are you to change diet/eating habits? ______

What is your family's / friends' attitude about health? _______________________________________

____

Do you feel that you have a good support system? Why or why not? __________________________

____