Carolina Nutrition
Making a difference in your health...

Carolina Nutrition Consultants, LLC

Client Intake Form

Thank you for taking the time to fill out this intake form! We know it is quite extensive, but this is important as we dive deep into your nutrition and health using a holistic perspective. Our relationship to food can be very complex. We look at health from all aspects - sleep, mental health, physical activity, stress, and of course, nutrition. By providing us with this information, we will be able to better serve your personal nutrition & health needs!

Patient Questionnaire

Personal Information

First name

Last name

Date of birth

Preferred Name

Age

Gender

- ◯ Male
- ◯ Female

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Genetic Background

- ☐ African American
- ☐ Mediterranean
- ☐ Caucasian
- ☐ Asian
- ☐ Native American
- ☐ Hispanic
- ☐ Northern European
- ☐ Other

If other, please specify

Occupation and Hours

Primary Address

Street

Unit

City

State/Province

Postal code

Preferred Primary Phone
Please specify if Home, Cell or Work number

Secondary Phone
Please specify if Home, Cell or Work number

Fax

Email Address

Best way to contact?

- ◯ Email
- ◯ Phone

Leave a message? ◯ Yes ◯ No

Primary Physician

Title | First name | Last name

Street | Unit

City | State/Province | Postal code

Work phone | Mobile phone | Fax number

Email address

Title/Occupation

Other Pertinent Provider

Title | First name | Last name

Work phone | Mobile phone | Fax number

Email address

Title/Occupation

City:

Other Pertinent Provider

Title | First name | Last name

Work phone | Mobile phone | Fax number

Email address

Title/Occupation

City:

Goals & Concerns

What are you hoping to get out of meeting with the Registered Dietitian?

List your three main health/nutrition concerns:

	Health/Nutrition Concerns
1.	
2.	
3.	

When was the last time you felt well?

Did something trigger your change in health?

What makes you feel better?

What makes you feel worse?

Comments:

Allergy Information

Please list any known food allergies:

Please list non-food allergies including medications/supplements:

Please list environmental allergies:

What type of allergic symptoms do you experience?

Family History

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

Family History

Family Member:	Health Condition:

Comments:

How Did You Hear About Us?

- ☐ Google
- ☐ MD Referral
- ☐ Current Client/Word of Mouth
- ☐ The Wellcollective/Studio Fire
- ☐ CNC Instagram
- ☐ Other

Medical History

Please check health conditions that your doctor has diagnosed and provide the date of onset.

Gastrointestinal

	Now	Past	Date of Onset
Celiac Disease	☐	☐	
Crohn's Disease	☐	☐	
Gastric or Peptic Ulcer Disease	☐	☐	
GERD/heartburn/reflux	☐	☐	
Irritable Bowel Syndrome	☐	☐	
Liver Disease	☐	☐	
Small Intestinal Bacterial Overgrowth	☐	☐	
Ulcerative Colitis	☐	☐	

Other Gastrointestinal conditions:

Indicate if Past or Current and include date of onset.

Respiratory

	Now	Past	Date of Onset
Asthma	☐	☐	
Bronchitis	☐	☐	
Chronic Sinusitis	☐	☐	
Emphysema	☐	☐	
Pneumonia	☐	☐	
Sleep Apnea	☐	☐	
Tuberculosis	☐	☐	

Other Respiratory conditions:

Indicate if Past or Current and include date of onset.

Inflammatory/Autoimmune

	Now	Past	Date of Onset
Chronic Fatigue Syndrome	☐	☐	
Epstein-Barr Virus	☐	☐	
Graves Disease	☐	☐	
Gout	☐	☐	
Hashimoto's thyroiditis	☐	☐	
Herpes	☐	☐	
Lupus SLE	☐	☐	
Poor Immune Function (frequent infection)	☐	☐	
Rheumatoid Arthritis	☐	☐	

Other Inflammatory/Autoimmune conditions:
Indicate if Past or Current and include date of onset.

Musculoskeletal/Pain

	Now	Past	Date of Onset
Chronic Pain	☐	☐	
Fibromyalgia	☐	☐	
Migraines	☐	☐	
Osteoarthritis	☐	☐	

Other Musculoskeletal/Pain conditions:
Indicate if Past or Current and include date of onset.

Cardiovascular

	Now	Past	Date of Onset
Atherosclerosis	☐	☐	
Elevated cholesterol	☐	☐	
Heart attack	☐	☐	

High blood pressure	☐	☐	
Irregular heart beat	☐	☐	
Mitral Valve Prolapse	☐	☐	

Other Cardiovascular conditions:
Indicate if Past or Current and include date of onset.

Neurological/Brain

	Now	Past	Date of Onset
ADD/ADHD	☐	☐	
Alzheimer's disease	☐	☐	
ALS	☐	☐	
Anorexia	☐	☐	
Anxiety	☐	☐	
Asperger's diabetes	☐	☐	
Autism	☐	☐	
Bulimia	☐	☐	
Eating disorder, Unspecified	☐	☐	
Memory problems	☐	☐	
Parkinson's disease	☐	☐	
Seizures	☐	☐	
Stroke	☐	☐	
Depression	☐	☐	

Other Neurological/Brain conditions:
Indicate if Past or Current and include date of onset.

Urinary/Gynecological

For men and women

	Now	Past	Date of Onset
Kidney Stones	☐	☐	
Prostate problems	☐	☐	
Urinary tract infection (UTI)	☐	☐	
Yeast overgrowth/infection	☐	☐	

Other Urinary/Gynecological conditions:

Indicate if Past or Current and include date of onset.

Cancer

	Type	Treatment
Cancer		

Metabolic/Endocrine

For men and women

	Now	Past	Date of Onset
Diabetes Type 1	☐	☐	
Diabetes Type 2	☐	☐	
Hypoglycemia	☐	☐	
Hypothyroidism (low thyroid)	☐	☐	
Hyperthyroidism (over active thyroid	☐	☐	
Infertility	☐	☐	
Metabolic Syndrome (pre-diabetes, insulin resistance)	☐	☐	
Polycystic Ovarian Syndrome (PCOS)	☐	☐	
Menopause	☐	☐	

Other Metabolic/Endocrine conditions:
Indicate if Past or Current and include date of onset.

Dermatological
For men and women

	Now	Past	Date of Onset
Acne	☐	☐	
Eczema	☐	☐	
Psoriasis	☐	☐	
Rosacea	☐	☐	
Skin Rash	☐	☐	

Other Dermatological conditions:
Indicate if Past or Current and include date of onset.

Describe any additional medical or health problem concerns:

Medications & Supplements

Please list all prescription medications and nutritional supplements, herbs/botanicals you are currently taking with the year started.

Medications

Medication Name	Dose	Fequency	Reason
			☐
			☐
			☐
			☐
			☐

Supplements

Supplement Name	Dose	Fequency	Reason
			☐
			☐
			☐
			☐
			☐

Frequent antibiotics >3 times per year? ○ Yes ○ No

Long term antibiotics? ○ Yes ○ No

Nutrition History

Have you ever worked with a Registered Dietitian before? ○ Yes ○ No

If yes, what approaches did you like? What did you not like?

Have you recently made any changes in your eating habits because of your health? ○ Yes ○ No

Please describe:

Do you currently follow a special diet?

- ☐ Gluten Free
- ☐ Low FODMAP
- ☐ Dairy free
- ☐ Vegetarian
- ☐ Paleo
- ☐ Keto
- ☐ Vegan
- ☐ Other

Height & Weight

Height:		Desired/goal weight:	
Current weight:		Weight 1 year ago:	
Usual Weight :			

Have you had any recent history of weight loss or weight gain? ◯ Yes ◯ No

If yes, please describe.

Do you have a history of yo-yo dieting/weight cycling? ◯ Yes ◯ No

If yes, please describe.

Does your weight affect how you feel about yourself ? ◯ Yes ◯ No

Please comment:

Number of meals eaten per day :

- ◯ 1 meal per day
- ◯ 2 meals per day
- ◯ 3 meals per day

Number of snacks eaten per day:

- ◯ None
- ◯ 1
- ◯ 2
- ◯ 3
- ◯ > 3

What % of meals do you eat out per week?

- ◯ >75%
- ◯ 50-75%
- ◯ 25-50%
- ◯ < 25%

Meal most often eaten out:

- ☐ Breakfast
- ☐ Lunch
- ☐ Dinner

Types of eating establishments most often frequented:

Do you avoid any particular foods or beverages? ◯ Yes ◯ No

If yes, describe what and why:

What are your comfort foods ?

Do you crave any foods?

Are there special textures you prefer? Or avoid certain textures for a particular reason?
Please describe:

What is your average daily water consumption (8 ounce glass)?

- ◯ 6-8
- ◯ 4-6 2-4 <2
- ◯ 2-4
- ◯ <2

Check all the factors that apply to your eating habits and lifestyle:

- ☐ Fast eater
- ☐ Erratic eating patterns
- ☐ Eat too much/overeat
- ☐ Late night eating
- ☐ Rely on convenience items
- ☐ Associate symptoms with eating
- ☐ Negative relationship with food
- ☐ Dislike healthy food
- ☐ Organic food is important to me
- ☐ Love to eat
- ☐ Love to cook
- ☐ Family members have different dietary needs
- ☐ I eat for performance (sports)
- ☐ Frequently skip meals
- ☐ Live or often eat alone
- ☐ Time constraints
- ☐ Drink too much alcohol
- ☐ Addicted to sugar/sweets
- ☐ Eat too many processed carbs (breads, pastas, chips, etc.)
- ☐ Struggle with eating issues
- ☐ Emotional eating
- ☐ Eat fast food frequently
- ☐ Poor snack choices
- ☐ Do not plan meals or menus
- ☐ Travel frequently
- ☐ Confused about nutrition advice
- ☐ Chronic dieter
- ☐ Poor cooking skills / Lack of cooking knowledge

Do you currently struggle with any of the following behaviors?

- ☐ Meticulously count calories or weight food
- ☐ Purposefully skip meals to save calories
- ☐ Purging after meals
- ☐ Frequently going on cleanses, detoxes, or fasts
- ☐ Exercise to "make up" for bad eating
- ☐ Weigh yourself more than once daily
- ☐ Guilt or shame after eating certain foods
- ☐ None of the above.

Please note any additional comments about your nutrition/eating habits :

Lifestyle

Do you engage in moderate cardiovascular physical activity for a minimum duration of 20 minutes at least 3 days a week?

For example: brisk walking, jogging, hiking, cardio exercise classes,cycling

○ Yes ○ No

Activity

	Low Intensity	Moderate Intensity	High Intensity	# of days per week	Duration (minutes)
Stretching/Yoga	☐	☐	☐		
Cardio/Aerobics	☐	☐	☐		
Strength Training	☐	☐	☐		
Sports or Leisure	☐	☐	☐		

Note any problems that limit your physical activity.

Do you smoke? ○ Yes ○ No

Do you chew tobacco? ○ Yes ○ No

How many years?

Packs per day?

Secondhand smoke exposure? ○ Yes ○ No

Do you currently use any of the following (i.e. marijuana, cocaine, crack, heroin, speed, etc)? ○ Yes ○ No

If yes, please describe the type of drugs?

How often you use them?

Daily Stressors

Rate on a scale of 1 (low) to 10 (high)

Stressors	1 - 10
Work or Academic	
Family	
Social	
Finances	
Health	

Do you currently experience excess stress in your life? ◯ Yes ◯ No

Do you easily handle stress? ◯ Yes ◯ No

How do you handle stress, what relaxes you?

Do you feel your life has meaning and purpose?

- ◯ Yes
- ◯ No
- ◯ Unsure

Do you believe stress is presently reducing the quality of your life? ◯ Yes ◯ No

Average number of hours you sleep per night during the week?

- ◯ <6
- ◯ 6-8
- ◯ 8-10
- ◯ 10+

Average number of hours you sleep per night during the weekends?

- ◯ <6
- ◯ 6-8
- ◯ 8-10
- ◯ 10+

Trouble falling asleep? ◯ Yes ◯ No

Rested upon waking? ◯ Yes ◯ No

Do you wake up during the night? ◯ Yes ◯ No

How many times?

How would you rate the overall quality of your sleep?

◯ 1 ◯ 2 ◯ 3 ◯ 4 ◯ 5

1 = Low, 5 = High

Do you struggle with any of the following symptoms on a regular basis?

- ☐ Constipation
- ☐ Diarrhea/Loose Stools
- ☐ Abdominal Cramping
- ☐ Fatigue
- ☐ Nausea/Vomiting
- ☐ Joint Pain
- ☐ Bloating
- ☐ Hair Loss
- ☐ Chronic Migraines
- ☐ Dizziness
- ☐ Stomachaches

Readiness Assessment

What do you think would make the most difference in your overall health?

In order to improve your health, how willing are you to:
Rate on a scale of 5 (very willing) to 1 (not willing)

	5	4	3	2	1
Significantly modify your diet	☐	☐	☐	☐	☐
Journal health habits	☐	☐	☐	☐	☐
Modify your lifestyle (e.g., work demands, sleep habits, exercise)	☐	☐	☐	☐	☐
Engage in regular exercise/physical activity	☐	☐	☐	☐	☐
Practice a daily relaxation technique	☐	☐	☐	☐	☐
Take nutritional supplements as recommended	☐	☐	☐	☐	☐
Have periodic lab tests to assess your progress	☐	☐	☐	☐	☐
Cook more at home & eat out less frequently	☐	☐	☐	☐	☐
Try new foods	☐	☐	☐	☐	☐

Comments:

Patient Narrative

Tell me your story

Please write a summary of any information that will be helpful to me regarding your health and medical history or in your own words.

3-Day Food Journal

It is important to keep an accurate record of your usual food and beverage intake as a part of your treatment
plan. Please complete this Food Journal for three consecutive days including one weekend day.

- **Do not change your eating habits at this time**, as the purpose of this food record is to analyze your current diet
- Record information as soon as possible after the food has been consumed
- Describe all foods and beverages consumed *as accurately and in as much detail as possible* including estimated amounts, brand names, cooking method, etc.
- Record the amount of each food or beverage consumed using standard measurements such as 8 ounces, ½ cup, 1 teaspoon, etc.
- Include any added items, for example: tea with 1 teaspoon honey, potato with 2 teaspoons butter, etc.
- List all beverages and types, including water, coffee, tea, sports drinks, sodas/diet sodas, etc.
- **Comment** on **any emotional or physical symptoms experienced** including hunger level, dieting thoughts, guilt, stress, bloating, fatigue, adverse reaction(s) experienced, timing of adverse reactions, etc.
- Include **comments about eating habits and environment** such as reasons for skipping a meal, when a meal was eaten at a restaurant, etc. and any additional details that may be important

Day 1 Food Journal

	Date	Time	Food and Beverages	Comments of Symptoms
Breakfast				
Snack				
Lunch				
Snack				
Dinner				

Day 2 Food Journal

	Date	Time	Food and Beverages	Comments of Symptoms
Breakfast				
Snack				
Lunch				
Snack				
Dinner				

Day 3 Food Journal

	Date	Time	Food and Beverages	Comments of Symptoms
Breakfast				
Snack				
Lunch				
Snack				
Dinner				

Client

X

Print Name: **Date:**