Client Information Sheet

Please help us serve you better by taking a few minutes to provide the following information:

Client Name: _____ D.O.B._____ Age: _____

Gender: ☐ M ☐ F Preferred Phone # _____

Email _____ Preferred method of contact _____

Employer Name/Type of Work _____

Marital Status: ☐ Married ☐ Single ☐ Separated ☐ Divorced Number of children: _____

Lifestyle

What are your current stresses? _____

_____

How many hours do you typically sleep each night? _____

What are your hobbies or interest? _____

_____

_____

Social History

Do you smoke? ☐ Yes ☐ No Amount/Day: _____ For how long have you smoked? _____

If you quit smoking, when? _____

Do you use alcohol? ☐ Yes ☐ No Number of drinks/week: _____

Do you use caffeine? ☐ Yes ☐ No How often/week: _____

Medical History

Height: _____ Current Weight: _____ Weight 1 year ago: _____ Desired Weight: _____

Have you recently lost/gained weight? ☐ Yes ☐ No Amount: _____ Over how many months?_____

Was this weight loss intentional? ☐ Yes ☐ No

Do you weigh yourself? ☐ Yes ☐ No How often? _____

Are you concerned with your weight? ☐ Yes ☐ No

Are you currently taking any vitamins, Minerals or Herbal supplements? ☐ Yes ☐ No

If Yes, Specify: _____

Please indicate whether you or a family member have/had any of the following conditions:

	Self	Family History	Relationship	Treatment
Heart Attack	☐	☐	_____	Yes / No
Cardiovascular Disease	☐	☐	_____	Yes / No
Stroke	☐	☐	_____	Yes / No
Diabetes	☐	☐	_____	Yes / No
High Blood Pressure	☐	☐	_____	Yes / No
Kidney Disease	☐	☐	_____	Yes / No
Cancer (type)	☐	☐	_____	Yes / No
Thyroid Disease	☐	☐	_____	Yes / No
High Cholesterol	☐	☐	_____	Yes / No
Arthritis	☐	☐	_____	Yes / No
Osteoporosis	☐	☐	_____	Yes / No
Obesity	☐	☐	_____	Yes / No
Intestinal Problems	☐	☐	_____	Yes / No
Food Allergies	☐	☐	_____	Yes / No
Food Intolerances	☐	☐	_____	Yes / No
Mental Health Issues	☐	☐	_____	Yes / No
Other: _____	☐	☐	_____	Yes / No

Are you currently being treated for any medical conditions?

_____

_____

_____

List any medications you are currently taking or have taken in the last year:

_____

_____

_____

Allergies to Medications: _____

List All Prior Surgeries:

_____ _____

_____ _____

Weight History (complete if applicable):

How many times have you tried to lose weight? _____ What did you do? _____

Why did you go on a diet? _____

Have you ever used any of the following for weight control?

Commercial Diet Programs ☐ Yes ☐ No _____

Liquid Diets ☐ Yes ☐ No _____

Fad Diets ☐ Yes ☐ No _____

Prescription Diet Pills ☐ Yes ☐ No _____

Over-the-counter diet pills ☐ Yes ☐ No _____

Have you ever been diagnosed with an eating disorder? ☐ Yes ☐ No

Please explain: _____

_____

Exercise History:

Is there any reason why you cannot or should not exercise? ☐ Yes ☐ No

If yes, please list reasons: _____

_____

Are you currently exercising? ☐ Yes ☐ No

Please list type, duration, frequency and intensity of exercise activities.

_____

_____

How much time per day could you devote to exercise? _____

For incorporation of physical activity, of the 3 options, please select which is most sustainable to apply to your lifestyle?

☐ Lightly active – 30 minutes of moderate activity (like walking), 0 minutes of vigorous activity (like jogging) and 5000 steps/day
☐ Moderately active – 30 minutes of moderate activity, 15 minutes of vigorous activity and 8000 steps/day
☐ Very active – 60 minutes of moderate activity, 30 minutes of vigorous activity and 10,000 steps/day
☐ Extremely active – 90 minutes of moderate activity, 60 minutes of vigorous activity and 15,000 steps/day

**A good rule of thumb:*
During moderate activity you can easily talk during the activity. During vigorous activity you cannot get out more than a few words without having to catch your breath.

Eating Habits:

Do you routinely skip meals? ☐ Yes ☐ No

If Yes, explain _____

How many days/week do you eat? Breakfast: _____ Lunch: _____ Dinner: _____ Snacks: ____

When do you usually snack? _____

What do you choose typically as a snack? _____

Do you buy or pack your lunch? ☐ Buy # of days/week: _____ ☐ Pack # days/week _____

Do you eat out? ☐ Yes ☐ No How Often? _____

Do you order take out? ☐ Yes ☐ No How Often? _____

Do you eat fast food? ☐ Yes ☐ No How Often? _____

List restaurants you usually choose: _____

_____

Who does the grocery shopping? _____

Who prepares/cooks the meals? _____

Do you read food labels? ☐ Yes ☐ No

What are your favorite foods? _____

_____

_____

What foods do you dislike? _____

_____

_____

To the best of your ability, please list the foods and drinks that you have consumed in the past 24 hours.

Meal	Time & Place	What did you eat & drink? (Include amount)
BREAKFAST		
SNACK		
LUNCH		
SNACK		
DINNER		
SNACK		
OTHER		

How many servings of vegetables do you typically eat per day? 0 1 2 3 4 5+

Circle the vegetables that you eat below.

Non-starchy Vegetables Asparagus, beets, broccoli, Brussel sprouts, cabbage, carrots, cauliflower, celery, cucumber, eggplant, green beans, mushrooms, okra, onions, peppers, summer squash (yellow or zucchini), tomatoes, turnips, wax beans
Leafy Vegetables Salad greens, kale, mustard greens, spinach, sprouts, turnip greens, watercress
Starchy Vegetables Corn, dried beans or peas (pinto, kidney, white, black, brown beans, lentils, split peas, black-eyed peas, etc.), green peas, lima beans, potatoes, sweet potatoes, winter squash (acorn, butternut), yams, mixed vegetables with corn, peas, or pasta.

How many servings of fruit do you typically eat per day? 0 1 2 3 4 5+

Circle the fruits that you eat.

Fresh Fruit Apple, apricot, banana, blackberries/blueberries/other berries, cantaloupe, cherries, grapefruit, grapes, honeydew, kiwi, mango, nectarine, orange, papaya, peach, pear, pineapple, plum, strawberries, tangerine, watermelon, other
Canned Fruit **(including fruit cups)** Applesauce, apricot, fruit cocktail, grapefruit sections, mandarin oranges, peaches, pears, pineapple, other
Dried Fruit Apple, apricot, cranberries, craisins, dates, figs, peaches, prunes, raisins, other
Juice Apple, cranberry, grape, grapefruit, mixed fruit, orange, pineapple, prunes, other

How many servings from the dairy group do you eat per day? (milk, milk alternatives, cheese, yogurt)

1 2 3 4+

How many servings of meat/meat alternatives do you eat per day? (chicken, beef, turkey, fish, etc., eggs, beans, nut butter, nuts, tofu, tempeh)

1 2 3 4 5 6+

Of theses how many are lean meats? (chicken, turkey, fish, eggs, tofu, tempeh, beans, nuts)

None less than half half more than half All

How many times per week do you eat red meat?

0 1-2 3-4 5-6 every day more than 1x per day

How many servings of grains do you eat per day? (rice, pasta, cereal, oatmeal, bread, etc.)

1 2 3 4 5 6 7 8+

Of these grains, how many are whole grains? (wheat bread, brown rice, quinoa, etc.)

None less than half half more than half All

How many times per week do you eat dessert?

0 1-2 3-4 5-6 every day more than 1x per day

What are your go to desserts? _____

Goal Setting

What does being healthy mean to you?

What are your goals for this program?

1.

2.

3.

On a scale from 1-10, how important is it to you to make the necessary changes to meet your goals?
(10 – extremely important; 1 – not important at all)

10 9 8 7 6 5 4 3 2 1

On a scale from 1-10, how confident are you that you can make the necessary changes to meet your goals?
(10 – extremely important; 1 – not important at all)

10 9 8 7 6 5 4 3 2 1

Circle where you fall on the scale – How ready are you to make the necessary changes to progress towards our personal goals?
(10 – extremely important; 1 – not important at all)

10 9 8 7 6 5 4 3 2 1

Please select the area in which you would desire more information and instruction:

☐ Portion Control
☐ Meal Patterns
☐ Reading Food Labels
☐ Healthy Tips for Dining Out
☐ Meal Planning
☐ Sodium
☐ Mindful Eating
☐ Other _____

_____ _____

Client Signature ***Date***