

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

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