Nutrition Intake

Medicat #__________________ Ht: ______________ Wt: _______________
Date: ______________________

Please fill out the following information to help our Nutrition Counselors provide an accurate and personalized plan for your visit.

Age: _______ **I identify my gender as:** ____

Reason for visit: ____

On a typical day, what do you eat? (Please include condiments, sauces, spreads, and beverages)

Breakfast: ____

____

Lunch: ____

____

Dinner: ____

____

Snacks: ____

____

What are your favorite foods?

____

What foods do you dislike?

____

Are you allergic to any foods?

____

Do you take vitamins or medications? (circle one) **YES** **NO**

If* YES*, what vitamins or medications?

____

Do you exercise? (circle one) **YES** **NO**

If* YES*, what type of exercise, for how long, and how many days a week? ___________________________

____

Who cooks your food? ____

How often do you eat out? ____

What would you like to gain from your appointment?

____

____

For office use only.

Patient Code: ____