Client Intake Form

Nutrition

What are a few of the main concerns you have regarding your nutritional health and diet currently?

Please share what a day in your life looks like in terms of what you eat, drink, exercise, work and sleep schedule. *(This gives us a way to walk in your shoes and understand how your day impacts your life and health.)*

What medications do you currently take?

What vitamins, minerals, and/or supplements do you currently take?

Do you smoke? No

What injuries, surgeries or health conditions have you had or do you have that impact your life currently?

Do you have any food or supplement allergies?

On a scale of 1-10, 1 being the lowest measure, how healthy & energetic do you feel?

10

What foods do you love?

What foods do you hate?

Name 1-3 changes that you know you need to make in your health and nutrition:

What holds you back or sabotages you from making those changes?

How does your mental and emotional health support or sabotage you?

How do your family & friends impact your health goals & longevity of them?

What programs and/diets have you tried before? Did they work for you? How or how not?

Are you ready to make your health a priority now?

What do you envision when you think of yourself as healthy, well and energetic? What does that look and feel like for you?

How can we best support you?

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