Nutrition Intake Form

Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone 1: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Phone2:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

SSN: \_\_\_\_\_\_-\_\_\_\_\_-\_\_\_\_\_\_\_DOB: \_\_\_\_-\_\_\_\_\_-\_\_\_\_\_\_Age:\_\_\_\_\_\_\_\_

Emergency contact/number:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Reason(s) for your visit:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you seen anyone else for your complaints? (please list) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

List any medications/dosage:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please list any supplements/dosage:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please list all surgeries/dates:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please list all known allergies to foods/drugs/other substances: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Give the amount of each that you consume:

\_\_\_\_\_ounces water \_\_\_\_\_daily\_\_\_\_\_not daily

\_\_\_\_\_ounces alcohol \_\_\_\_\_daily\_\_\_\_\_not daily

\_\_\_\_\_ounces coffee/tea \_\_\_\_\_daily\_\_\_\_\_not daily

\_\_\_\_\_ounces soda \_\_\_\_\_daily\_\_\_\_\_not daily

\_\_\_\_\_ounces juice \_\_\_\_\_daily\_\_\_\_\_not daily

\_\_\_\_\_other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_daily\_\_\_\_\_not daily

Give percentage for each of the following:

\*Where food prepared \*How food prepared:

\_\_\_\_baked/broiled \_\_\_\_home \_\_\_\_microwave \_\_\_\_fresh

\_\_\_\_restaurant \_\_\_\_fried \_\_\_\_canned

\_\_\_\_fast food \_\_\_\_boiled/steamed \_\_\_\_frozen

\_\_\_\_vending machine \_\_\_\_BBQ \_\_\_\_prepackaged

My appetite is: \_\_\_normal \_\_\_\_excessive \_\_\_poor \_\_\_\_none

I crave: \_\_\_sweets \_\_\_salt \_\_\_chocolate \_\_\_water \_\_\_dirt \_\_\_other\_\_\_\_\_\_\_

Foods that disagree with me: \_\_\_raw vegetables \_\_\_raw fruit \_\_\_fats \_\_\_egg \_\_\_fried \_\_\_milk/dairy \_\_\_greasy \_\_\_onions \_\_\_spiced \_\_\_beans \_\_\_sugar \_\_\_cabbage \_\_\_other Symptoms that you get: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How many times do you have BM? \_\_\_\_x day \_\_\_\_x week

Do you use laxatives? \_\_Y \_\_N How often? \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Brand? \_\_\_\_\_\_\_\_\_

Do you get the urge to have BM? \_\_Y \_\_N Pain with BM? \_\_Y \_\_N

Have you ever had worms/parasites? \_\_Y \_\_N How treated? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I have: \_\_heartburn \_\_indigestion \_\_gas \_\_bloating \_\_belching

I have pain in: \_\_neck \_\_mid back \_\_low back \_\_hip \_\_knee \_\_ankle \_\_feet \_\_shoulder \_\_elbow \_\_wrist \_\_hands \_\_other\_\_\_\_\_\_\_\_\_\_\_\_\_

I get: \_\_swollen joints \_\_sore joints \_\_joints pop/crack \_\_jaw pops

\_\_leg cramps w/ rest \_\_leg cramps w/ activity \_\_foot cramps at rest \_\_foot cramps w/ activity \_\_flat feet \_\_burning feet \_\_tingling in hands/feet

**\*Female Specific\***

My menstrual periods are: \_\_\_regular \_\_irregular \_\_no period in ( ) months

\_\_two or more/month \_\_abnormal since ( ) years of age \_\_problems before 1st child \_\_problems after 1st child \_\_uterus in position \_\_uterus prolapsed

\_\_bladder prolapsed \_\_menopause at age ( ) \_\_hysterectomy at age ( )

Age of first period \_\_\_ On birth control/how long \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Hormone replacement: \_\_estrogen \_\_progestin \_\_oral \_\_patch \_\_wild yam

I have/am: \_\_children \_\_been pregnant \_\_miscarried \_\_aborted \_\_sterile

I have:\_\_fibrocystic breasts \_\_breast cancer \_\_produce milk but not nursing

I get: \_\_bladder infections \_\_yeast infections \_\_vaginal burning/itching \_\_vaginal dryness \_\_painful intercourse

**\*Male Specific\***

I am: \_\_overly tired \_\_exhausted \_\_getting too old for anything \_\_impotent

My prostate is: \_\_normal \_\_enlarged \_\_had cancer \_\_removed

I have: \_\_pain on urination \_\_difficult to start flow \_\_difficult to stop flow \_\_dribbling of urine \_\_decreased stream size \_\_pain/pressure after sex

I get up to urinate \_\_\_\_times per night

My libido is: \_\_normal \_\_excessive \_\_increased \_\_decreased \_\_absent

\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*

Please review this form to be sure your answers are accurate. Thank you for choosing our clinic. We look forward to working with you on your health goals.

Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Printed name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_