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: _____ Pronouns: _____

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