Nutrition Intake Form

Leslie Langevin, RD

Date:

Name				
Date of Birth		Age:	Gender: M F	
Address				
City, State, Zip cod				
Phone	Cell:	Home:	Work:	
Email				
Best way to contact?	Email Phone Leave a message? Y N			
Primary Physician	Name:	Email:	City:	Phone:
Other Pertinent Provider	Name:	Email:	City:	Phone:
Referred by				

Complaints/Concerns

What do you hope to achieve in your visit?

List your three main health/nutrition concerns:
1)
2)
3)

When was the last time you felt well?

Did something trigger your change in health?

What makes you feel better?

What makes you feel worse?

Allergy Information

List Food Allergies	
List non-food allergies (Meds/supplements)	
List environmental allergies	
What are the symptoms?	

Medications and Supplements

Please list all prescription medications and supplements, herbs/botanicals you are currently taking.

Medication Name	Dose	Frequency	Reason
Supplement Name	**Dose**	**Frequency**	**Reason**

Nutrition History

Have you ever had a nutrition consultation? Yes No	
Have you made any changes in your eating habits because of your health? Yes No (describe below)	
Do you currently follow a special diet or nutritional program? Yes No (describe below)	
Do you avoid any particular foods? Yes No (describe below)	

Height:	Weight:	Desired weight:
Highest Weight:	Lowest Weight:	BMI:
Usual weight range:	Waist circumference:	
Have you had any recent history of weight loss or gain? (please describe)		
Do you have (or had) an eating disorder? Yes No (describe below)		
How many meals per day do you eat? How many snacks?		
How many meals do you eat out per week?		
Do you have any adverse food reactions (allergies or intolerances)? Yes No (describe below)		
Do you drink alcohol? Yes No How many drinks per week?		
Do you drink coffee or other caffeinated beverages? Yes No How many drinks per day?		

Do you use any artificial sweeteners? Yes No (which ones?)		
Favorite foods:	Dislike Foods:	Unsafe (but like):

Check all the factors that apply to your current lifestyle and eating habits:

___ Fast Eater
___ Erratic eating patterns
___ Eat too much/overeat
___ Late night eating
___ Rely on convenience items
___ Love to eat
___ Love to cook
___ Family members have different tastes
___ Live or often eat alone
___ Time constraints
___ Struggle with eating issues
___ Emotional eater
___ Eat fast food frequently
___ Poor snack choices
___ Do not plan meals or menus
___ Eat because I have to
___ Negative relationship with food
___ Dislike healthy food
___ Travel Frequently
___ Confused about food/nutrition

Lifestyle Information

List the exercise that you participate in weekly.

Activity	Type/Intensity (low-high)	# of days per week	Duration (minutes)
Stretching/yoga			
Cardio/Aerobics			
Strength Training			
Sports or Leisure			
Problems that limit physical activity:			

Average number of hours of sleep per night during the week:	
Average number of hours of sleep per night during the weekend:	
Trouble falling asleep? Yes No	Trouble staying asleep? Yes No

Do you have any sensitivities to chemical or environmental products such as perfumes, pesticides, etc? If so please list below: