E Nutrition
Your online nutritionist

Nutritional Intake Form

Name: _____ **Date**: _____

Date of Birth: (mm/dd/yy)_____ ☐ **Male** ☐ **Female**

Address: _____

Home Phone: _____ **Cell Phone**: _____

Email: _____ **Occupation**: _____

How did you hear about us?_____
(Health Care Provider, Friend, Newspaper, Website, etc)

Preferred method for reminder calls: Call Text Email
(Please Circle One)

Family Doctor: _____ Number: _____

Emergency Contact:

Name: _____ Relation: _____

Home Phone Number: _____ Work Phone Number: _____

Please list your main health goals and/or concerns:

1. _____
2. _____
3. _____

Please list any major surgeries, illness or traumas from the past 5 years:

1. _____
2. _____
3. _____

Medication and Supplements: Please list all current medications, supplements, vitamins, minerals, herbs or homeopathic remedies, along with daily dosages, length of use, reasons for taking and any side effects you may be experiencing.

Medications	Dose/Day	How Long?	Reason for Medication	Side Effects
1.				
2.				
3.				
4.				

Supplements	Dose/Day	How Long?	Reason for Medication	Side Effects
1.				
2.				
3.				
4.				

In the last 5 years how many **courses of antibiotics** have you taken? _____

Your Medical History

Please indicate whether you have any allergies or sensitivities:_____
(Medicines, Environmental, Food, Other)

Have you ever been exposed to toxic chemicals, solvents, sprays, pesticides, herbicides, heavy metals while at work, home or travelling?
If yes, please indicate what type and when this occurred:_____

How often do you have a bowel movement?_____

Please check all boxes below that apply to you:

☐ Diabetes	☐ Chronic Ear Infections	☐ Unexplained weight loss/gain	☐ Asthma/Bronchitis
☐ Thyroid Condition	☐ Tonsils Removed	☐ Cancer Type:_____	☐ Anxiety/Nervousness
☐ Chronic Fatigue	☐ Multiple Sclerosis	☐ Headaches	☐ Stroke
☐ Alcoholism	☐ Seizures/Epilepsy	☐ Cold Sores	☐ Tuberculosis
☐ Liver Disease	☐ Depression	☐ Double Vision	☐ Numbness/Tingling
☐ Varicose Veins	☐ Drug Addiction	☐ Arthritis	☐ Nausea/Vomiting
☐ Bloating/Gas	☐ Mental Illness	☐ Gallbladder Problems	☐ Kidney Disease
☐ Crohn's or Colitis	☐ Hypertension	☐ Loss of Balance/Coordination	☐ Bladder Infections
☐ Ulcers	☐ Heart Disease	☐ Dizziness	☐ Muscle Cramps/Spasms
☐ Eczema	☐ High/Low Blood Pressure	☐ High Cholesterol	☐ Osteoporosis
☐ Sinus Problems	☐ Alzheimer's Disease	☐ Diarrhea	☐ Poor Concentration
☐ Chronic Sore Throat	☐ Parkinson's Disease	☐ Constipation	☐ Other:_____
☐ Candida/Leaky Gut	☐ Digestive Problems	☐ Night Sweats	☐ Asthma/Bronchitis

Female Clients

Are you currently trying to get pregnant? ☐ yes ☐ no
Are you pregnant? ☐ yes ☐ no If yes, how far along are you? _____

Are you pre-menopausal or menopausal? ☐ yes ☐ no
If yes, please list any symptoms your experiencing: _____

Current Dietary Habits

How many meals do you eat daily?_____ Snacks?_____

Please give examples of typical meals for:

Breakfast:_____

Lunch:_____

Dinner:_____

Snacks:_____

Do you experience symptoms after eating or if meals are missed? Please explain:_____

Please check any of the boxes below if you regularly eat, drink or use the following?

☐ Margarine	☐ Fast Foods	☐ Fruit Juice	☐ Red Meat
☐ Candy	☐ Sweetners such as Aspartame	☐ Milk	☐ Tap Water
☐ Fried Foods	☐ Beer	☐ Soft Drinks	☐ Filtered/Purified Water
☐ Processed Foods	☐ Wine	☐ Cigarettes	☐ Baked Goods
☐ Luncheon Meats	☐ Spirits	☐ Recreational Drugs	☐ Coffee

Lifestyle

What do you currently do for exercise?_____

What is the frequency of these activities?_____

On average how many hours of sleep do you get a night?_____ Do you wake feeling rested?_____

Please rate your stress level: 1 2 3 4 5 6 7 8 9 10
Minimal High

Do you currently have a coping mechanism for stress?_____

What are your favorite hobbies?_____

Client Statement

I _____understand and acknowledge that the services provided are at all times restricted to consultation on the subject of health matters intended for general well-being and are not meant for the purpose of medical diagnosis, treatment, or prescription of medicine for any disease, or any licensed or controlled act which may constitute the practice of medicine. The statement below is being signed voluntarily.

Cancellation Policy: Please note that bookings for practitioners must be cancelled a minimum of 24 hours prior to appointments. For late cancellations or missed appointments, 50% of the session will be charged.

Signature_____ Date_____