Nutrition Housecalls
11419 NE 100th Street
Kirkland, WA 98033
(206) 604-5239

New Client Intake Form

Date: ___/___/____

CLIENT INFORMATION

Last Name	First Name	Middle Initial
Address (street, city, state, zip)		
Phone (Home)	Phone (Work/Cell)	E-mail

Gender	Birth Date	Age	Height	Weight	Occupation

Do you have children? ☐ Yes ☐ No If so, how old are they?

Are you pregnant? ☐ Yes ☐ No If so, when are you due?

Do you see a medical doctor, naturopath or other medical provider? If so, please provide their name(s):

I. GOALS

A. Please list your major health goals:

1) _____

2) _____

3) _____

II. FAMILY HISTORY

Has anyone in your family, *including yourself*, grandparents, parents and siblings, been diagnosed with any of the following conditions? If yes, please indicate who and age at which they were diagnosed.

	Yourself	Relative	Age diagnosed
☐ AIDS/HIV+			
☐ Arthritis (osteoarthritis)			
☐ Autoimmune condition (Lupus, RA)			
☐ Cancer			
☐ Cardiovascular Disease (incl. heart attack)			
☐ Digestive disorder (colitis, Crohn's, Celiac, etc.)			
☐ Diabetes			
☐ Hypoglycemia/hyperglycemia			
☐ High blood pressure (hypertension)			
☐ High cholesterol			
☐ Kidney disease or failure			
☐ Liver disease/hepatitis			
☐ Osteoporosis			
☐ Pulmonary disease (incl. asthma)			
☐ Thyroid issues (hypo- or hyperthyroid)			
☐ Other			

III. PERSONAL HISTORY

A. MEDICATIONS: It is very important that we are aware of any medications, including over-the-counter medication, you are taking (such as Tylenol, Advil, etc.). Please specify the medication, the reason why you are taking it and the dosage/frequency:

Please list all supplements that you take, including manufacturer/brand and dose:

Do you have any allergies? If so, please specify:

Medications:

Foods:

Environment (trees, dust, pollen, etc.):

Chemicals (perfumes, cigarette smoke, cleaning supplies, etc.):

B. INJURIES/SURGERIES/HOSPITALIZATIONS: Please list any present/past injuries, surgeries or hospitalizations and approximate date(s):

C. DIABETES INFORMATION: Please answer the following questions if you have diabetes:

Do you check your blood sugar? □ Yes □ No If so, how often? _____

What are your typical blood sugar levels? _____

What was your most recent HbA1c level (example: 6.5)? _____ When was that test taken? _____

How well do you think you are managing your diabetes?

D. REVIEW OF SYSTEMS

1. HEAD & NECK (check all that apply)

- ☐ Significant hair loss
- ☐ Dry hair or scalp
- ☐ Headaches or migraines (circle one or both): If yes, please include frequency, intensity, treatments used, time of day, and known triggers _____
- ☐ Night blindness
- ☐ Macular degeneration
- ☐ Dark circles under eyes
- ☐ Post nasal drip
- ☐ Frequent nose bleeds
- ☐ Sinus congestion
- ☐ Bleeding gums or loose teeth
- ☐ Cracked lips &/or swollen, red tongue
- ☐ Bad breath
- ☐ Goiter (diagnosis of enlarged thyroid)
- ☐ Other: _____

2. CARDIOVASCULAR (check all that apply)

- ☐ Poor circulation
- ☐ Diagnosis of anemia
- ☐ Electrolyte imbalance
- ☐ Chest pain or palpitations
- ☐ Arrhythmia
- ☐ Edema
- ☐ Bruise easily
- ☐ Other conditions not mentioned here or on page 1 of application: _____

3. RESPIRATORY (check all that apply)

- ☐ Asthma
- ☐ COPD
- ☐ Difficulty breathing
- ☐ Emphysema
- ☐ Frequent colds/flu
- ☐ Other: _____

4. GASTROINTESTINAL (check all that apply)

- ☐ Constipation
- ☐ Diarrhea
- ☐ Gallstones
- ☐ Hepatitis
- ☐ Hemorrhoids
- ☐ Hernia
- ☐ Indigestion/pain
- ☐ Abdominal cramping
- ☐ Blood, mucous, undigested food in stool
- ☐ Nausea/vomiting
- ☐ Excessive fullness after eating
- ☐ Excessive gas
- ☐ Bloating
- ☐ Reflux/GERD
- ☐ Very sensitive to chemicals/perfumes
- ☐ Sleepy after meals
- ☐ Problems with fatty foods
- ☐ Sugar cravings
- ☐ Gluten sensitivity/wheat allergy
- ☐ Other: _____

5. UROGENITAL (check all that apply)

- ☐ Frequent UTI
- ☐ Excess urination
- ☐ Decreased or insufficient urination
- ☐ Unusually colored urine
- ☐ Painful urination
- ☐ History of prostate cancer

Females only:

- ☐ Currently pregnant
- ☐ Trying to get pregnant
- ☐ Currently past menopause
- ☐ Currently perimenopausal
- ☐ Irregular menstrual cycles

Length of menstrual cycle _____ days

Duration of menses _____ days

- ☐ Other: _____

6. SKIN (check all that apply)

- ☐ Dry flaky, scaly skin
- ☐ Greasy, scaly skin
- ☐ Unusual skin rash
- ☐ Delayed wound healing
- ☐ Itching
- ☐ Hives
- ☐ Eczema
- ☐ Other: _____

7. MUSCULOSKELETAL AND NEUROLOGICAL (check all that apply)

- ☐ Frequent fractures
- ☐ Diagnosis of osteoporosis
- ☐ Numbness in extremities
- ☐ Persistent tremors
- ☐ Mental confusion or memory loss
- ☐ Swollen or painful joints
- ☐ Fainting
- ☐ Depression
- ☐ Other _____

E. LIFESTYLE

How would you rate your overall level of stress (0= no stress; 10=overwhelming stress): _/10

How would you rate your overall level of energy (0=exhausted; 10=very high energy): ___/10

How many hours of sleep do you get each night? _____Do you feel rested upon waking? Yes / No

Do you exercise? Yes No

If so, please describe: _____

Nutrition	Please circle the answers that best describe you		
I eat while involved in other activities (watching TV, reading, writing, working, etc.)	Often	Sometimes	Rarely/Never
I eat when I'm bored, upset, lonely, angry, anxious/worried	Often	Sometimes	Rarely/Never
I eat past point of being full or eat large amounts of foods quickly	Often	Sometimes	Rarely/Never
My thoughts of food, weight or body image affect my quality of life	Often	Sometimes	Rarely/Never
I wait until I'm extremely hungry to eat	Often	Sometimes	Rarely/Never
I hide the food I eat (or the amount I eat) from others	Often	Sometimes	Rarely/Never
I eat the same foods every day	Often	Sometimes	Rarely/Never
I skip meals. If so, please specify why: _____	Often	Sometimes	Rarely/Never
I feel irritable, lightheaded, low energy, nauseous or get a headache when I don't eat	Often	Sometimes	Rarely/Never
I eat in my car, standing up, in front of the fridge	Often	Sometimes	Rarely/Never
I crave refined carbohydrates (sugar, candy, pastries, chips, crackers, bread, pasta, etc.)	Often	Sometimes	Rarely/Never
I use sugar and/or caffeine in foods and drinks to give me a lift if I'm low on energy	Often	Sometimes	Rarely/Never
I consume artificial sweeteners (Splenda, Nutrasweet, aspartame, saccharin, etc.)	Often	Sometimes	Rarely/Never
I have a history of taking antibiotics	Often	Sometimes	Rarely/Never

If you smoke, please specify: _____ packs/day for _____ years

If you're a past smoker, when did you quit? _____

Are you a vegan or vegetarian? ☐ Yes ☐ No If so, please specify: _____

How much water do you drink? ____glasses/day **or** _____ounces/day

Do you drink soda? ☐ Yes ☐ No If so, please specify brand/amount/frequency: _____

Do you drink coffee? ☐ Yes ☐ No If so, please specify type (latte, drip, etc.), amount & frequency: _____

Do you drink alcohol? ☐ Yes ☐ No If so, please specify type/amount/frequency: _____

Please specify any other beverages that you drink (juice, sports drinks, tea, etc.): _____

How many meals do you eat per day? ____meals/day How often do you snack? _____snacks/day

Do you prepare your own meals? ☐ Yes ☐ No

How much time do you have on a daily basis to prepare your meals? _____

Where do you shop for food? _____

List any specific food cravings you experience: _____

What are your favorite foods? _____

Which foods do you dislike (if any)? _____

Are there any foods that give you headaches, stomachaches or other symptoms? _____

What is it that YOU think holds you back from being healthy, in great shape, losing weight, etc?

_____

If your goal involves weight loss, list any diets/programs that you have tried in the past (and please specify if you are currently following a diet):

_____

I certify that the above statements are true and complete. If any information changes (especially related to my medication, medical symptoms or a diagnosis), I agree to inform Nutrition Housecalls of those changes as soon as possible.

_____ _____

Client's Signature Date