Wellness Solution Centers
Take a new road to better health

Nutritional Intake Form

PERSONAL INFORMATION

First Name: _____ Last Name: _____

Email: _____

Phone: Home: _____ Work: _____ Mobile: _____

Age: _____ Height: _____ Birthdate: _____

Current weight: _____ Weight six months ago: _____ One year ago: _____

What is your "realistic" ideal weight? _____

SOCIAL INFORMATION

Relationship status: _____

Children : _____ Pets: _____

Occupation: _____ Hours of work per week: _____

MEDICAL INFORMATION

Do you take any supplements or medications? Please list: _____

_____

What role does sports and exercise play in your life? _____

_____

At what point in your life did you feel best? _____

Any serious illnesses/hospitalizations/injuries/stressful events? _____

_____

Do you or have you ever had an eating disorder? i.e. anorexia, bulimia, pica, rumination disorder, binge eating disorder, body image distortion, avoidant/restrictive food intake disorder? If yes please explain.

_____

_____

_____

Do you have any food allergies, intolerances, or sensitivities? _____

HEALTH INFORMATION

How is/was the health of your mother? _____

How is/was the health of your father? _____

How is your sleep? _____ How many hours? _____ Do you wake up at night? _____

Why? _____

Any pain, stiffness, swelling, joint pain, or headaches? _____

Constipation/Diarrhea/Gas/Bloating/Digestive issues? _____

Do you suffer from fatigue (circle answer)? A. always B. sometimes C. never

Allergies, skin rashes, or sensitivities? Yes or No Please explain: _____

Any history of antibiotic use? Yes or No If so, when? _____

NUTRITION INFORMATION

Do you eat breakfast daily? A. always B. sometimes C. never

How many meals do you eat daily? _____

Do you snack often? Yes or No What do you eat for snacks?_____

Do you eat dairy (circle answer)? Yes or No Do you eat meat? Yes/No

Do you eat grains (pasta, bread, rice, cereal, etc.)? Yes or No

Do you use artificial sweeteners (Aspartame-NutraSweet® & Equal®; Saccharin-Sweet'N Low®; Sucralose-Splenda®; Acesulfame K; Neotame)? Yes/No

My liquid consumption includes (circle all that apply and indicate amount per day)

- Water
- Soda
- Diet soda
- Tea

How many servings of fruit do you have in a day? _____ How many servings of vegetables do you have in a day? _____

Do you cook? _____ What percentage of your food is home cooked? _____

Do you crave sugar, coffee, certain foods, or have any major addictions? _____

When do your cravings occur most often?
A) After meals
B) Mid-day
C) Evening (after supper)

When eating a meal I am...
A) Sitting with others/sitting alone
B) Standing
C) On the go/in my vehicle/working at my desk
D) In front of the computer, on the phone, or other media device

I tend to:
A) chew my food thoroughly and eat slowly
B) sometimes chew well
C) eat as fast as I can with little to no chewing

What do you do to cope with stress? _____

Will family and/or friends be supportive of your desire to make food and/or lifestyle changes? _____

ADDITIONAL COMMENTS

Anything else you would like to share? _____

_____