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610-800-4703

Intake and Health Goals Form

Please complete this form as thoroughly and accurately as possible. All information is strictly confidential and is necessary in order for me to reach a deeper understanding about your health condition, dietary and lifestyle habits, and health goals.

Client Information

Name____ Date________________________
Address____
Phone____ Email________________________

Date of birth_________________ Gender_____ Height______ Weight________
Relationship status single / married / divorced / widowed

Emergency Contact (name/phone)__________________________ Relationship__________________

What reasons do you have for seeking nutritional advice? _______________________________________
____
____

How long have you had this condition or issue of concern? _____________________________________
Have you seen a doctor for this issue? ____
If yes, what was the diagnosis and treatment plan? _____________________________________
____

Have you used other therapies for treatment? If yes, please list and note your body's response and the effectiveness of the therapies. ____
____
____

What worsens this condition? ____
____

Please list any other concerns you would like to address ______________________________________
____
____

Personal Information / Lifestyle

Do you have children? ______ How many? ________
Who do you live with? ____
What is the stress level at home? ____
Are you exposed to any harmful toxins at home? (pesticides, building materials, mold, etc.) ______________
Do you have pets? ____
Occupation ________________________________ Normal work hours _____________
Is your job stressful? Y / N / sometimes What is your commute time? ______________________
Are you exposed to chemicals or toxins at your workplace? (specify)__________________________
____

How many hour of sleep do you get each night? ____________ Rate your quality of sleep ___________________
Do you wake feeling rested? ____________________________ Do you wake throughout the night? __________
How many times and for what reason?

____

How often do you exercise? 4-5 times per week / 1-3 times / never
What type of exercise? ____
If you do not exercise, what prevents you from doing so?
Time / Family / Work / Pain / Fatigue / Physical pain / Unmotivated

____
What do you do for stress release/relaxation? ____
Do you or have you ever smoked? Y / N If yes, how much? ____
Do you use recreational drugs? ____
Do you consume alcohol? ____

Medical History

How would you describe your general state of health? Excellent / Good / Fair / Poor
Blood Type: __________________ Typical Blood Pressure: ________________
Total Cholesterol: ___________ HDL/LDL: ________________ Triglycerides:_________________
Vitamin D levels: _____________
Do you wear: corrective lenses / dentures / hearing aids / prosthetics / implants
(List): ____

**For the following tables please use the backside of the form for additional space*

Please indicate any hospitalizations, surgeries, or injuries you have experienced:

Hospitalization	Date	Symptoms	Condition Resolved?

Current medications/supplements: Please list all you take on a regular basis

Medication/Supplement	Dose	Length of Use	Reason

Allergies and or food sensitivities:

Allergy/Sensitivity	Symptoms	Treatment/ Avoidance

Date of last complete physical exam? ______________________________

Have you taken antibiotics in the past 5 years? Y / N   If yes, specify______________________________

____

Were you frequently given antibiotics as a child? Y / N Specify ______________________________

____

Have you ever been diagnosed or suffered with the following? *Please circle all that apply*

Alcoholism	Depression/ Anxiety	High Blood Pressure	Pneumonia
Alzheimer's	Diabetes	High Cholesterol	Psoriasis
Anemia	Eating Disorder	HIV / AIDS	Rheumatoid Arthritis
Arthritis	Eczema	Intestinal Parasites	STD
Asthma	Endometriosis	Leaky Gut	Stroke
Autoimmune Disease	Epilepsy	Lyme Disease	Thyroid Condition
Cancer	Fibromyalgia	Mental Illness	Hormone Imbalance
Cardiovascular Disease	Food Poisoning	Migraines	Canker Sores
Celiac Disease	GERD	Neuropathy	Other:
Chronic Fatigue Syn.	Gastric/Duodenal Cancer	Numbness of hands/feet	
Chron's Disease	Head Injury	Osteoporosis	
Colitis	Hepatitis	Pancreatitis	

Are you currently experiencing any of the following?

Allergies	Constipation	Brain fog	Sudden weight gain
Appetite imbalance	Diarrhea	Headaches	PMS
Bleeding gums	Edema	Joint pain	Insomnia
Bruising easily	Fatigue	Skin rash	Stress
Canker sores	Flatulence	Weight loss	

Childhood History:

Were you breastfed? Y / N

Were you immunized? Y / N   Any reactions? ______________________________

Did you have any of the following "childhood" illnesses?

ADD/ADHD	Meningitis	Mumps	Other…
Frequent Ear Infections	Whooping Cough	Rheumatic Fever	
Chicken Pox	Measles	Autism	
Eczema	Thrush / Candida	Asperger Syndrome	

Family History

Has anyone in your family been diagnosed with any of the following? (indicate "S" for self, "F" father, "M" mother, "G" grandparent, and "O" for other behind each applicable condition)

Alcoholism/ Drug Abuse	Chrons / Colitis	Heart Disease	Mental Illness
Alzheimer's Disease	Diabetes	High Blood Pressure	Multiple Sclerosis
Asthma	Eczema	High Blood Cholesterol	Osteoporosis
Cancer	Epilepsy	Kidney Disease	Osteoarthritis
Celiac Disease	Fibromyalgia	Liver Issues	Thyroid Disorder

Please list any other illnesses of your relatives such as siblings or parents: ______________________________________
____
____

Digestive Health

How often do you have a bowel movement? 3x daily / 2 x daily / 1x daily/ 3-5 week / 1-2 week
Consistency: Loose / Soft-formed / Hard
Do you suffer with any of the following? Please note any observations
Constipation? Y / N ____
Diarrhea? Y / N ____
Bloating / Distended abdomen? ____
Flatulence after meals? Y / N ____
Heartburn/ Reflux? Y / N ____

Female Health

Are you pre-menopausal or menopausal? ____
Are you taking hormone replacement therapy? Y / N
Do you or have you ever taken birth control pills / IUD? Y / N ___________________________
List symptoms or concerns: ____
Number of pregnancies and your age at each: ____
Number of births and your age at each: ____
Natural deliveries? ________ C-sections? __________ Are you currently trying to conceive? Y / N
Have you ever suffered with infertility? ____

Nutritional Habits

What time of day do you eat the following:
Breakfast ____________ Lunch ______________ Dinner ________________
Please provide examples of foods you typically consume at the following meals:
Breakfast:____
Lunch: ____
Dinner: ____
Snacks: ____
Do you feel satisfied after meals? Y / N
What are your favorite foods? ____
How often do you eat them? ____
Do you avoid certain foods? Explain: ____
Do you experience certain symptoms if meals are missed? Explain: _________________________
Do you experience any symptoms after meals? Explain: _________________________________
Do you eat while engaging in other activities? Y / N
Do you eat more while feeling depressed or under stress? Y / N
Do you experience energy crashes? Y / N
If yes, when? ____
Do you crave: Sugar / Chocolate / Salt / Protein / Fats / Other: ____________________________
Are you on a special diet? Y / N
Explain: ____
How many glasses of water do you drink daily? _____ Do you drink purified or filtered water? Y / N
How often do you eat meat? Daily / 3-5 times week / 1 time week or less
What types? ____

How often do you consume dairy?   Daily / 3-5 times week / 1 time or less
What types? ____

How often do you consume vegetables? Daily / 3-5 times week / 1 time or less
What types? ____

How often do you consume fruits?   Daily / 3-5 times week / 1 time or less
What types? ____

How often do you consume grains (refined or whole)? Daily / 3-5 times week / 1 time or less
What types? ____

How often do you consume fats? Daily / 3-5 times week / 1 time or less
What types? ____

What types of fats/oils do you cook with (butter, margarine, olive oil, etc.)? ____________________________

Do you drink coffee? Y / N   How many cups per day? ________________

Do you drink caffeinated tea? Y / N   How many cups per day? __________

Do you drink soda? Regular / Diet / None   If yes, how often? _________________________________

Do you use artificial sweeteners? Y / N   If yes, what types? ________________________________

How often do you use the microwave? Never / Monthly / Weekly / Daily / 2 times or more daily

Do you enjoy cooking? Y / N   How many meals do you cook at home each week? ____________________

How much time do you have to prepare meals daily? ____

Where do you shop for food? ____

Do you generally purchase organic or conventional foods? ____________________________________

What are your favorite places to eat outside the home? ______________________________________

What are your favorite foods? ____

What do you consider to be healthy foods? ____

Health Objectives

Where do you see yourself in 5 years? ____
____

Regarding food and lifestyle, are there any changes that you haven't made but believe you should? __________
____

Regarding food and lifestyle, is there anything you have tried to or believe you should avoid? ______________
____

Are there any obstacles or challenges that you currently experience when making food and lifestyle changes? ____
____

Do you foresee any obstacles or challenges in the future that may deter you from achieving your goals? ________
____

Do you have a support system (friends, family, coworkers, etc.) that will positively influence you in reaching your goals?
____

Describe what goals you would like to achieve by the next 3 months?
____
____

By the next 6 months? ____
____

In 1 year? ____
____

Level of commitment for lifestyle changes:

Please circle to indicate your intention to change the following if needed:

Increasing Water Intake	Yes	No	Maybe
Adjusting Eating Habits	Yes	No	Maybe
Taking Supplements	Yes	No	Maybe
Adjusting Alcohol Intake	Yes	No	Maybe
Reducing Soda Intake	Yes	No	Maybe
Quitting Smoking	Yes	No	Maybe
Improving Sleep Habits	Yes	No	Maybe
Exercising	Yes	No	Maybe

What are your expectations in working with me to achieve your health goals? ____________________________________

____

____

____

Is there anything that you would like to address that was not covered by this form? ______________________________

____

____

____

I have filled this form as accurately as possible and all the information I have provided is true to the best of my knowledge. I will update *Kristin Lubrano Lobianco, CNT, LLC* of any significant changes. I understand and agree that this confidential information of my medical health history will be maintained by *Kristin Lubrano Lobianco, CNT, LLC* and will not be released to any individual except when I have authorized this release in writing or when required by law.

Signature ____ Date ____________________

Print ____

Please bring this completed form to our initial consultation. It can be printed out and completed or completed and emailed to krislubrano@terravitanutrition.com

Thank you!

Kristin Lubrano Lobianco, CNT

Kristin Lubrano Lobianco, LLC

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