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	Overeat on most days	Binge or uncontrollable eating
Snack between most meals	Restrict amount of food consumed	Induce vomiting
Exercise excessively	Restrict types of food consumed	Use laxatives or diuretics
Graze most of day	Intentionally skip meals	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

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 (-)