

THE FAMILY WELLNESS CENTER

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Nutrition Coaching Intake Form

Please return this form prior to your first visit.

Name _____	Date of first visit _____
Address _____	City/State/Zip _____
Phone # (home) _____	(work) _____ (cell) _____
Email _____	
Age _____	Date of Birth _____
Gender: female _____ male _____	
Single _____ Married _____ Separated _____ Divorced _____ Widowed _____ Partnership _____	
Live with: Spouse _____ Partner _____ Parents _____ Children _____ Friends _____ Alone _____	
Occupation _____ Employer _____	
Emergency Contact _____ Phone _____	
How did you hear about our center? _____	

Reason for Visit:

What are your most important health concerns? List in order of importance:

- 1) _____
- 2) _____
- 3) _____
- 4) _____
- 5) _____

Please describe any important events which may have contributed to any of the above problems:

If you have seen other practitioners for these problems, indicate when and for how long, along with the results of these evaluations or treatments: _____

Please list 3-5 goals regarding what you hope nutrition counseling will help you achieve.

Please list all conditions currently monitored by a health care provider:

Are any activities affected by your health concerns: family time ____ social time ____ sleep ____
work ____ fitness ____ recreational activities ____ bathing ____ other _____

Height _____ Weight _____ Max Weight _____ When _____ Goal Weight _____

Current Medications

Name	Dosage	For What?

Current Nutritional Supplements (such as vitamins)

Name	Dosage	For What?

List any Allergy or Reactions to Medications or Supplements (List type of reaction)

List Hospitalizations and Surgeries

List Current Specific Diets you Follow (Vegetarian, Mediterranean, Paleo, Keto, IMF, etc)

Eating Behaviors (Describe mealtime and snack patterns)

Food Allergies and Sensitivities

___ Wheat Allergy ___ Dairy Allergy ___ Nut/Peanut Allergy

___ Wheat Sensitivity ___ Dairy Sensitivity ___ Sugar Sensitivity

Other _____

Any foods you will not give up? _____

Who does the grocery shopping? You ___ Family Member ___ Friend ___ Other ___

Eat out? Yes ___ No ___ If so, how often? Daily ___ Weekly ___ Bi-Weekly ___ Monthly ___

Where? _____

Do you prepare your own food? Yes ___ No ___ Do you enjoy cooking? Yes ___ No ___

Tobacco:

Do you currently Smoke? _____ Chew? _____ Vape? _____

If yes to either, how much daily and for how long have you been doing so? _____

If no, did you ever smoke or chew/for how long/when did you stop? _____

Drug Use:

Do you use Medical Marijuana? _____ If yes, how often? _____

Do you use recreational drugs? _____ If yes, type and frequency _____

Have you ever been treated for substance abuse? ___ If yes, where and when _____

Movement:

Do you currently exercise? _____ If yes, please explain your routine _____

Sleep:

Average number of hours per night: _____ Fall asleep easily? Yes _____ No _____

Wake often during the night? Yes ___ No ___ Wake up feeling rested? Yes _____ No ___

Do you now or have you ever worked the night shift? Yes _____ No _____

For the following list, please circle

Y=a condition you have now P=a condition you had in the past N=never had the condition

MENTAL/EMOTIONAL

Treated for emotional problems	Y P N	Depression	Y P N
Mood Swings	Y P N	Anxiety or nervousness	Y P N
Tension	Y P N	Memory problems	Y P N
Poor concentration	Y P N	Seasonal depression	Y P N

ENDOCRINE

Hypothyroid	Y P N	Heat or cold intolerances	Y P N
Hypoglycemia	Y P N	Diabetes	Y P N
Excessive thirst	Y P N	Excessive hunger	Y P N
Fatigue	Y P N		

CARDIOVASCULAR

Heart disease	Y P N	Fainting	Y P N
High/Low blood pressure	Y P N	Palpitations/Fluttering	Y P N
Blood clots	Y P N	Chest pain	Y P N

GASTROINTESTINAL

Trouble swallowing	Y P N	Heartburn	Y P N
Change in appetite	Y P N	Ulcer	Y P N
Nausea	Y P N	Vomiting (illness or induced)	Y P N
		Bowel Movements: How Often? _____	
		Is this a change? _____	
Blood in stool	Y P N	Constipation	Y P N
Pain or cramps	Y P N	Diarrhea	Y P N
Belching or passing gas	Y P N	Gall Bladder disease	Y P N
Black stools	Y P N	Liver Disease	Y P N
Jaundice (yellow skin)	Y P N		

On the table below, please indicate if you or a family member has had any of the following now or in the past, along with years affected if known:

Self	Specified Relative	Disease
		Alcoholism
		Anemia
		Anorexia
		Arthritis
		Asthma
		Binge Eating
		Bulimia
		Cancer
		Compulsive overeating
		Crohn's disease/colitis
		Depression
		Diabetes
		Food Allergies or Sensitivities
		Heart Disease
		Hepatitis
		Herpes
		High Blood Pressure
		High Cholesterol
		HIV
		Hypoglycemia
		Irritable bowel syndrome
		Kidney disease
		Lupus
		Lyme disease
		Mental illness
		Migraine Headaches
		Multiple Sclerosis
		Stomach/Intestinal Ulcers
		Stroke
		Substance Abuse
		Thyroid disease

Food Frequency List

Please record how frequently you consume the following items by checking off the appropriate columns and indicating specific types and comments.

	More than once per day	Once daily	A few times/week	A few times/month	Once per month	A few times per year	Do not consume	Types & comments
BEVERAGES								
Alcohol								
Coffee								
Decaf coffee								
Soda								
Diet soda								
Green or Herbal Tea								
Iced Tea								
Sweetened beverage								
Diet sweetened beverage								
Energy Drinks								
Juice								
Water (# of oz?)								
PROTEINS								
Beef								
Chicken								
Turkey								
Pork								
Ham								
Fish								
Seafood								
Eggs								
Tofu								
GRAINS								
Whole grain breads								
White/wheat bread								
Cereal								
Pasta								
Rice								
Oatmeal								
Other grains								

	More than once per day	Once daily	A few times/week	A few times/month	Once per month	A few times per year	Do not consume	Types & comments
FATS								
Butter								
Margarine								
Fried foods								
Nut butters								
Nuts/seeds								
Avocado Oil								
Canola/Vegetable Oil								
Coconut Oil								
Olive Oil								
Other oil								
Mayonnaise								
Salad Dressing								
DESSERTS								
Cake								
Cookies								
Pie								
Ice cream								
Frozen yogurt								
Candy								
Chocolate								
Pastry/Donut								
Diet or artificially sweetened desserts								
Other desserts								
FIBER								
Beans, legumes, Lentils								
Fresh or frozen fruit								
Canned fruit								
Dried fruit								
Fresh vegetables								
Frozen vegetables								
Canned vegetables								
Leafy greens								

	More than once per day	Once daily	A few times/week	A few times/month	Once per month	A few times per year	Do not consume	Types & comments
MISCELLANEOUS								
Diet Foods								
Frozen dinners								
Diet frozen foods								
Pizza								
Sugar subs – artificial sweeteners								
Stevia								
Soy products								
Vegetarian alternatives								
DAIRY								
Cow's milk								
Cheese								
Plain yogurt								
Sweetened yogurt								
Goat Milk or Cheese								
Milk Alternative								
SNACK FOODS								
Chips								
Pretzels								
Tortilla chips								
Popcorn								
Crackers								
Other snack foods								
Granola Bars								
Protein Bare								
EATING OUT								
Restaurant Foods								
Take outs								
Fast foods								

If you compulsively overeat, what foods are you most likely to consume during such episodes?

Do you experience food cravings? If yes, explain.

Please complete the attached 4 day food diary and bring to first visit.

Primary Health Care Provider

Name _____

Address _____

City/State/Zip _____

Phone _____ Fax _____

Do you give The Family Wellness Center permission to consult with my health care provider regarding your health and treatment. Yes _____ No _____

Signature _____ Date _____

Consent to Treat: I, the undersigned, have voluntarily applied for and agree to participate in treatment at The Family Wellness Center at Briarsdale. Nutrition Coaching is not intended to be a substitute for professional medical advice, diagnosis, or treatment. Always seek the advice of your physician or other qualified health provider with any questions you may have regarding a medical condition.

The ultimate responsibility of the fees is that of the undersigned client. **CLIENTS ARE REQUESTED TO PROVIDE 24 HOUR NOTICE OF CANCELLATION. WITHOUT SUCH NOTICE CLIENTS WILL BE BILLED FOR THE PROFESSIONAL TIME AT THE REGULAR HOURLY RATE.**

Your signature indicates your understanding and acknowledgement of the foregoing information.

Signature _____ Date _____

**Thank you for completing this comprehensive intake form
so we may better serve you and use our time together wisely.**

Woman Only

Onset of Menes (age) _____ First day of last Menstrual Period _____

Number of Pregnancies _____ Number of Children _____ Ages of Children _____

Complications with Pregnancies _____

Abortions/Miscarriages? _____

Use Contraceptive? Yes _____ No _____ If yes, what type and how long? _____

Experiencing Peri-Menopause? Yes _____ No _____ Post-Menopause? Yes _____ No _____

Any Complications with Menopause _____