

Nutrition Intake Form

Please help us provide you with a complete evaluation by taking the time to fill out this questionnaire carefully. All of your information is confidential.

Personal Identifying Information and Contact

Legal Name		Preferred Name
Age	Date of Birth (mm/dd/yyyy)	Sex and/or Gender Identity
Street Address		City, State, and Zip Code
Preferred Phone Number		May we leave a message here? Check: <input type="checkbox"/> YES or <input type="checkbox"/> NO
Preferred Email Address		

Emergency Contact Information

Name	Relationship to You
Preferred Contact Information	

Medical Providers & Referral Information

Primary Care Physician or Referring Physician	Phone Number
Street Address	City, State, and Zip Code

What do you hope to achieve during your visit with a nutritionist?:

What are your top three health/nutrition concerns or symptoms?:

1.

2.

3.

Family History Please list any family history of the following: heart disease, high blood pressure, stroke, overweight, diabetes, cancer, lung disease, kidney disease, mental illness, addiction, etc.:

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Medical History: Please note health conditions you have currently or in the past. Write "C" for current and "P" for past.

- | | |
|---|---|
| <input type="checkbox"/> Acne | <input type="checkbox"/> GI Condition: _____ |
| <input type="checkbox"/> Addiction _____ | <input type="checkbox"/> GERD/Heartburn |
| <input type="checkbox"/> ADD/ADHD/Executive Function Disorder | <input type="checkbox"/> Hiatal Hernia |
| <input type="checkbox"/> Allergies: Enviro _____ | <input type="checkbox"/> Peptic Ulcer |
| <input type="checkbox"/> Allergies: Seasonal _____ | IBD: <input type="checkbox"/> Crohn's <input type="checkbox"/> Ulcerative Colitis |
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> IBS: Type _____ |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Gout |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Headaches or <input type="checkbox"/> Migraines |
| <input type="checkbox"/> Autoimmune Condition: _____ | <input type="checkbox"/> Heart Condition: _____ |
| Blood Sugar: | <input type="checkbox"/> High Blood Pressure /Hypertension |
| <input type="checkbox"/> Pre-Diabetes | <input type="checkbox"/> High Cholesterol |
| <input type="checkbox"/> Diabetes Type 1 | <input type="checkbox"/> Hyperthyroid |
| <input type="checkbox"/> Diabetes Type 2 | <input type="checkbox"/> Hypothyroid |
| <input type="checkbox"/> Hypoglycemia | <input type="checkbox"/> Kidney Stones |
| <input type="checkbox"/> Cancer: Type _____ | <input type="checkbox"/> Memory Concerns |
| <input type="checkbox"/> Celiac Disease | <input type="checkbox"/> Neurological Disease: _____ |
| <input type="checkbox"/> Chronic Fatigue Syndrome/SEID | <input type="checkbox"/> Obesity <input type="checkbox"/> Overweight |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Osteopenia <input type="checkbox"/> Osteoporosis |
| <input type="checkbox"/> Eating Disorder: _____ | <input type="checkbox"/> Osteoarthritis |
| <input type="checkbox"/> Eczema | <input type="checkbox"/> Physical Limitation: _____ |
| Female Health: | <input type="checkbox"/> Psoriasis |
| <input type="checkbox"/> Fertility Concerns | <input type="checkbox"/> Prostate |
| <input type="checkbox"/> Menopause | <input type="checkbox"/> Sexual Dysfunction |
| <input type="checkbox"/> Menstrual Concerns | <input type="checkbox"/> Sleep Apnea |
| <input type="checkbox"/> Polycystic Ovarian Syndrome (PCOS) | <input type="checkbox"/> Urinary Tract Infections |
| <input type="checkbox"/> PMS | Other/Comments: _____ |
| <input type="checkbox"/> Fibromyalgia | |

Pertinent Lab & Diagnostic Data (can be provided as a separate document):

Trauma, Surgeries & Hospitalizations:

Height: _____ **Weight:** _____ **Ideal Weight:** _____

Highest Adult Weight & Year: _____ **Lowest Adult Weight & Year:** _____

Digestive Function: Good Fair Poor

Bowel Movements: Daily <1x day 1-2x day

Please indicate how often you experience the following symptoms:

Heartburn	<input type="checkbox"/> Frequently	<input type="checkbox"/> Often	<input type="checkbox"/> Occasionally	<input type="checkbox"/> No/Rarely
Belching	<input type="checkbox"/> Frequently	<input type="checkbox"/> Often	<input type="checkbox"/> Occasionally	<input type="checkbox"/> No/Rarely
Gas/Flatulence	<input type="checkbox"/> Frequently	<input type="checkbox"/> Often	<input type="checkbox"/> Occasionally	<input type="checkbox"/> No/Rarely
Bloating	<input type="checkbox"/> Frequently	<input type="checkbox"/> Often	<input type="checkbox"/> Occasionally	<input type="checkbox"/> No/Rarely
Stomach Pain	<input type="checkbox"/> Frequently	<input type="checkbox"/> Often	<input type="checkbox"/> Occasionally	<input type="checkbox"/> No/Rarely
Nausea/Vomiting	<input type="checkbox"/> Frequently	<input type="checkbox"/> Often	<input type="checkbox"/> Occasionally	<input type="checkbox"/> No/Rarely
Diarrhea	<input type="checkbox"/> Frequently	<input type="checkbox"/> Often	<input type="checkbox"/> Occasionally	<input type="checkbox"/> No/Rarely
Constipation	<input type="checkbox"/> Frequently	<input type="checkbox"/> Often	<input type="checkbox"/> Occasionally	<input type="checkbox"/> No/Rarely

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Have you had prolonged or regular use of NSAIDs? (Advil, Aleve, Motrin, Aspirin)

Have you had prolonged or regular use of Tylenol?

Have you had prolonged or regular use of PPIs or acid blocking drugs?

How often do you take antibiotics? >3 times per year? Frequent antibiotics use in childhood?

Medications and Supplements: Please list all **prescription medications** and **nutritional supplements, herbs** you are currently taking. Use a separate sheet if needed.

Name	Dosage	Frequency	Length of Time	Purpose

Do you follow a particular diet/eating pattern or have any dietary restrictions?:

Please describe any changes you have made to your diet to improve your health:

Please list food allergies/intolerances/sensitivities and the reaction you experience when eating these foods:

Eating Style: Based on how you eat on a regular basis, please check all that apply:

- | | | |
|---|--|--|
| <input type="checkbox"/> Fast Eater | <input type="checkbox"/> Late night-eater | <input type="checkbox"/> Confused about food/nutrition |
| <input type="checkbox"/> Family member(s) have different tastes | <input type="checkbox"/> Eat because I have to | <input type="checkbox"/> Do not plan meals/menus |
| <input type="checkbox"/> Erratic eater | <input type="checkbox"/> Time constraints | <input type="checkbox"/> Frequently eat fast food |
| <input type="checkbox"/> Love to eat | <input type="checkbox"/> Negative relationship with food | <input type="checkbox"/> Rely on convenience items |
| <input type="checkbox"/> Emotional eater (stressed, bored, sad, etc.) | <input type="checkbox"/> Dislike "healthy" food | <input type="checkbox"/> Poor snack choices |
| <input type="checkbox"/> Eat too much | <input type="checkbox"/> Struggle with eating issues | |
| | <input type="checkbox"/> Travel frequently | |