CONTACT INFORMATION	
Name:	**Today's Date (mm/dd/yyyy):**
Home Phone:	**Mobile Phone:**
Email Address:	**Preferred Contact Method:** Text
BASIC INFORMATION	
Primary Physician:	**Phone:**
OCCUPATION, PERSONAL INFORMATION & INTERESTS	
Occupation:	**How Long:**
Education:	
Interests & Passions:	

DEMOGRAPHICS		
Age:	**Date of Birth (mm/dd/yyyy):**	**Gender:** Female
Genetics: White	**Ethnicity:** Non-Latino/Hispanic	**Marital Status:** Divorced
Weight (lbs):	**Highest Adult Weight(lbs):**	**Lowest Adult Weight(lbs):**
Height (ft/in):		

MEDICAL INFORMATION

What types of health practitioners are you currently working with?

What are your top three reasons for wanting to see a nutritionist?

MEDICATIONS & SUPPLEMETS

Current Medications (Over the counter and prescriptions)

Name	Dosage	Frequency

CURRENT DIETARY OR HERBAL SUPPLEMENTS		
Name	**Dosage**	**Frequency**

PHYSICAL ACTIVITIES		
Type	**Frequency**	**Duration (min)**
Cardio:	Daily	
Strength building:	Daily	
Stretching:	Daily	
Sports or Leisure:	Daily	

How many times each week do you eat each meal at home versus out? None

FOR WOMEN ONLY!

Are you currently pregnant? No

Are you actively trying to conceive? No

Are you breastfeeding? No