DOMINION
Women's Health, Inc.

Please be certain this intake form is completed and returned to our dietitian, Leslie Torbert, one week prior to your appointment date.
Fax: (804) 730-0839

Nutrition Therapy – New Client Intake Form

Appointment Date & Time: _____ **Referred by:** _____

Name: _____
Last **First** **Middle**

What health and/or nutrition concerns would you like to focus on during your visit? _____

_____

Allergies		**Allergic Symptoms Experienced**
Food		
Medication		
Supplement		
Environmental		

Nutritional supplements and herbs/botanicals currently taking: _____

_____

Lifestyle Information

Do you engage in physical activity on a regular basis?	Yes____ No____	If yes, complete the table below
Activity	**# of Days per Week**	**Duration (minutes) per Session**

How many hours do you sleep on week nights? <6_____ 6 - 8_____ 8 - 10_____ 10+_____

How many hours do you sleep on weekends? <6_____ 6 - 8_____ 8 - 10_____ 10+ _____

Check which apply to you: Trouble falling asleep _____ Wake up during the night _____ Don't feel rested _____

How do you handle stress? What helps you relax? _____

_____

Nutrition History

Have you ever had an appointment with a dietitian or nutritionist? Yes_____ No _____

Have you changed your eating habits for a health reason? Yes_____ No_____ Please describe. _____

_____

Are you currently following a particular diet or nutrition plan? Yes_____ No _____ Please describe. _____

_____

_____

Do you avoid any particular foods? Yes_____ No_____ Please explain. _____

_____

Do you have any adverse food reactions (intolerances or allergies)? Yes_____ No_____ Please explain. _____

_____

Height: _____ Current Weight: _____ Usual Weight Range: _____ Desired Weight: _____

Have you recently lost or gained weight? Yes_____ No_____ If yes, please describe. _____

_____

Do you have or have you had an eating disorder in the past? Yes_____ No_____ If yes, please describe. _____

_____

_____

How many meals do you eat each day? _____ Snacks? _____Favorite meal? _____

How many meals do you buy from a restaurant or fast food **per week?** 0 - 1_____ 2 - 3_____ 4 - 6 _____ >6_____

Do you drink alcohol? Yes_____ No_____ If yes, how many drinks **per week?** _____

Do you drink caffeinated beverages? Yes_____ No_____ If yes, how many cups **per day?** _____

Do you use any natural or artificial sweeteners? Yes_____ No_____ If yes, which ones? _____

Circle all of the factors that apply to your eating habits and current lifestyle:

Love to eat	Fast eater	Live alone or eat alone often
Love to cook	Erratic eating patterns	Do not plan meals or menus
Emotional eater	Eat too much	Time constraints
Late night eater	Rely on convenience foods	Travel frequently
Struggle with eating issues	Eat fast food frequently	Eat only because I have to
Family members have different tastes	Make poor snack choices	Negative relationship with food
Dislike cooking	Confused about food/nutrition	Don't know how to cook

Food Diary: Please record what you eat and drink during one typical day (24 hour period). Please be sure to include all beverages, cream and sweetener added to beverages, and condiments added to foods.

Time woke up: __________ Bedtime: __________

Time	Food/Beverage Items	Amount (e.g. cups, oz, tsp)	Location (Home/Away)

Food Frequency Questionnaire – How often do you eat the following?						
Food	**Never or <4x/year**	**Rarely or <4x/month**	**Once/wk**	**2x/wk**	**3x/wk**	**Daily**
Cheese	☐	☐	☐	☐	☐	☐
Yogurt, Kefir	☐	☐	☐	☐	☐	☐
Cow's Milk	☐	☐	☐	☐	☐	☐
Milk Substitute (soy, coconut, almond, rice, or hemp seed milk)	☐	☐	☐	☐	☐	☐
Red Meat	☐	☐	☐	☐	☐	☐
Pork (pork loin, pork roast, pork chops, barbecue)	☐	☐	☐	☐	☐	☐
Processed Meat (sausage, bacon, lunch meat)	☐	☐	☐	☐	☐	☐
Chicken	☐	☐	☐	☐	☐	☐
Eggs	☐	☐	☐	☐	☐	☐
Cold Water Fish (*striped bass, wild Alaskan salmon, herring, sardines, anchovies, mackerel, Alaskan halibut, Alaskan cod)*	☐	☐	☐	☐	☐	☐
Other fish or shellfish- Indicate type:	☐	☐	☐	☐	☐	☐
Beans, Legumes (black beans, kidney beans, white beans, lentils)	☐	☐	☐	☐	☐	☐
Whole Soy Foods (edamame, soy nuts)	☐	☐	☐	☐	☐	☐
Tofu, Tempeh	☐	☐	☐	☐	☐	☐
Soy "meat alternative" (ex. Tofurkey, soy "sausage", soy "bacon")	☐	☐	☐	☐	☐	☐
Berries	☐	☐	☐	☐	☐	☐
Other Fruits- Indicate type:	☐	☐	☐	☐	☐	☐
Cruciferous Vegetables (cabbage, broccoli, Brussels sprouts)	☐	☐	☐	☐	☐	☐
Green Leafy Vegetables (e.g. spinach, kale, collards, greens)	☐	☐	☐	☐	☐	☐
Yellow Fruits and Vegetables (e.g. yellow peppers, corn)	☐	☐	☐	☐	☐	☐
Other Green Fruits and Vegetables (e.g. peas, broccoli, avocado, cucumbers)	☐	☐	☐	☐	☐	☐
Blue/Purple Fruits and Vegetables (e.g. blueberries, prunes, beets, purple cabbage)	☐	☐	☐	☐	☐	☐
Red Fruits and Vegetables (e.g. cherries, apples, tomatoes, kidney beans)	☐	☐	☐	☐	☐	☐
Orange Fruits and Vegetables (e.g. orange, cantaloupe, carrots, sweet potato)	☐	☐	☐	☐	☐	☐
White/Tan Fruits and Vegetables (e.g. onions, garlic, ginger, nuts)	☐	☐	☐	☐	☐	☐
Turmeric, Cumin, Ginger, Rosemary, Oregano, Parsley	☐	☐	☐	☐	☐	☐
Nuts, Nut Butters- Indicate type:	☐	☐	☐	☐	☐	☐
Avocado, Extra Virgin Olive Oil , Canola Oil	☐	☐	☐	☐	☐	☐
Vegetable oil (corn, sunflower, safflower, etc. – NOT olive oil)	☐	☐	☐	☐	☐	☐
Butter, ghee	☐	☐	☐	☐	☐	☐
White Rice	☐	☐	☐	☐	☐	☐
White Pasta	☐	☐	☐	☐	☐	☐
White Bread	☐	☐	☐	☐	☐	☐
Bagels	☐	☐	☐	☐	☐	☐
English Muffins	☐	☐	☐	☐	☐	☐
Pancakes or Waffles	☐	☐	☐	☐	☐	☐

Food	Never or <4x/year	Rarely or <4x/month	Once/wk	2x/wk	3x/wk	Daily
Buttermilk Biscuits	☐	☐	☐	☐	☐	☐
Chips	☐	☐	☐	☐	☐	☐
Pretzels	☐	☐	☐	☐	☐	☐
Popcorn	☐	☐	☐	☐	☐	☐
Other Snack Food (crackers, Goldfish)	☐	☐	☐	☐	☐	☐
100% Whole Wheat, Rye, Barley (whole wheat bread and pasta)	☐	☐	☐	☐	☐	☐
Other Whole Grains (millet, quinoa, amaranth, flax, oats, brown rice)	☐	☐	☐	☐	☐	☐
Ice Cream	☐	☐	☐	☐	☐	☐
Pastries, cookies, cakes	☐	☐	☐	☐	☐	☐
Juice- Indicate type:	☐	☐	☐	☐	☐	☐
Punch, Lemonade, or Sweet Tea	☐	☐	☐	☐	☐	☐
Diet Soda	☐	☐	☐	☐	☐	☐
Soda (not diet)	☐	☐	☐	☐	☐	☐
Red Wine	☐	☐	☐	☐	☐	☐
Tea (white, green, black)	☐	☐	☐	☐	☐	☐

Daily Intake Summary

What type(s) of protein do you consume most days of the week? (Check all that apply.)

☐ Animal meat ☐ Beans ☐ Eggs ☐ Soy-based ☐ Dairy ☐ Nuts and seeds

How many servings of fruit do you have in a day?	
How many servings of vegetables do you have in a day?	

Provide an estimate of the amount of each beverage that you consume on an average day.
Circle the label that is most appropriate based on how you consume the beverage.

Water: ____ ounces, cup(s) Diet soda: ____ cup(s), can(s), liter(s) Tea: ____ cup(s)

Coffee: ____ ounces, cup(s) Non-diet soda: ____ cup(s), can(s), liter(s) Other: _____