NUTRITIONAL CONSULTING INTAKE FORM

Please fill out this form several days before your appointment and email to me at laura@lauralacey.com

Date:		Email:	
First Name:		Last Name:	
Phone (Home):		Phone (Cell):	
Phone (Work):			
Address:			
City:		State:	Zip:

Date of Birth: Occupation:

How did you hear about me?

Are you pregnant? Yes No If so, how many weeks pregnant are you?

Are you breastfeeding? Yes No If so, how old is your baby?

What are your most important nutritional concerns?

1)

2)

3)

Are you on a special diet? Yes No If so, which one?

How many meals a day do you eat? Yes No Explain below:

Do you have any food allergies? Yes No List below:

Do you have any food cravings? Yes No If yes, explain below:

Are you taking any vitamins, supplements or herbs? Yes No List below:

Do you generally Cook Eat out Take in Explain below:

Are you discovering any discomfort such as nausea, vomiting, swelling or diarrhea? Yes No If yes, explain below:

HEALTH HISTORY

For the next sections please enter either **Y, P** *or* **N** *for all the following conditions.*
Y= a condition you have now **P**= a condition you had in the past **N**= never had condition

MENTAL/EMOTIONAL

	Treated for emotional problems		Depression
	Mood swings		Anxiety
	Poor concentration		Seasonal depression

ENDOCRINE

	Hyperthyroid		Heat or cold intolerance
	Hypoglycemia		Diabetes
	Excessive thirst		Excessive hunger
	Fatigue		

CARDIOVASCULAR

	Heart disease		Fainting
	High/low blood pressure		Palpitations
	Blood clots		Chest pain

GASTROINTESTINAL

	Change in appetite		Heartburn
	Nausea		Vomiting
	Constipation		Diarrhea
	Belching		Passing gas
	Gall bladder disease		Liver disease

NUTRITIONAL SUPPLEMENTS (VITAMINS)

Name	Dosage	For what?

List any medications or supplements you may have an allergic reaction to:

Do you smoke cigarettes?	Yes No	If so, how much daily?	
How long have you been smoking?		Have you tried to quit?	Yes No

Please describe your recreational drug use – type and frequency:

EXERCISE

Do you currently exercise?	Yes No	Please describe what you do and how frequently:

SLEEP

Average amount of sleep per night:	
Do you fall asleep easily?	Yes No
Do you wake up often during the night?	Yes No
Do you feel rested when you wake up?	Yes No

Please let me know if there is any other information or concerns that I should know about:

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