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Nutrition Therapy & Wellness

INTAKE FORM

Name:_____ DOB/Age:_____ Date:_____
Address:_____
Phone (cell)_____ Email_____ Preferred contact_____
Describe your recent eating and digestion history that brought you here_____
_____
_____
_____
Height:_____ Current Weight:_____ Lowest Weight: _____ When:_____
Highest Weight:_____ When:_____ "Comfortable" Weight:_____ When:_____
Have you been able to maintain your "comfortable" weight for any period of time? Yes _____No_____
If yes, how long? _____ How often do you weigh yourself?_____
When was your last physical?_____
Have you ever had any abnormal bloodwork results? Yes_____ No_____ If yes, please list or bring abnormal tests:_____
Do you have any significant family medical history? Yes_____ No_____ If yes, please list here:
_____
_____
Check any of the following medical/physical issues that currently apply to you:
Low energy levels ___ Bloating/edema___ Constipation___ Diarrhea ___ Dental Problems ___
Insomnia ___ Reflux___ Gas___ Diabetes (high blood sugar) ___ Low blood sugar_____ Headaches___
Light headedness___ Cold sensitivity___ Bruise easily___ Muscle Cramps___ Hair Loss___ Increased hair on skin___ Insulin resistance___ High Blood pressure___ Other:_____
Please list any other medical or psychiatric diagnoses:_____
_____ _____
Have you started menstruation? Yes___ No___ If so, have you ever lost a cycle?_____
At what weight approximately did you start menstruating? _____lbs. What age?_____
Please list any nutritional supplements (including vitamins, minerals, herbals):_____
_____
Current medications:_____
_____
Have you ever or are you currently participating in the following behaviors?
Describe your last disordered eating behavior/s (Food, amount, time of day, place, hunger, emotions, anxiety level, other):_____
_____
Bingeing? Yes___ No___ Last Time:_____ Frequency: ____x/week
Vomiting following food intake? Yes___ No ___ Last Time:_____ Frequency _____x/week
Laxative (or enema) abuse? Yes___ No___ Last Use:_____ Frequency_____ x/week
What type?_____
Use of diet pills (or diuretics)? Yes___ No___ Last Use: _____ Frequency ____x/week
Restricting calories? Yes___ No___ Current calorie level_____ Current eating plan_____
Which foods are you currently restricting?_____
_____
Please list any diet, low-fat or fat-free foods or condiments you consume, when, and how much:
_____
Food allergies, or foods you have never liked _____
Any history of compulsive exercise? Y___ N___ Please describe your current exercise routine_____
_____
With whom do you currently live?_____

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INTAKE FORM

Who does most of the grocery shopping? _____ Planning?_____ Cooking?_____
How many times per week do you normally dine out?_____
What types of restaurants and what types of entrée choices do you normally make?
_____
Do any members of your family have weight issues? (i.e. obesity, eating disorders) Yes___ No ___
If yes, who?_____
Does your family sit down for family meals? Yes___ How often/where?_____ No____
What obstacles do you face when trying to change your relationship with food and/or your nutritional intake?_____
_____
Please provide any other information in the space below regarding your eating habits that you feel we should be made aware of while you're here (e.g. any other food fears or rituals here):
_____
_____
_____

This section will be completed during your initial session

Dx:_____Ht:_____ Wt:_____ IBW (+/- 10%):_____ % IBW_____
BMI_____ Growth %ile for Wt_____ Wt Range Goal:_____ Est. Current Calorie Intake_____ Estimated Calorie needs_____ Nutrition Concerns/Plan: Wt Gain:_____ Maintenance_____
Goals to improve relationship with food:_____
Nutrition Counseling plan of care for initial and future sessions:
_____
_____
_____

Angela Lovell, MAPC, RDN, LD Signature:_____
CPT/ICD10 Codes:_____
Date:_____