collective HEALTHCLINIC

Nutrition Intake: Initial Assessment

Name: Date:
Date of birth:

Have you seen a nutritionist before: _____

Experience:_____

Primary Health Goals:_____

Biggest Obstacle:_____

How is nutrition related to health in your opinion:

Supplements:_____

Medications:_____

Food Allergies/Sensitivities:_____
_____
_____

Bowels: Regular (1x/day) Constipated Loose Stools

Alcohol:# drinks in a week_____ Caffeine: #drinks in a day_____

Smoking: # smokes a day_____

Exercise/Activity: explain what you do in a week:
_____
_____

What exercise do you focus on:_____

How much water in mL:_____

Do you cook:_____ Eat out: How often_____

Stress level (between 1-10 (10 being highest stress) and cause:

_____

Sleep Patterns:_____

Job/Occupation:_____

What is motivating you to change today:

_____

Vacation or Special Events coming up:_____

Only if applicable:

Height:_____ BMI:_____

Weight:_____ Body Fat %:_____

Final Goal:_____

Eating Schedule:

Breakfast:_____

Snack:_____

Lunch:_____

Snack:_____

Dinner:_____

Snacks:_____

Sweet:_____ Salty:_____ Carbs:_____

e: _____