sbnutrition

Health History and Nutrition Intake Form

Name:
Age:
Height:
Weight:
Any weight changes over last year?
Primary (referring) doctor:

What are your goals for our meeting today?

1.
2.
3.

HEALTH:

Medical Conditions: (please list if applicable)

Medications/Supplements: (list name/dosage/frequency)

GENERAL NUTRITION:

Food Allergies/Intolerances: (please list foods and symptoms experienced)
How would you rate your current eating habits on a scale of 1-10? (1= horrible; 10= perfect) :
Do you do your own grocery shopping?
What grocery stores do you shop at?

Do you prepare your own meals?
Do you buy any specialized foods (i.e. organic, vegetarian, etc.)?
Do you read food labels? If so, what do you look for on the label?
How often do you dine out in restaurants?
Per day?
Per week?
What type of restaurants do you frequent (i.e. coffee shops, fast foods, ethnic cuisine)?
How much fluid (per 8 ounce glass) do you drink daily?
What type of fluids do you drink?
Do you drink coffee, tea, caffeinated beverages?
How many cups per day?

EXERCISE NUTRITION (if applicable):

Do you use erogenic agents when exercising (i.e. sport drinks, bars, gels, etc.)?
If yes, what types? How much?

How much fluid do you drink?

Before exercise?
During Exercise?
After Exercise?

FITNESS/EXERCISE:

Fitness Level(please circle):	Inactive	Recreational	Competitive
Do you have any races/events you want to train for?			
Please list your daily fitness regimen:			
(Include type of exercise performed, duration and time of day you exercise)			
Total Hours of Exercise per day:			
Total Hours of Exercise per week:			

Current Eating Pattern

Please list the times, types of foods and drinks (including amounts) you consume during a typical day:

Time:	Meal/Snack (circle one) List Foods Consumed:
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