Medical Nutrition Therapeutics LLC

Nutrition Intake Form

Please fill out this questionnaire prior to your appointment. This information will contribute to the development of a nutrition program based on your needs and current lifestyle habits. Please feel free to include any additional information that you feel might be relevant to your current situation.

Name _____

Intentions and goals for this consultation

_____

_____

Age _____ Date of Birth _____ Height _____ Current Weight _____

Do you have a weight range you want to work towards? _____

Have you ever had your body composition measured? ◯ Yes ◯ No

If yes, how was I it measured and what were your results? _____

Please provide information about your past medical history. Check all that apply.

◯ Diabetes ◯ Cardiovascular Disease ◯ Kidney Disease ◯ Irregular Menstruation

◯ High Cholesterol ◯ Cancer ◯ Digestive Disorder ◯ Pulmonary Disorder

◯ Orthopedic ◯ Neurological ◯ Osteoporosis ◯ Rheumatologic

◯ Other _____

Do you have any food allergies or intolerances? ◯ Yes ◯ No

If yes, please list_____

Do you take any vitamin, mineral or herbal supplements? ◯ Yes ◯ No

If yes, please list all supplements_____

Are you currently on any medication? ◯ Yes ◯ No

If yes, please list all medication_____

Please list your current exercise/physical activity patterns:

_____

_____

How do you personally view your health and current lifestyle patterns?

_____