NUFIT – Nutrition Optimized
0434 442 686
camwild@nufit.com.au
www.nufit.com.au

Client Intake Form

Please fill out the following questions as best you can. If there is a particular question you don't understand or want to fill out, we can discuss them at our first meeting. Thank you.

Name_____ Date_____

Phone (h)_____(w)_____ (m) _____

Address_____

Email _____ Referred by _____

Personal Information

Birthday _____ Age _____Height _____ Weight _____ Gender _____

Ethnicity _____ Marital Status _____Children_____

Occupation _____ Hours in regular work week _____

What is the main reason for your visit? _____

Are you seeing any other health professionals at this time? ❑ Y ❑ N If yes, please list _____

_____

How well do you sleep?_____ Bedtime _____Waking time _____

On a scale of 1-10 (10 being the highest) how would you rate your stress level? _____

What causes stress for you? _____

List any regular physical activities (frequency and duration) _____

_____

List other hobbies or passions? _____

Do you smoke? ❑ Y ❑ N How much? _____

Do you drink alcohol? ❑ Y ❑ N How often? _____

Use recreational drugs? ❑ Y ❑ N Type/how often? _____

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Condition	Self	Mother	Father	Grand Parent	Condition	Self	Mother	Father	Grand Parent
Heart Disease					Drug Abuse				
Cancer					Alcohol Abuse				
Autoimmune					Hepatitis				
Allergies					Chronic Pain				
Depression					Lungs/Chest				
Arthritis					Skin				
Diabetes					Gallbladder				
HIV/AIDS					Reproductive				
Thyroid Disorder					Stroke				
High Blood Pressure					Osteoporosis				
Migraines					Bone Fractures				
PMS					Gastrointestinal				

Health History (please mark and X in the box for either yourself and/or family members)

Any other conditions not mentioned above? anemia, crohns, colitis, ulcers, chronic infection cold/flu:

_____

How would you describe your overall health? _____

Last course of antibiotics? _____ What were they prescribed for? _____

Do you have any amalgam (silver) dental fillings? ❑ Y ❑ N How many? _____

Recent weight loss or weight gain? ❑ Y ❑ N If yes, how much? _____

Do you have any know allergens? ❑ Y ❑ N If yes, list allergy and symptoms _____

_____

Medications/Supplements	Dosage	Frequency

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Nutrition and Dietary Habits

How many meals do you typically eat per day? _____ Do you snack? _____

How many times a week do you:

eat out at restaurants? _____ eat breakfast? _____

cook meals at home? _____ grocery shop? _____

Do you normally eat alone or with friends/family? _____

Where do you grocery shop? _____

What is your weekly budget? _____ Do you read food labels? ❑ Y ❑ N

What is your favorite meal? _____

What are your favorite restaurants? _____

What 3 foods might you struggle to give up?

_____

_____

_____

What 3 foods might you struggle to eat?

_____

_____

_____

How much water do you drink per day? _____ Foods you crave? _____

Do you drink coffee? ❑ Y ❑ N how much? _____ Sodas? ❑ Y ❑ N how much? _____

Do you have any food allergies? ❑ Y ❑ N List: _____

What are your allergy symptoms? _____

Have you tried any popular diets? ❑ Y ❑ N Which ones? _____

What was your experience? _____

What is your present diet: ❑ vegetarian ❑ vegan ❑ gluten free

❑ dairy free ❑ kosher ❑ other? _____

Are you pleased with your present diet? ❑ Y ❑ N What would you like to change? _____

_____ Have you tried to make these changes? ❑ Y ❑ N

What influences your food choices?

❑ Taste ❑ Nutrition ❑ Price ❑ Convenience ❑ Family Members ❑ Friends

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How often do you have a bowel movement? _____ List any problems or issues? _____

_____

Eating Patterns: (check all that apply)

- ❑ eat too much
- ❑ eat too little
- ❑ forget to eat
- ❑ emotional eater
- ❑ eat out of boredom
- ❑ hungry all the time
- ❑ late night snacking
- ❑ fast eater
- ❑ eat in the car
- ❑ poor choices
- ❑ healthy choices
- ❑ no joy in eating

What do you consider healthy food choices? _____

_____

What do you consider poor food choices? _____

_____

How often do you eat the following foods in an average day/week?

Food	Servings day/week	Food	Servings day/week	Food	Servings day/week
Fruits		Pork		Pasta	
Vegetables		Nuts/Seeds		Bread	
Whole Grains		Dairy		Fried Foods	
Red Meat		Eggs		Fast Food	
Poultry		Soy Products		Juice	
Seafood		Legumes		Desserts/Sweets	

Women Only: Check those that apply.

- ❑ Perimenopausal
- ❑ Menopausal
- ❑ Regular periods
- ❑ Irregular periods
- ❑ Pregnant (how many months? _____)

Do you suffer from PMS? ❑ Y ❑ N If yes, please describe_____

_____

Are you taking any birth control? ❑ Y ❑ N If so, for how long _____

Are you taking any hormone replacement? ❑ Y ❑ N Please describe _____

_____

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Please list any other additional information that you feel would be helpful:

_____

_____

_____

_____

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CLIENT AGREEMENT AND RELEASE

I, the undersigned, understand that the nutritional and supplemental consultation services offered to me by **Cameron Wild** of **Nufit** are educational in nature and intended to provide me with well researched nutritional information. Nutritional counselling services may include, but will not necessarily be limited to; instruction in the development of eating habits, supplementation, physical exercise, rest, attitudinal and behaviour changes.

The counselling offered under this Agreement is acknowledged and understood to be of a strictly *non-medical* and *non-physiological* nature and is *accepted solely* and *exclusively* for *instructional purposes only*. Suggestions made for diet and/or supplement products are intended to support and balance the body with the sole intention of enhancing general health, and are not intended to diagnose, treat, cure, or prevent any disease.

Nothing expressed, written, or implied should be considered as medical advice for dealing with any given medical condition. The information received cannot replace the advice or treatment of a qualified health care professional. I also agree that I have been advised to discuss the recommendations with my prescribing physician.

I, _____, hereby certify that I fully understand the above information, and agree to ask for clarification on any information I do not understand during or after the consultation session. I agree to disclose all known medical conditions and have answered all questions openly and honestly. I agree to keep the practitioner informed of any future changes in my medical conditions and treatments.

This agreement is being signed voluntarily and not under duress of any kind.

Name_____

Signature_____ Date_____