Client Information

Name:	Date of Birth:
Phone number:	

Address

Address Line 1	Address Line 2	
City	State	Zip

Height (Inches)	Usual weight	Current weight	Desirable weight
Gender			

Profession

What is your main reason for this consultation?

Have you experienced a recent: Weight gain Weight loss None (circle one) If yes, please explain

Do you have problems with:			
	Yes	No	If Yes, Please Explain
diarrhea			
constipation			
heartburn			
heartburn			
vomiting			

Do you have any food allergies? If yes, please explain	Do you have any food intolerances? If yes, please explain

List all regularly taken:
Medications
Supplements (include protein powders, teas, shakes, etc.)
Vitamins

List any medical issues you would like me to be aware of (i.e. high blood pressure, cholesterol, IBS, etc):

Please list any psychological issues diagnosis (i.e. depression, anxiety, type of eating disorder):

Describe any physical limitations or injuries?

Describe your current physical activity routine:

How often do you do these? (amount of time/days per week, also try to give speed of machines/intensity level to help better determine how many calories burned on a weekly basis from exercise):

How many times a week do you eat out or order take-out?

What are your nutrition questions or concerns?

What do you hope to take away from this session?