RECSPORTS
UNIVERSITY of FLORIDA

# NUTRITION SERVICES

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*

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

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: ______/______/______
mm dd yyyy

*Do not write below line – For office purposes only:*

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BMI @ CBW: IBW ± 10%:

MSJ: _______ kcals * __________ AF Maintenance: _______________ kcals & _____________ g pro ( - )

Avg Intake:

B-

Sn-

L-

Sn-

D-

Sn-

SoC:

Goals:

1.

2.

3.

Notes: