THE FAMILY WELLNESS CENTER

1000 Briarsdale Rd Suite A, Harrisburg, PA 17109 717-558-8500 feelalive@thefamilywellnesscenter.com

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?_____	
Blood in stool	Y P N	Is this a change?_____	
Pain or cramps	Y P N	Constipation	Y P N
Belching or passing gas	Y P N	Diarrhea	Y P N
Black stools	Y P N	Gall Bladder disease	Y P N

Jaundice (yellow skin) Y P N Liver Disease 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 _____

_____