Nutrition Consultation Intake Form

Name: ___________________________ UF ID: (______ - ______)

Last, First Preferred name(s)

DOB: _____ / _____ / ______

mm / dd / yyyy Age: ________ yrs

Sex assigned at birth: ____________________ Gender identification: ____________________

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

Year: □ Undergraduate _________ (yr) □ Post-grad _________ (yr) □ Staff ____________ (position)

Referred by: □ Self □ Personal Trainer □ SHCC _________ □ Other __________

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? ____________________________

History:

Height: _____ ft _____ in Present weight: _____ lbs Usual 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

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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  □ Binge or uncontrollable eating
- □ Snack between most meals  □ Induce vomiting
- □ Exercise excessively  □ Restrict amount of food consumed
- □ Graze most of day  □ Restrict types of food consumed
- □ Overeat most of day  □ Use laxatives or diuretics
- □ Skip/miss meals  □ 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
Current activities: _________________________________
# 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: _____/_____/_______

Do not write below line – For office purposes only:

BMI @ CBW:  IBW ± 10%:
MSJ: _______ kcals * _______ AF  Maintenance: _______ kcals & _______ g pro (  -  )
Avg Intake: _______  SoC:
B-  Goals:
S n-  1.
L-  2.
S n-  3.
D-  
S n-  
Notes: