MYCORENUTRITION

Nourish your core.

Nutrition Intake Form

Name_____

Address_____

Phone Number_____Email Address_____

Occupation_____Birthday_____

Age_____ Height_____

Current Weight_____lbs. Goal Weight_____lbs.

Current Body Fat%_____ Goal Body Fat %_____

Your Goals for nutrition counseling in order of importance:

1. _____
2. _____
3. _____
4. _____

Have you successfully lost weight in the past? If yes what

worked for you?_____

_____

What was your lowest adult weight?_____Highest_____

What are your most important health concerns? List in order of importance:

1. _____
2. _____
3. _____

Any additional diagnoses_____

Current Medications

Name	Dose	For What?
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Nutritional Supplements (such as vitamins)

Name	Dose	For What?
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Do you follow a specific type of diet?

_____

Do you avoid any foods or groups of foods due to problems with digestion or unwell feelings?_____

_____

_____

_____

Do you drink alcohol? How often?_____

_____

Do you smoke or chew tobacco?_____

Average amount of sleep per night?_____hours

Do you exercise regularly?_____If so what type and how often?

_____

On a scale of 1-10 how would you rate your stress level with 10 being extremely stressed. _____

In the past, what have been the biggest barriers to better health and achieving your goals?

What lifestyle changes are you willing to make?