Tree of Life Wellness Services, LLC

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Intake Form-Nutrition Today's date _____

Name:_____Address:_____
Date of birth: _____ Day Phone_____ Eve phone_____
Cell/other _____ Email address _____
How would you prefer I contact you?_____OK to leave a message? Yes No
Occupation _____How did you hear about me? _____

What are your nutrition/wellness goals? _____
_____
_____

What particular changes would you like to make? (Please circle)
Eat healthier Exercise more Weight management Eating out Portion size
Alcohol calories Food labels Meal planning Healthy food preparation Food journal
Body image Negative thoughts about self EMDR for weight loss Supplements

Please circle any nutrition-related concerns:
Emotional/stress eating Overweight Underweight Cravings Bingeing
Purging Bulimia Anorexia Diabetes Anemia Constipation
Diarrhea Fatigue/low energy Sports nutrition

Height_____ Current weight_____ Desired weight _____
Number of days a week that you typically exercise and how long: _____
Types of exercise: _____
When was your last physical exam with a primary physician? _____
Health concerns? _____
Please list any medications/herbs/vitamins/supplements that you take:_____
_____
_____

Are you: Breastfeeding _____ Pregnant _____ Trying to conceive _____
Are you vegetarian? _____
Any known food intolerances/allergies? _____

How comfortable are you with your body? (Please circle)
Very uncomfortable Uncomfortable Neutral Comfortable Very comfortable

On a scale of 1-5, how motivated are you to make changes? (Please circle, 1=low, 5= high)
1 2 3 4 5