HARMONIC, LLC.
NUTRITION & WELLNESS

New Client Intake Form

Name: _____ Date: _____

Phone – Home: _____ Cell: _____ Work:_____

Address: _____

Email: _____ Profession: _____

Reason for appointment: _____ How did you hear about us?_____

Have you ever worked with a Nutritionist? ❒Yes ❒No If yes, who:_____

Please list names of any of the following professionals with whom you are working:

Therapist: _____ Physician: _____

Psychiatrist: _____ Trainer: _____

Age: _____ DOB: _____ Ht: _____ Wt: _____

Are you currently being treated for any medical conditions: ❒Yes ❒No Specify: _____

_____

List medications you are currently taking: _____

Are you following a special diet? ❒Yes ❒No Specify:_____

List food and/or vitamin/mineral supplements you are taking: _____

Weight History

Do you weigh yourself? ❒Yes ❒No How often? _____

Your highest weight:_____ Age _____ Lowest weight:_____ Age _____ Desired wt: _____

"Set point" is a weight where the body tends to stabilize with normal eating. What do you think your set point weight is? _____ Last time you weighed this? _____ For how long? _____

How many calories do you think you need to maintain your current weight? _____

How many calories do you think you need to maintain your desired weight? _____

What is your family's attitude about health? _____

What is your family's attitude about weight? _____

Check to indicate which family members:

Try to eat healthfully: ❒Mom ❒Dad . ❒Sister ❒Brother ❒Partner ❒Grandparents

Try to control their weight: ❒Mom ❒Dad .❒Sister ❒Brother ❒Partner ❒Grandparents

Are "overweight": ❒Mom ❒Dad ❒Sister ❒Brother ❒Partner ❒Grandparents

Menstrual History – men skip to next section

Are you currently menstruating: ❒Yes ❒No ❒Have never menstruated Age began: _____

Approximate weight at time of first menstruation: _____ Approximate height: _____

Date last menstrual cycle:_____ Average weight fluctuation during menstrual cycle? _____

Are you taking birth control pills/estrogen pills? ❒Yes ❒No

Do you experience PMS? ❒Yes ❒No Describe: _____

As you lose weight, do your cycles become irregular or cease? ❒Yes ❒No At what weight? _____

Eating Patterns

Describe what hunger feels like to you: _____

Describe what fullness feels like to you: _____

How do you know when to quit eating? _____

❒Yes	❒No	I usually eat when I get hungry
❒Yes	❒No	I often eat when I'm not hungry
❒Yes	❒No	I can tell the difference between physical hunger and "emotional hunger"
❒Yes	❒No	Nutrition facts influence my decisions about what to eat. Check all that apply: ___Calories ___Carb ___ Fat ___Vitamins ___ Minerals Other: _____
❒Yes	❒No	I try to follow a very specific meal plan.
❒Yes	❒No	I find it almost impossible to follow a specific meal plan.

❒Yes	❒No	I eat standing up	❒Yes	❒No	I eat faster than others
❒Yes	❒No	I eat in the car	❒Yes	❒No	I eat slower than others
❒Yes	❒No	I eat while watching TV	❒Yes	❒No	I eat when stressed
❒Yes	❒No	I eat while reading	❒Yes	❒No	I eat when bored
❒Yes	❒No	I eat while on the computer	❒Yes	❒No	I eat when anxious
❒Yes	❒No	I eat with others	❒Yes	❒No	I eat when lonely

What are your favorite foods? _____

_____

_____

What food don't you like? _____

_____

_____

List foods you typically avoid: _____

_____

_____

Do you drink alcohol? ❒Yes ❒No Number of drinks/wk:_____

Do you use drugs? ❒Yes ❒No Explain: _____

Do you smoke cigarettes? ❒Yes ❒No ❒Quit Do you chew gum? ❒Yes ❒No ❒A lot

Check any of the following that describes your **recent** eating patterns:

❒ Eat 3 meals a day.	❒ Graze most of the day	❒ Induce vomiting
❒ Eat 3 meals with snacks	❒ "Overeat" most of the day	❒ Use laxatives
❒ Eat less than most others	❒ Restrict amount of food consumed	❒ Use diuretics
❒ Eat more than most others	❒ Restrict types of foods consumed	❒ Exercise excessively
❒ Eat basically "normally"	❒ Binge eat	❒ Self harm in response to eating

Dieting History

How many times have you tried to control your weight? _____

Age at first attempt: _____ years Your height at that time? _____ Weight? _____

What did you do?_____

Why did you go on the diet? _____

_____

Have you ever used any of the following in an attempt to control your weight? Add any comments such as your age(s), how effective you thought it was, etc.

❒Yes ❒No Eat "healthfully" _____

❒Yes ❒No Exercise _____

❒Yes ❒No Count calories/carbs _____

❒Yes ❒No Weight Watchers _____

❒Yes ❒No Other diet programs _____

❒Yes ❒No Low carb diets _____

❒Yes ❒No Liquid diets _____

❒Yes ❒No Fad diets _____

❒Yes ❒No Prescription diet pills _____

❒Yes ❒No Over-the-counter pills _____

❒Yes ❒No Laxatives _____

❒Yes ❒No Diuretics _____

❒Yes ❒No Ipecac Syrup _____

❒Yes ❒No Vomiting _____

❒Yes ❒No Self designed program _____

❒Yes ❒No Intuitive eating _____

❒Yes ❒No Negative self-talk _____

❒Yes ❒No Other: _____ _____

Do you eat uncontrollably at times? ❒Yes ❒No Age(s): _____

Describe: _____

_____

_____

Is this followed by: ❒ Vomiting ❒ Laxative Use ❒ Excessive Exercising

❒ Dieting ❒ Self-Harm ❒ Negative Emotions

❒ Other (explain) _____

Have you ever been diagnosed with an eating disorder? ❒Yes ❒No

Please explain: _____

Additional thoughts about your attempts to control weight and what you feel needs to happen now:_____

_____

_____

Disordered Eating Behaviors

Please check if you experience any of the following:

❒	I avoid eating a food if I don't know how it was prepared
❒	I avoid eating a food if I don't know it's nutritional content
❒	I won't eat unless I'm able to exercise or purge afterward
❒	I become upset if I am unable to eat at a certain time
❒	I become upset if I eat foods other than what I planned
❒	I eat foods that are different from the rest of my family

❒	I count calories	❒	I won't eat in front of others
❒	I count fat grams	❒	I have safe foods and unsafe foods
❒	I count carbohydrate grams	❒	My eating is very ritualized
❒	I count protein grams	❒	I compare what I eat to what others eat
❒	I count Weight Watchers points	❒	I hide food so others will think I ate it
❒	I cut my food into small pieces	❒	I hide food so I can binge
❒	I weigh / measure my food	❒	I feel guilty after eating
❒	I refuse to eat after a certain hour	❒	I believe there are good foods / bad foods
❒	I eat the same foods daily	❒	I feel ashamed of my eating
❒	I'm scared to try new foods	❒	Food seems to be controlling my life

Exercise History

Are you currently exercising? ❒Yes ❒No Describe: _____

_____

_____

Describe your past history with exercising: _____

_____

Do you / have you ever exercised compulsively? ❒Yes ❒No At what ages: _____

Do you have any physical conditions that limit your ability/safety to exercise? ❒Yes ❒No

Please describe: _____

Your Specific Needs and Hopes

What would you like to achieve as a result of nutrition counseling. Please note anything else you feel we should know.

_____

_____

_____

_____

_____

Thank you for choosing Harmonic Nutrition & Wellness, LLC. We look forward to partnering with you on your health and wellness journey.