RECSPORTS
UNIVERSITY of FLORIDA

NUTRITION SERVICES

Nutrition Consultation Intake Form

Name: _____ UF ID: (_____ - _____)
Last, First Preferred name(s)

DOB: _____ / _____ / _____ Age: _____ yrs
mm / dd / yyyy

Sex assigned at birth: _____ Gender identification: _____

Where do you live: □ On-campus □ Off-campus □ Greek housing □ With parents □ Other: _____

Year: □ Undergraduate _____ (yr) □ Graduate _____ (yr) □ Staff _____(position)

Have you seen a Dietitian before: □ Yes □ No If yes, who/when? _____

Why do you want to see a Dietitian? (check all that apply)

□ Weight loss □ General healthy eating □ Vegan/Vegetarian

□ Weight gain □ Training goals □ Other: _____

What are your goals for nutrition counseling? _____

_____

_____

How did you hear about Nutrition Services at RecSports? _____

History:

Height: _____ ft _____ in Weight 1 year ago: ____ lbs

Current weight: ____ lbs Weight at high school graduation: ____ lbs (year: _____)

How often do you weigh yourself?: □ Daily □ Weekly □ Rarely □ Never

Have you ever had concerns about your weight (underweight/overweight)? □ Yes □ No

If yes, please explain: _____

Are you being treated for any medical condition: □ Yes □ No

If yes, please explain: _____

Intake:

List any medications you are currently taking: _____

List vitamin/mineral/preworkout/other supplements you are taking: _____

Do you follow any special diet for personal or religious reasons?: □ Yes □ No

If yes, please specify: _____

Who prescribed this diet for you?: □ Doctor □ Friend/Family □ Self □ Other: _____

Do you have any food allergies?: □ Yes □ No □ Unsure

If yes, list foods to which you are ALLERGIC: _____

Do you drink alcohol?: □ Yes □ No If yes, number of drinks: _____ /day _____ # days/week

1 drink = 1.5 oz 80-proof liquor; 5 oz wine; 12 oz beer

Do you consume caffeinated beverages/products? : □ Yes □ No

If yes, please specify: _____

How would you describe your recent eating/behavior patterns (last 3 months)? (check all that apply)

□ Eat 3 meals per day
□ Snack between most meals
□ Exercise excessively
□ Graze most of day
□ Overeat most of day
□ Skip/miss meals
□ Binge or uncontrollable eating
□ Induce vomiting
□ Restrict amount of food consumed
□ Restrict types of food consumed
□ Use laxatives or diuretics
□ Other:

Lifestyle:

Do you smoke/vape/edibles?: □ Yes □ No If yes, for how many years?: ____ Type & quantity?: _____

How many hours of sleep do you get per night?: _____ hrs (weekday) _____ hrs (weekend)

Are you currently physically active?: □ Yes □ No

Activity: _____ _____ _____

days/week: _____ _____ _____

mins/workout: _____ _____ _____

Are you satisfied with your current level of activity?: □ Yes □ No

If no, how would you like to change it?: _____

Please provide any additional information you feel may be helpful: _____

_____

Contact Information:

Email: _____ Cell: _____ Date: _____/_____/_____
mm dd yyyy

Do not write below line – For office purposes only:

BMI @ CBW: IBW ± 10%:

Maintenance: _____ kcals (MSJ: _____ kcals * _____ AF) & _____ g pro (-)