

Intake Form

Name:

Address:

Email Address:

Phone Number:

How did you hear about Grown to Heal Nutrition?

Sex:

Age:

Ethnicity:

Occupation:

Height:       Weight:       Desired Weight (if applicable)

What is your main reason for visiting a Nutrition Therapist?

List your three main health goals:

List any obstacles you have to achieving these goals:

Medical History

Who is your primary care provider?

Phone number:

Please list any medical conditions that you are currently suffering from:

Please list any past medical conditions:

Please list your family’s history of illness:

Have you ever undergone surgery?

If so, what?

Have you ever been diagnosed with food allergies?

If so, please indicate which foods:

Are you taking any medications?

Please list:

Are you taking any dietary/herbal supplements?

Please list:

\*Fertility (Only answer the following if applicable)

How long have you been trying to get pregnant?

Have you ever taken birth control pills, Depo-Provera, IUD, etc.?

If yes, what kind and how long have you been off of it?

Have you ever been pregnant?

Have you undergone any fertility-related treatments by your doctor (IVF, IUI, etc.)?

Women Only

Are you currently using birth control pills?

If yes, what kind?

If no, have you ever used before?

Are you currently on hormone replacement therapy?

If yes, what kind?

Are you menstrual cycles normal?

Do you experience PMS symptoms?

If so, what symptoms?

Nutrition:

How many meals do you eat per day?

Do you eat breakfast everyday?

Do you typically skip meals?

Do you cook?

If not, does someone else cook for your household?

How often do you eat home cooked meals per week?

What is your favorite food?

What is your favorite meal?

What foods do you not eat or dislike?

What are your favorite five ingredients?

What is the one food that you crave most?

What is your current diet if applicable (if applicable, check all that apply)?

Vegetarian  Vegan  No Gluten

No Dairy  Weight Loss diet, describe

List any food intolerances:

Do you have a history of dieting?

How many times per week do you eat out at a restaurant?

Who does the grocery shopping in your household?

Check all the factors that may be obstacles for you and your health:

Emotional Eating

Overeating

Under eating

Meal Planning

Cooking

Cravings

Eating Out

Family members have special dietary needs

Family members don’t enjoy healthful foods

Please list your typical breakfast, lunch, and dinner:

Breakfast

Lunch

Dinner

How much of the following do you consume per day?

Caffeine

Soda

Tea

About how much water do you drink per day?

Do you drink alcohol?

If yes, how often?

How many drinks per week?

Do you use tobacco?

If yes, how much and how often?

Do you participate in any recreational drug use?

If so, what kind and how often?

Overall Health

Do you currently exercise?

If yes, how often per week?

What types of exercise?

About how many hours of sleep do you get per night?

Do you fall asleep with ease?

Do you wake up feeling rested?

How many times per day do you have a bowel movement?

On a scale of 1 to 10, how well formed are your bowel movements (1 is soft; 10 is hard)?

Rate the following from 0=never to 10=everyday

Gas

Bloating

Abdominal discomfort

Diarrhea

Constipation