Intake Questionnaire

General Information

Name: _____ Age:____ Date of Birth:_____

Address:_____ City:_____ State:___ Zip:_____

Phone:_____ Email:_____

Genetic Background: African American Hispanic Mediterranean Asian

Native American Caucasian Northern European Other: _____

Emergency Contact: _____ Phone:_____ Relationship:_____

When, Where, and from Whom did you last receive medical or health care? Any recent hospitalizations?

_____

_____

Allergies (w/reaction):_____

Current Health Concerns/Medical History:

Problem/Diagnosis	Severity (mild-severe)	Treatment

Current Medications (including prescription and over the counter)

Medications	Dosage	Start Date	Reason for Use

Nutritional Supplements (Vitamins/Minerals/Herbs, etc)

Medications	Dosage	Start Date	Reason for Use

Family History

Maternal:_____

Paternal:_____

Detailed Social History

Sleep

How many hours each night on average?_____

Do you have problems falling asleep? Y☐or N☐. Staying asleep? Y☐or N☐

Do you snore? Y☐or N☐. Do you feel rested upon awakening? Y☐or N☐.

Do you use sleeping aids? ___ If Yes, explain:_____

Substances

Do you currently smoke? ____ What type and how much?_____

How many times have you attempted to quit?____ What methods?_____

If you previously smoked, how many years?

Do you use recreational drugs? ___ If so which ones/how often_____

Alcohol

How many alcoholic beverages in a week?☐None☐1-3☐4-6☐7-10☐>10

Previous intake? ___ Any problems with alcohol? _____

Exercise

Do you feel motivated to exercise?☐Yes ☐A little☐No

Are there any problems that limit exercise?☐Yes ☐No. Explain: _____

Do you feel unusually fatigued or sore after exercise?☐Yes ☐No

Activity	Type (Cardio/Strength/etc)	Length of time (min)	Times per week

Nutrition

Have you ever been in a formal nutrition program before?____ How many times?__

What program?_____

Do you currently follow a specific diet? Vegetarian/Vegan Elimination Low Fat

Low carb Low sodium No Dairy Gluten Free Other: _____

Do you have any food allergies or sensitivities? _____

How many meals do you eat a day? ___ How many meals do you eat out a week? ___

Would you describe yourself as a picky eater?_____ Do you cook? _____

Who does the grocery shopping?_____

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

Love to eat Fast easter Eat too much Binge Eating Late night

Dislike healthy foods Time constraints Travel Frequently Poor snack choices

Eat more than 50% of meals away from home Do not plan meals or menus

Don't care to cook Confused about nutrition advice Eat out of convenience

Emotional eater Eat too little under stress Eat too much under stress

The most important thing I should change about my diet to improve my health is:

_____

_____

List the three worst foods you eat during the average week:

1._____

2._____

3._____

List the three healthiest foods you eat during the average week:

1._____

2._____

3._____

Weight

Height (feet/inches) _____ Current Weight (lbs) _____ BMI _____

Usual weight range? +/- 5lbs _____ Desired weight range _____

Highest adult weight _____ Lowest adult weight _____

How often do you weigh yourself? ☐ Daily ☐ Weekly ☐ Monthly ☐ Rarely

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Stress

Do you feel like you have an excessive amount of stress in your life? _____

☐ Work ☐ Family ☐ Social ☐ Finances ☐ Health ☐ Other

Do you feel like you can easily cope with your stressors? _____

What are your coping mechanisms? _____

Psychosocial

Are you happy? _____ Do you feel your life has meaning and purpose? _____

Readiness Assessment

On a scale from 1-5, how willing 5 (very willing) to 1 (not willing) are you to make changes:

Significantly modify your diet	1.☐ 2.☐3.☐4.☐5.☐
Modify your lifestyle (i.e. sleep habits, stress reduction, etc).	1.☐ 2.☐3.☐4.☐5.☐
Engage in regular exercise	1.☐ 2.☐3.☐4.☐5.☐
Daily journal during your modifications	1.☐ 2.☐3.☐4.☐5.☐
Follow up regularly with your physicians	1.☐ 2.☐3.☐4.☐5.☐

How supportive do you think the people in your household will be to the above changes? 5 (very supportive) to 1 (not supportive) 1.☐2.☐3.☐4.☐5.☐

How confident are you of your abilities to make changes in your life and stick to them?

5 (very confident) to 1 (not confident) 1.☐2.☐3.☐4.☐5.☐

Please list your top biggest goals of this program?

1._____

2._____

3._____

4._____

5._____