Lifestyle NUTRITION WNY, PLLC
NUTRITION DESIGNED WITH YOU IN MIND

Intake Questionnaire

Personal Information

Legal first name

Last name

Street

Unit

City

State/Province

Postal code

Home phone

Mobile phone

Email address

Date of birth

Gender

Relationship status

Occupation

Hours per week

Referred by

Health Insurance
Please include if you scheduled your appointment online or if you were unable to provide your insurance information at the time of scheduling your appointment.

Policy Holder

Legal first name

Last name

Date of birth

Phone number

Gender

Street

Unit

City

State/Province

Postal code

Insurance Company

Payer Id

Coverage Type

Member Id

Plan Id

Group Id

Copay

Deductible

Family History

Paternal Family Illnesses

- Heart Disease
- High Cholesterol
- Cancer
- Other
- High Blood Sugar
- High Blood Pressure
- Kidney Disease

Maternal Family Illnesses

- Heart Disease
- High Cholesterol
- High Blood Sugar
- High Blood Pressure

Cancer
Kidney Disease
Other

Personal Health History

Medical Diagnosis

Diagnosis	Current	Past	Approximate Date of Diagnosis

Past Hospitalizations/Surgeries

Hospitalization/Surgery	Date	Reason

Have you ever taken birth control? Yes No

Have you ever been on hormone replacement therapy? Yes No

Supplements

List all supplements you're currently taking including vitamins, herbs, minerals.

Supplement	Dose/Frequency	Start Date	Reason

Medications

List all medications you're currently taking.

Medication	Dose/Frequency	Start Date	Reason

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List your current health concerns in order of importance

Health Concerns

Do you experience digestive difficulties?
(i.e. bloating constipation, gas, constipation)

List any food or environmental allergies you experience

Food/Environmental Allergies	Reaction

Diet

How much water do you drink daily?

Do you consume coffee? Yes No

Do you consume tea? Yes No

Do you consume alcohol? Yes No

List any other drinks you consume

How many times a week do you eat meat?

How many vegetables do you eat per day?

How many fruits do you eat per day?

What are your favorite foods?

What foods do you avoid?

Do you experience any symptoms after meals?

Describe your relationship with food
Please be very specific

Lifestyle

How many hours do you sleep a night?

Do you have trouble falling asleep? Staying asleep? You wake frequently during the night?

Do you wake feeling rested? Yes No

Do you do any structured exercise? Yes No

How often do you exercise?

What level of stress are you currently experiencing?

List your main stressors

How many hours per day do you use a computer?

How many hours per day do you watch TV?

Do you or have you used recreational drugs? Yes No

Is there anything that will get in the way of following a treatment plan in order to achieve results?

What is your level of commitment to improving your health?

1 2 3 4 5 6 7 8 9 10

1 = Lowest, 10 = Highest