# THE FAMILY WELLNESS CENTER

1000 Briarsdale Rd – Suite A Harrisburg, PA 17109 717-558-8500 (fax) 717-558-8567

## Nutrition Counseling 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_____

How did you hear about our center? _____

Emergency contact: Name _____ Relationship _____ Phone_____

Primary Care Provider: Name _____ Phone_____

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.

_____

_____

_____

Height _____Weight _____Max weight & when _____Goal Weight_____

For the following, 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 |

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 |

Hospitalizations and Surgeries (types and dates):

_____

_____

_____

Current Medications:

| Name | Dosage | For what? |
|---|---|---|
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |

Nutritional Supplements (such as vitamins):

| Name | Dosage | For what? |
|---|---|---|
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |

Please list any medications/supplements you may have an allergy/reaction to and the type of reaction:_____
_____

Tobacco:

Do you currently smoke?_____ Do you currently chew? _____
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? _____
_____

Recreational Drug Use:

Type and frequency_____
Have you ever been treated for substance abuse. If yes, where and when_____
_____

Exercise:

Do you currently exercise? If yes, please explain. _____
_____

Sleep:

Average amount of sleep per night: _____
Do you fall asleep easily? Y or N Do you wake often during the night? Y or N
Do you wake up feeling rested? Y or N

Method of payment for first visit_____

Consent for Treatment: I, the undersigned, have voluntarily applied for and agree to participate in treatment at The Family Wellness Center at Briarsdale. The ultimate responsibility of the fees is that of the undersigned client. **CLIENTS ARE REQUESTED TO PROVIDE 24 HOURS 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.

Please sign your name _____Date_____

## Nutrition Intake – Food Frequency List

Name:_____ Date:_____

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**<br>Alcohol | | | | | | | | |
| Coffee | | | | | | | | |
| Decaf coffee | | | | | | | | |
| Soda | | | | | | | | |
| Diet soda | | | | | | | | |
| Green Tea | | | | | | | | |
| Herbal Tea | | | | | | | | |
| Iced Tea | | | | | | | | |
| Sweetened beverage | | | | | | | | |
| Diet sweetened beverage | | | | | | | | |
| Juice | | | | | | | | |
| Water (# of oz?) | | | | | | | | |
| | | | | | | | | |
| **PROTEINS**<br>Beef | | | | | | | | |
| Chicken | | | | | | | | |
| Turkey | | | | | | | | |
| Pork | | | | | | | | |
| Ham | | | | | | | | |
| Fish | | | | | | | | |
| Seafood | | | | | | | | |
| Eggs | | | | | | | | |
| Tofu | | | | | | | | |
| | | | | | | | | |
| **GRAINS**<br>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**<br>Butter | | | | | | | | |
| Margarine | | | | | | | | |
| Fried foods | | | | | | | | |
| Nut butters | | | | | | | | |
| Nuts/seeds | | | | | | | | |
| Olive/Canola Oil | | | | | | | | |
| Other oil | | | | | | | | |
| Mayonnaise | | | | | | | | |
| Salad Dressing | | | | | | | | |
| | | | | | | | | |
| | | | | | | | | |
| **DESSERTS**<br>Cake | | | | | | | | |
| Cookies | | | | | | | | |
| Pie | | | | | | | | |
| Ice cream | | | | | | | | |
| Frozen yogurt | | | | | | | | |
| Candy | | | | | | | | |
| Chocolate | | | | | | | | |
| Pastry/Donut | | | | | | | | |
| Diet or artificially sweetened desserts | | | | | | | | |
| Other desserts | | | | | | | | |
| | | | | | | | | |
| | | | | | | | | |
| **FIBER**<br>Beans or legumes | | | | | | | | |
| 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**<br>Diet Foods | | | | | | | | |
| Frozen dinners | | | | | | | | |
| Diet frozen foods | | | | | | | | |
| Pizza | | | | | | | | |
| Sugar subs – artificial sweeteners | | | | | | | | |
| Organic products | | | | | | | | |
| Soy products | | | | | | | | |
| Vegetarian alternatives | | | | | | | | |
| | | | | | | | | |
| **DAIRY**<br>Cow's milk | | | | | | | | |
| Cheese | | | | | | | | |
| Plain yogurt | | | | | | | | |
| Sweetened yogurt | | | | | | | | |
| Artificially sweetened yogurt | | | | | | | | |
| Milk Alternative | | | | | | | | |
| | | | | | | | | |
| **SNACK FOODS**<br>Chips | | | | | | | | |
| Pretzels | | | | | | | | |
| Tortilla chips | | | | | | | | |
| Popcorn | | | | | | | | |
| Crackers | | | | | | | | |
| Other snack foods | | | | | | | | |
| | | | | | | | | |
| **EATING OUT**<br>Restaurant Foods | | | | | | | | |
| Take outs | | | | | | | | |
| Fast foods | | | | | | | | |
| | | | | | | | | |
| | | | | | | | | |
| | | | | | | | | |

Are you currently following any special dietary guidelines, including vegetarianism/veganism? If yes, please explain.

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

Do you experience food cravings? If yes, explain.

Please record an example of one day of what you usually eat, indicating approximate ***time***, ***location***, ***food item***, and ***amount*** from getting up in the morning until going to bed. If your intake varies from day to day please list two days.