Nutrition Pre-intake Form

Please fill this form prior to your appointment. This information will contribute to the development of a nutrition plan based on your needs and current lifestyle habits.

Name ____Date of Birth____________________

Home Address____________________________City__________________Postal Code__________________

Cell phone__________________Home phone__________________Work phone_________________________

Best number to call you at? ________ May I can leave a voice message on these numbers? ☐Yes ☐No

Email____

Primary Health Care Provider: Name and phone number____

Referred by: ____

Are you currently working outside the home? If so, what is your occupation? ____________________________

Have you seen a registered dietitian in the past? If yes, when and why? _______________________________

What do you expect from me as your dietitian?

What are your goals at this time? What do you want to change? Tell me a little bit about what some of your health goals might be?

☐ weight loss ☐ improved eating habits ☐ improved exercise habits ☐ reduced use of medications
☐ Improved cardiac function ☐ lower cholesterol ☐ improved blood sugars ☐ improved blood pressure
other____

Of all the above goals, which one feels most important/urgent?
Why?____

If you were to achieve those goals, how do you think it would improve your quality of life?

____

(Chart with following) Have you ever been diagnosed with any of the following:

Do any family members have any of the following health conditions:

☐ Diabetes ☐ High Blood Pressure ☐ High Cholesterol ☐ Sleep apnea ☐ Obesity ☐ Eating Disorder

☐ Mental Health (anxiety/depression) Other____

Health Behaviour History

How long have the identified health behaviours been an area of challenge?

____

Have you tried anything in the past to change your habits, your health, your eating and/or your body? If so,explain____

____

Which of those things worked well for you?

____

Which of those things didn't work well for you?

____

What makes now a good time to engage in lifestyle behaviour change?

____

Until now, what has blocked you or held you back from changing these things?

____

How COMMITTED are you to change your behaviours and habits?

Not at all ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10 Completely

How CONFIDENT are you to changes your behaviours and habits?

Not at all ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10 Completely

How MOTIVATED are you to change your behaviours and habits?

Not at all ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10 Completely

Social Support

Current living situation (who lives with you): ____

Do you have children? If yes, how many and what are their ages?

____

Nutrition History

What is your current weight?________ Height__________

Have you had any recent history of weight gain or loss?____

What do you think is your "best" weight?____

Do you follow a particular diet? ____

Do you avoid certain food? Please list____

Do you have any especially strong cravings? If so, what are they?____

What are your food likes or dislikes? ____

Do you have any food allergies or intolerances ☐Yes ☐No If Yes, please indicate

____

Do you take any vitamin, mineral or herbal supplements? ☐Yes ☐No If yes, please list all supplements ____

How many meals do you eat out? ____

What type of eating establishment do you frequent?_____________________________________

(chart) What was your food intake yesterday?

Food/drink	Amount	Method of Preparation	Location	With Whom

Lifestyle Information

What types of activities and/or movements do you engage in?

____

Approximately, how many minutes/hours per week? ____________________________________

How much alcohol do you consume on a weekly basis? _________________________________

Other substances?____

Do you smoke? ☐Yes ☐No

How many hours of sleep do you get on an average weeknight? __________ Weekend? ___________

Do you wake up feeling rested? ____

Do you find yourself having trouble falling asleep or staying asleep?
Explain ____

Do you do anything to help you fall asleep? If so, Explain

____

Do you have a C-Pap machine? If so, how often do you use it? ___________________________

How stressful would you rate your current life situations?
Not at all ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10 Very

What other information would you like to let me know?

____

____

Please read and sign:Signature_____________________________ Today's Date _________________

Thank you for taking your time to complete this form. I look forward to meeting with you soon!