Health Intake Form

Name: _____ Date:_____

Date of birth: _____ Age:_____

Address: _____

Home phone: _____ Cell phone: _____

Email: _____

Emergency contact & phone number: _____

Occupation: _____ Work Schedule: _____

Height: _____ Weight: _____

Lowest/highest adult weight? _____ Desired weight? _____

Smoking history: _____ Hours of sleep? _____

List any food allergies: _____

How often do you eat from a deli or restaurant? _____

Do you add salt to your meals? _____ Do you skip meals? _____

How many glasses of water do you drink each day? _____

How often do you drink coffee or tea? _____

How often do you drink alcoholic beverages? _____

What other beverages do you drink? _____

List medical conditions, surgeries or injuries:

_____

_____

List family history for medical condition:

_____

_____

List medications, vitamins or herbal supplements you take: _____

_____

_____

_____

_____

How many hours per day do you sit for TV, computer or cell phone? _____

Do you crave any foods? _____

How is your food intake affected by stress? _____

_____

Describe any current exercise regimen:

_____

_____

List any weight management programs or diets you may have tried:

_____

_____

What are your goals?

_____

_____

Why do you want to reach these goals?

_____

_____

_____

_____

(use back of page if needed)