



## Integrative Wellness Center Medical Nutrition Therapy Intake Form

All information provided will be kept completely confidential for the exclusive use of MarinHealth Integrative Wellness Center staff, practitioners and/or physicians in order to provide you the best possible care.

Today's Date: \_\_\_\_\_

Patient's Name: Mr. / Mrs. / Ms. (circle one) \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone (Home): \_\_\_\_\_ (Cell): \_\_\_\_\_

Email: \_\_\_\_\_ @ \_\_\_\_\_ Occupation: \_\_\_\_\_

What is the BEST way to communicate with you in between office visits? \_\_\_\_\_

Home phone  Cell phone  Email

Is there any place you DO NOT want us to leave a message? \_\_\_\_\_

Age: \_\_\_\_\_ Birth Date: \_\_\_\_\_

Primary Physician's Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Emergency Contact Name / Relation: \_\_\_\_\_ Phone: \_\_\_\_\_

### Goals and Readiness Assessment

*I would like to visit with the dietitian, today because...*

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*My food and nutrition-related goals are...*

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*My overall, health goals are...*

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**Integrative Wellness Center**

1350 S. Eliseo Greenbrae, CA 94904 | O 1-415-925-7620

www.mymarinhealth.org

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The biggest challenge(s) to reaching my nutrition goals is/are:

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In the past, I have tried the following techniques, diets, behaviors, etc. to reach my nutrition goals...

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On a scale of 1 (not willing) to 5 (very willing), please indicate your readiness/willingness to do the following:

To improve your health, how ready/willing are you to...	1	2	3	4	5
Modify your diet					
Take nutritional supplements each day (if appropriate)					
Keep a record of everything you eat each day					
Modify your lifestyle (ex: work demands, sleep habits, physical activity)					
Practice relaxation techniques					
Engage in regular exercise/physical activity					
Have periodic lab tests to assess your progress					

Please list the medications are you currently taking (prescription and/or over-the-counter):

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Do you take any vitamins or other dietary supplements? Yes/No

If yes, please list what they are, the brand and how often you take them.

Type of Supplement (e.g. vitamin D, fish oil etc)	Brand (e.g. Nature's way)	Dose (e.g. 1000 IU)	How often? (e.g. 1 x day, 1 x week)

## Past Medical History

Please indicate whether you or your relatives (parents, grandparents, siblings) have been diagnosed with any of the following diseases or symptoms. Specify which relative and the date of diagnosis.

	Illness/Disease/Symptom	Self: Age Diagnosed	Relative: Age Diagnosed	Describe/Specify
<input type="checkbox"/>	Allergies (Specify)			
<input type="checkbox"/>	Anemia			
<input type="checkbox"/>	Anxiety or Panic Attacks			
<input type="checkbox"/>	Arthritis (Osteoarthritis or Rheumatoid)			
<input type="checkbox"/>	Asthma			
<input type="checkbox"/>	Autoimmune Condition (Specify)			
<input type="checkbox"/>	Cancer (Specify)			
<input type="checkbox"/>	Chronic Fatigue Syndrome			
<input type="checkbox"/>	Crohn's Disease or Ulcerative Colitis			
<input type="checkbox"/>	Depression			
<input type="checkbox"/>	Diabetes (Specify: Type I, II, Pre-diabetes, Gestational Diabetes)			
<input type="checkbox"/>	Epilepsy, Convulsions, or Seizures			
<input type="checkbox"/>	Eye Disease (Specify)			
<input type="checkbox"/>	Fibromyalgia			
<input type="checkbox"/>	Food Allergies or Sensitivities			
<input type="checkbox"/>	Gallbladder Disease/Gallstones(specify)			
<input type="checkbox"/>	Gout			
<input type="checkbox"/>	Heart Attack/Angina			
<input type="checkbox"/>	Heartburn			
<input type="checkbox"/>	Heart Disease (Specify)			
<input type="checkbox"/>	Hepatitis			
<input type="checkbox"/>	High Blood Fats (Cholesterol, Triglycerides)			
<input type="checkbox"/>	High Blood Pressure (Hypertension)			
<input type="checkbox"/>	Hypoglycemia (Low Blood Sugar)			
<input type="checkbox"/>	Intestinal Disease (Specify)			
<input type="checkbox"/>	Inflammatory Bowel Disease (Crohn's or Ulcerative Colitis)			
<input type="checkbox"/>	Irritable Bowel Syndrome			
<input type="checkbox"/>	Kidney Disease/Failure or Kidney Stones			
<input type="checkbox"/>	Lung disease (Specify)			
<input type="checkbox"/>	Liver disease			
<input type="checkbox"/>	Osteoporosis			
<input type="checkbox"/>	PMS			
<input type="checkbox"/>	Polycystic Ovarian Syndrome			

## Weight History

Would you like to be weighed today? Yes/No

Height \_\_\_\_\_ Current Weight \_\_\_\_\_ Desired Body Weight \_\_\_\_\_

Highest Adult Weight \_\_\_\_\_ When? \_\_\_\_\_ Weight 1 year ago \_\_\_\_\_

Have you had any recent changes in your weight that you are concerned about? Yes/No

If yes, please explain: \_\_\_\_\_

Has your weight changed in the last year? Yes/No

If yes, what was your weight one month ago \_\_\_\_\_ 6 months ago \_\_\_\_\_

## Usual Food Intake

Compared to your normal food intake, has your current food intake changed during the past month?

Unchanged \_\_\_\_\_ more than usual \_\_\_\_\_ less than usual \_\_\_\_\_

Have you recently changed the type of food you are eating? (If yes please explain)

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Please check any of the following problems which have kept you from eating adequately over the past 2 weeks

- |   |  |  |
|---|--|--|
| <input type="checkbox"/> Poor appetite                      | <input type="checkbox"/> Food tastes different | <input type="checkbox"/> Dry mouth         |
| <input type="checkbox"/> Mouth sores                        | <input type="checkbox"/> Nausea                | <input type="checkbox"/> Smells bother me  |
| <input type="checkbox"/> Difficulty swallowing              | <input type="checkbox"/> Nausea                | <input type="checkbox"/> Feel full quickly |
| <input type="checkbox"/> Pain on swallowing                 | <input type="checkbox"/> Diarrhea              | <input type="checkbox"/> Feel full quickly |
| <input type="checkbox"/> Pain in general (please site pain) | <input type="checkbox"/> Fatigue               |  |

## Digestive History

Do you associate any digestive symptoms with eating certain foods? Yes No

If yes, please explain: \_\_\_\_\_

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How often do you have a bowel movement? \_\_\_\_\_

If you take laxatives, what type/brand and how often?

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## Meal Preparation

Have you recently changed the type of food you are eating? (If yes please explain)

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How many meals do you eat away from home on weekdays? \_\_\_\_\_ Breakfast \_\_\_\_\_ Lunch \_\_\_\_\_ Dinner

How many meals do you eat away from home on weekends? \_\_\_\_\_ Breakfast \_\_\_\_\_ Lunch \_\_\_\_\_ Dinner

List restaurants where you often eat?

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## 3 Day Food Diary

Please keep a food diary for 3 days. Write down all the foods and drinks consumed. Please include how much (the amount you ate or serving size) and any information about how it was prepared (i.e. baked, grilled, sautéed).

Day 1	Day 2	Day 3
Breakfast	Breakfast	Breakfast
Lunch	Lunch	Lunch
Dinner	Dinner	Dinner
Snacks	Snacks	Snacks

## Exercise & Other Lifestyle Habits

What type of exercise do you most enjoy (e.g. walking, running, swimming) \_\_\_\_\_

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### How often do you exercise?

- 1-2 days / week       I don't exercise very often because I don't really enjoy it
- 3-4 days / week
- 5-7 days / week       I enjoy exercising but don't have time

### For how long do you normally exercise?

- Less than 30 mins. / workout
- 30-45 mins. / workout
- >45 mins. / workout

What are your leisure activities/hobbies? \_\_\_\_\_

Do you drink alcoholic beverages? Yes/No

If yes how often? How many per day or per week? \_\_\_\_\_

Are you a smoker? Yes/No