Holistic Nutrition Intake Form - New Beginnings (Package #1)

Thank you for taking the time to fill out this form as well as the **Weekly Food Diary** in their entirety! Please be as detailed as possible as the information you provide will be used to create a customized plan to help address your identified nutritional goals. Please do your best to complete these forms **1 week** prior to your first appointment so we can make sure to have a fulsome discussion. If you have any questions or concerns, please contact me at nourishedawayoflife@gmail.com.

Thank you in advance and I look so forward to working with you on your journey towards increased health and wellness!

Client Information:

Name: _____

Full Address: _____

Primary Telephone Number(s): _____

Email Address: _____

DOB: _____

Gender: _____

Current Body Weight: _____

Height: _____

Marital Status: _____

Name of Significant Other: _____

Do you have any children? Yes ( ) No ( ). If yes, please list their names and ages.

_____

_____

_____

Primary Health Concerns and Goals:

- What are your main health concerns leading you to seek assistance from a Holistic Nutritionist? Ie. Food sensitivities, digestive difficulties, fatigue, skin issues etc.

Type to enter text

- Please list your **top 5** dietary and lifestyle goals to help focus our sessions! Ie.Learn about substitutions for dairy or otherwise, broaden my healthy recipe options or healthy ways to manage stress etc.

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Personal Health History

- Have you ever been diagnosed with a health issue or illness? Ie. Fatty Liver Disease, Stones, Celiac Disease etc. If yes, please provide details below:

Type to enter text

- List any family history (siblings, parents and/or grandparents) relating to health issues or illnesses.

Type to enter text

- Are you currently under the care of another health care practitioner(s)? If yes, please provide details below:

Type to enter text

- Please list any medications you are currently taking.

Medication Name	Dosage and Duration	Prescribed by?

- Please list any supplements, including herbal or homeopathic remedies, you are currently taking.

Supplement Name	Dosage and Duration	Prescribed by?

- Over the past 2 years, have you taken any antibiotics? If yes, please provide details below:

Antibiotic Name	Dosage/Duration	Prescribed by

- Do you have any silver-mercury fillings? Yes ( ) No ( )
- Do you have any tattoos? Yes ( ) No ( )
- Have you had surgery to remove any of the following:
  - ☐ Gallbladder
  - ☐ Appendix
  - ☐ Tonsils
- How often do you have bowel movements? _____
- Do certain foods impact the consistency and/or frequency your bowels movements? If yes, please provide details below:

Type to enter text

- Please describe the typical consistency of your bowel movements.
  - ☐ Separated hard lumps, hard to pass
  - ☐ Lumpy and sausage-shaped
  - ☐ Sausage shaped with cracks
  - ☐ Smooth sausage shaped
  - ☐ Soft blobs with clear edges
  - ☐ Mushy consistency
  - ☐ Watery, no solid pieces

Women's Health History (If male, please move to the Lifestyle section)

- Usual length of your menstrual cycle (ie. 28 days): _____
- How would you describe your typical cycle?
  - ☐ Irregular (early/too short)
  - ☐ Irregular (late/too long)
  - ☐ Regular
  - ☐ Irregular - all over the map
- How would you describe your typical mensural flow?
  - ☐ Light
  - ☐ Moderate
  - ☐ Heavy
- Do you experience pre-menstrual symptoms? If yes, please detail them below and include duration/intensity?

Type to enter text

- Do you experience menstrual pain?
  - ☐ No
  - ☐ Yes -before
  - ☐ Yes - during
  - ☐ Yes - after
- Are you currently taking birth-control medications? If yes, what type and for how long? _____

- Have you noticed any recent changes to your menses such as the frequency, duration, flow or PMS? If yes, please provide details:

Type to enter text

- Are you or could you be pregnant? Yes ( ) No ( ). If yes, what is your expected due date? _____

Lifestyle Overview

- Please describe any physical activities you are currently involved in:

Type to enter text

- What type of activities do you enjoy in your spare time?

Type to enter text

- How would you rate your current energy levels?

☐ Low
☐ Moderate
☐ High

- Please provide an overview of your current sleep habits. Make sure to elaborate on your typical bedtime, the length of your sleep, whether you wake in the night and if you feel rested upon waking:

Type to enter text

- What is your current occupation? _____
- What is the nature of your work? _____

_____

- What is your typical work schedule? _____
- How many hours do you spend sitting each day? _____
- Do you currently enjoy your workplace? _____
- Are you currently exposed to chemicals in your place of employment? If yes, please provide details below:

Type to enter text

- How long have you been employed in your current workplace and/or occupation?

_____

- How many hours are you spending in front of screens each day? _____
- How many minutes/hours do you turn off devices (including televisions) **before** bedtime? _____

- Are you currently taking recreational drugs? Yes ( ) No ( )

  If yes, how often and what type? _____

- Do you smoke? Yes ( ) No ( )

If yes, what is the frequency and duration? _____

- Do you drink alcohol? Yes ( ) No ( )

  If yes, how much are you consuming daily? _____

Emotional Health and Well-being

- How would you rate your current stress level?

☐ Low

☐ Moderate

☐ High

- What are the major causes of your stress? Please provide details below:

Type to enter text

- How do you generally deal with your stress? Please provide details below:

Type to enter text

- Would you describe yourself as an emotional eater? If yes, please provide details below:

Type to enter text

- Please describe any major life events over the past 5 or so years that may have negatively impacted your emotional well-being and/or physical well-being:

Type to enter text

- How might you describe your overall emotional well-being? Please comment on whether or not your emotional well-being is an area of concern for you.

Type to enter text

Dietary Habits and Preferences:

- What are some nutritional habits that you are particularly pleased with?

Type to enter text

- Dietary changes can often be overwhelming. What are some of the challenges you might face in reaching your nutritional goals?

- List 3 foods that you **love** eating. Please indicate how often you are consuming these foods.

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- Do you struggle with any ongoing food cravings? If yes, please provide details below:

Type to enter text

- How many main meals along with snacks are you consuming each day?

Type to enter text

- Do you have any dietary restrictions due to religious or cultural beliefs or for personal reasons (ie vegan)? If so, please provide details below:

Type to enter text

- Are there any foods that you are consuming regularly that you are absolutely not willing to part with? If yes, please identify type along with reason.

_____

- How many glasses of water do you consume each day? _____
- Do you consume any of the following beverages? If so, please rate the amount you are consuming: (0 = never, 1 = rarely, 2 = regularly, 3 = often)

  Caffeine:____ Fruit Juice (fresh): ____ Fruit Juice (concentrate): _____

  Milk: _____ (identify type ie. skim, 1% etc.) _____

  Herbal Tea: _____ Soda (diet): ____ Soda (regular): _____

- How might you describe your overall relationship with food?

Type to enter text

- Do you have any known food sensitivities and/or allergies? If yes, please identify them below:

Type to enter text

- Do you currently follow any specific "diets" and why? (ie. Paleo, Keto, Weight Watchers etc.). OR have you tried any diets in the past and, I so, what was your experience?

Type to enter text

- Please provide an overview of your skill in the kitchen. Please include details such as your interest in cooking, how much time you have to cook and eat prep as well as whether you cook for yourself or also for others.

Type to enter text

- Do you have any interest in learning more about body cleansing and overall detoxification in the future? Yes ( ) No ( ).
- Do you have any interest in learning more about our Metabolic Reset Program offered at the beginning of each new year in the month of January? Yes ( ) No ( ).

Thank you so much for taking the time to complete both the **intake form for Package #1 - New Beginnings** along with the **Weekly Food/Beverage Diary**. As mentioned previously, all of the information you provide is absolutely essential to helping me create a customized plan for us to discuss at our first session!

Yours in Health,

Amanda McIlhone