CELINAS ECLECTIC STUDIO

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CLIENT INTAKE FORM

Please take a few minutes to fill out this form and answer the following questions.
Try to answer them as completely and honestly as possible. The more details you provide, the better we can tailor our time together to meet your individual nutrition needs and goals. All answers are confidential.
Please be prepared to describe your eating habits for the past 7 days, and bring this form with you to your first nutrition counseling session. You may also send it to the following email address: celinas.e.studio@gmail.com
If you have any questions about completing the form, please call: **602-751-3323**

A. PERSONAL INFORMATION

DATE

DATE OF BIRTH

BIOLOGICAL GENDER

FIRST NAME

LAST NAME

HOME ADDRESS

CITY

STATE

ZIP CODE

EMAIL ADDRESS

PHONE NUMBER

EMERGENCY CONTACT

PREFERRED CONTACT METHOD

EMERGENCY PHONE #

MARITAL STATUS ☐ Married ☐ Partnered ☐ Single ☐ Divorced ☐ Widowed

OCCUPATION

CHILDREN ☐ Yes ☐ No If yes, number of children? Ages?

B. NUTRITION GOALS AND EXPECTATIONS

1. What are your reasons for the consultation? What are your top 3 health concerns?

2. What are your personal nutritional goals? (check all that apply)

- ☐ Want to lose weight
- ☐ Want to gain weight
- ☐ General healthy eating
- ☐ Vegetarian/Vegan diet
- ☐ Disordered eating concerns
- ☐ Food allergy or intolerance
- ☐ Sport performance
- ☐ Personalized meal plan
- ☐ Expert guidance
- ☐ Recipes
- ☐ Support and motivation
- ☐ Other (please specify)

3. What eating habits would you like to work on?

4. How committed are you to making changes in your nutrition habits? (Please check)

1	2	3	4	5	6	7	8	9	10
☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

1 - is not committed at all, 10 - is very committed

5. Have you already had dietary consultations for your current reason or another?

☐ Yes ☐ No If so, when was the last time?

C. LIFESTYLE INFORMATION

1. Do you smoke?

☐ Yes ☐ No If yes, how often, how much:

2. Are you exposed to second hand smoke regularly?

☐ Yes ☐ No

3. Do you drink alcohol?

☐ Yes ☐ No If yes, how often, how much:

4. What is your job like?

☐ Mostly sitting
☐ Mostly physically demanding
☐ Shift work
☐ Night duty
☐ Irregular working hours
☐ Business trips
☐ Travel abroad
☐ Domestic
☐ Other (please specify)

5. Are you currently physically active? Do you do regular exercise?

☐ Yes ☐ No If yes, please describe your current physical activity:

Activity	Type/Intensity (Light - Moderate - Vigorous)	# Days/week	Duration (minutes)
Aerobics/Cardio (walking, running, biking, etc.)			
Strength Training (pilates, weight lifting, etc.)			
Sports or Leisure (football, basketball, tennis, swimming etc.)			
Stretching			
Other (describe)			

6. Do you have any exercise limitations? Yes No If yes, please describe:

7. On a scale of 1-10, how would you rate your stress level? (Please check)

1	2	3	4	5	6	7	8	9	10

1 - very low, 10 - very high

8. Do you feel you handle stress in a healthy manner? Yes Most days Seldom

9. Do you believe stress is presently reducing the quality of your life? Yes No

10. Daily stressors:

Work
Family
Finances
Health
Social
Other (please specify)

11. List your 3 biggest sources of stress:

a.

b.

c.

12. Average number of hours you sleep per night during the week?

<6 hours 6 to 8 hours 8 to 10 hours 10 or more hours

13. Average number of hours you sleep per night on the weekends?

<6 hours 6 to 8 hours 8 to 10 hours 10 or more hours

14. Do you nap? If so, how many minutes/hours?

15. Do you have trouble falling asleep?

Yes No

16. Are you rested upon waking?

Yes No

17. Do you wake up during the night?

Yes No If yes, how many times?

18. How would you rate the overall quality of sleep?

1 2 3 4 5 6 7 8 9 10

1 - very low, 10 - very high

19. What are your hobbies and leisure activities?

D. PERSONAL AND FAMILY MEDICAL HISTORY

1. Please check any family (parents and siblings) history of the following:

- Arthritis, rheumatoid, family member:
- Asthma, family member:
- Alcoholism, family member:
- Alzheimer's disease, family member:
- Cancer, family member:
- Depression, family member:
- Diabetes 1 or 2, family member:
- Drug addiction, family member:
- Eating disorder, family member:
- Food intolerance, family member:

- Genetic disorder, family member:
- Glaucoma, family member:
- Heart disease, family member:
- High blood pressure, family member:
- Infertility, family member:
- Kidney disease, family member:
- Lung disease, family member:
- Mental illness, family member:
- Migraine headaches, family member:
- Neurological disorders, family member:
- Obesity, family member:
- Osteoporosis, family member:
- Stroke, family member:
- Suicide, family member:
- Other, family member:

2. Please list all your past and present medical conditions:

Medical Condition	When	Comments
Gastro-intestinal		
Celiac disease		
Crohn's disease		
Diverticular disease		
Gastric reflux disease		
Irritable bowel (IBS)		

Medical Condition	When	Comments
Lactose intolerance		
Ulcerative Colitis		
Gastric or peptic ulcer		
Respiratory/Pulmonary		
Asthma		
Bronchitis		
Chronic Sinusitis		
Emphysema		
Pneumonia		
Sleep apnea		
Tuberculosis		
Hematology / Blood		
Anemia, type: _____		
Bleeding disorder		
Thalassemia		

Medical Condition	When	Comments
Hepatic / Pancreatic		
Cirrhosis		
Gallbladder disease		
Hepatitis		
Pancreatitis		
Renal		
Chronic kidney disease		
Dialysis		
Kidney failure		
Kidney stones		
Nephritis		
Urinary		
Incontinence		
Urinary Tract Infections		
Other: _____		

Medical Condition	When	Comments
Cancer		
Type: _____		
Type: _____		
Cardiovascular		
Angina/chest pain		
Cardiovascular disease		
Heart valve disease		
High blood pressure		
High cholesterol		
Peripheral artery disease		
Stroke		
Metabolic / Endocrine		
Metabolic syndrome		
Pre-diabetes		
Diabetes, type: _____		

Medical Condition	When	Comments
Hypoglycemia		
Polycystic ovary disease		
Infertility		
Thyroid disease		
For Females		
Currently pregnant		
Irregular / No periods		
Gestational Diabetes		
Peri-menopausal		
Post-menopausal		
For Men		
Benign prostatic hyperplasia		
Prostate cancer		
Infertility		
STD, type:_____		

Medical Condition	When	Comments
Other: _____		
Inflammatory / Autoimmune		
Chronic fatigue		
Fibromyalgia		
Gout		
Lupus SLE		
Rheumatoid Arthritis		
Musculo-skeletal		
Osteopenia		
Osteoporosis		
Osteoarthritis		
Neurological		
Addiction		
ADD/ADHD		
Anxiety		

Medical Condition	When	Comments
Autism		
Depression		
Headaches		
Migraines		
Multiple Sclerosis		
Parkinson's Disease		
Seizures		
Sleep difficulties		
Eating Disorder		
Anorexia		
Binge eating		
Bulimia		
Compulsive overeating		
Other: _____		
Other: _____		

Medical Condition	When	Comments
Dermatological		
Acne		
Eczema		
Rosacea		
Skin rashes		
Allergies, sensitivities		
Foods		
Foods		
Foods		
Foods		
Foods		
Allergies		
Medications		
Medications		
Medications		

Medical Condition	When	Comments
Medications		
Medications		
Allergies		
Environmental		
Environmental		
Environmental		
Environmental		
Environmental		
Other medical condition		
Other: _____		
Other: _____		
Other: _____		
Other: _____		
Other: _____		
Other: _____		

3. Please list any previous injuries, and surgeries (provide the date & your age, if known):

Injuries, surgeries	When	Comments
Injuries		
Back injury		
Broken _____		
Head injury		
Neck injury		
Other: _____		
Other: _____		
Other: _____		
Surgeries		
Appendectomy		
Gall Bladder		
Hernia		
Hysterectomy		
Tonsillectomy		

Injuries, surgeries	When	Comments
Dental Surgery		
Other: _____		
Other: _____		
Other: _____		
Other: _____		
Other: _____		

4. Hospitalizations: ___

Where hospitalized	When	For what reason
a.		
b.		
c.		
d.		
e.		
f.		
g.		

5. Read the following symptoms and fill in the number that applies, rate the severity or frequency of the symptom from 0 to 4. If the answer is yes or no, fill with Y or N.

0 - do not have the symptom, does not apply the symptom
1 - it is a minor or infrequent symptom
2 - it is a moderate symptom or occurs occasionally
3 - it is a significant symptom or occurs frequently
4 - it is a severe symptom, or you are aware of it almost all the time

- Cold hands and feet
- Cold intolerance
- Daytime sleepiness
- Difficulty falling asleep
- Early waking
- Fatigue
- Frequent fever
- Flushing
- Heat intolerance
- Night waking
- Nightmares
- Peeling, soft or splitting nails
- Belching or gas within 1 hr. of a meal
- Distaste for meat (not a vegetarian or for moral reasons)
- Bloating after eating
- Only specific foods cause bloating
- Sleepy after eating
- Sensitive to smoke
- Pain between the shoulder blades
- Metallic taste in the mouth
- Bitter taste in mouth, especially after meals
- Wake up without remembering dreams
- Trouble tolerating greasy foods
- Trouble tolerating garlic or onions
- Sensitive to chemicals (perfume, insecticides, exhaust fumes)
- Crave coffee or sugar in the afternoon
- Sweet cravings
- Crave bread or noodles
- Carve salt or salty foods
- Crave greasy or fatty foods
- Lactose intolerant
- Coated tongue
- Bad breath
- Sweat a lot
- Sweat at night
- Feet have a strong odor or sweat easily
- Sweat has strong odor
- Irritable, shaky if miss a meal
- Metallic taste in the mouth
- Frequent thirst
- Frequent urination
- Frequent infections

- [ ] Cuts take a long time to heal
- [ ] Numbness or tingling in the extremities
- [ ] Hypoglycemia
- [ ] Ankles swell
- [ ] Become cold easily or when others are not
- [ ] Depression
- [ ] Difficulty losing weight
- [ ] Frequent colds or flu
- [ ] Become dizzy when standing up suddenly
- [ ] Trouble getting out of bed in the morning
- [ ] Tend to be a “night” person
- [ ] Tendency to worry
- [ ] Keyed up, trouble calming down
- [ ] Feelings of insecurity
- [ ] Clench or grind teeth
- [ ] Jaw clicks, pops, locks or makes noise
- [ ] Decreased ability to taste or smell
- [ ] Get hives
- [ ] Taken birth control pills
- [ ] Fungus or yeast infections
- [ ] Yes [ ] No History of anorexia or bulimia
- [ ] Anemia that is unresponsive to iron
- [ ] Hands tremble
- [ ] Calves cramp at night
- [ ] Legs cramp after walking, better after rest
- [ ] Dark circles under the eyes
- [ ] Sense of fullness after meals
- [ ] Feel better if you don’t eat
- [ ] Exercise makes you feel worse
- [ ] Fluid retention
- [ ] Yes [ ] No Yellow in the whites of the eyes
- [ ] Yes [ ] No Are you a vegan (no dairy, meat, or fish)
- [ ] Yes [ ] No Aspirin is effective in relieving pain
- [ ] Conjunctivitis
- [ ] Distorted sense of smell
- [ ] Distorted taste
- [ ] Ear fullness
- [ ] Ear noises
- [ ] Ear ringing, buzzing
- [ ] Yes [ ] No Do you have tinnitus (ringing in your ears)
- [ ] Ear pain
- [ ] Eye crusting
- [ ] Eye pain
- [ ] Headache
- [ ] Migraine
- [ ] Afternoon headaches
- [ ] Tension headaches (base of skull)
- [ ] Hearing loss
- [ ] Hearing problems
- [ ] Lid margin redness
- [ ] Sensitivity to loud noises

- [ ] Trouble seeing at night
- [ ] Eyes sensitive to bright light
- [ ] Vision problems
- [ ] Back muscle spasm
- [ ] Calf cramps
- [ ] Chest tightness
- [ ] Foot cramps
- [ ] Joint deformity
- [ ] Joint pain
- [ ] Joint stiffness
- [ ] Joints click or pop
- [ ] Muscle pain
- [ ] Muscle spasms
- [ ] Muscle stiffness
- [ ] Muscle twitches around eyes
- [ ] Muscle twitches in arms or legs
- [ ] Muscle weakness
- [ ] Neck muscle spasm
- [ ] Yes [ ] No Have you ever had a herniated disc
- [ ] Tendonitis
- [ ] Agoraphobia
- [ ] Anxiety
- [ ] Difficulty concentrating
- [ ] Difficulty with balance
- [ ] Difficulty with thinking
- [ ] Difficulty with memory
- [ ] Difficulty with speech
- [ ] Difficulty with judgment
- [ ] Dizziness
- [ ] Fainting
- [ ] Fearfulness
- [ ] Irritability
- [ ] Light-headedness
- [ ] Phobias
- [ ] Panic attacks
- [ ] Paranoia
- [ ] Seizures
- [ ] Suicidal thoughts
- [ ] Tremor, trembling
- [ ] Binge eating
- [ ] Bulimia
- [ ] Can't gain weight
- [ ] Carbohydrate craving
- [ ] Carbohydrate intolerance
- [ ] Poor appetite
- [ ] Alternating constipation/diarrhea
- [ ] Anal spasms
- [ ] Bad teeth
- [ ] Bleeding gums
- [ ] Bloating of lower abdomen
- [ ] Bloating of whole abdomen
- [ ] Burping
- [ ] Canker sores
- [ ] Cold sores
- [ ] Constipation

- [ ] Cracking at the corner of lips
- [ ] Poor chewing
- [ ] Diarrhea
- [ ] Difficulty swallowing
- [ ] Dry mouth
- [ ] Farting
- [ ] Gastric reflux
- [ ] Gallbladder attacks (past or present)
- [ ] Heartburn
- [ ] Hemorrhoids
- [ ] Intolerance to lactose
- [ ] Intolerance to all milk products
- [ ] Intolerance to gluten (wheat)
- [ ] Intolerance to corn
- [ ] Intolerance to eggs
- [ ] Intolerance to fatty foods
- [ ] Intolerance to yeast
- [ ] Liver disease/jaundice yellow eyes or skin)
- [ ] Lower abdominal pain
- [ ] Mucus in stools
- [ ] Blood in stools
- [ ] Black or tarry stools
- [ ] Clay-colored stools
- [ ] Greasy or shiny stools
- [ ] Undigested fat in stool
- [ ] Strong stool odor
- [ ] Undigested food in stools
- [ ] Nausea
- [ ] Periodontal disease
- [ ] Sore tongue
- [ ] Upper abdominal pain
- [ ] Vomiting
- [ ] Acne on back
- [ ] Acne on chest
- [ ] Acne on face
- [ ] Acne on shoulders
- [ ] Athlete's foot
- [ ] Cellulite
- [ ] Ears get red
- [ ] Bruise easily
- [ ] Blush or face turns red for no reason
- [ ] Eczema
- [ ] Herpes - genital
- [ ] Hives
- [ ] Jock itch
- [ ] Lackluster skin
- [ ] Moles color/size change
- [ ] Oily skin
- [ ] Pale skin
- [ ] Psoriasis
- [ ] Rash
- [ ] Sensitive to bites
- [ ] Shingles
- [ ] Skin cancer
- [ ] Strong body odor
- [ ] Thick calluses

- [ ] Vitiligo
- [ ] Anus itching
- [ ] Arms itching
- [ ] Ear canals itching
- [ ] Eyes itching
- [ ] Feet itching
- [ ] Hands itching
- [ ] Legs itching
- [ ] Nipples itching
- [ ] Nose itching
- [ ] Penis itching
- [ ] Roof of mouth itching
- [ ] Scalp itching
- [ ] Skin in general itching
- [ ] Throat itching
- [ ] Dryness of eyes
- [ ] Dryness of feet
- [ ] Cracking of feet
- [ ] Peeling of feet
- [ ] Brittle, coarse hair
- [ ] Hair breaks or falls out easily
- [ ] Increased body hair
- [ ] Hands cracking
- [ ] Hands peeling
- [ ] Mouth, throat dryness
- [ ] Dry flaky skin or dandruff
- [ ] Enlarged/neck
- [ ] Tender/neck
- [ ] Enlarged/tender lymph nodes
- [ ] Bitten nails
- [ ] Brittle nails
- [ ] Curve up nails
- [ ] Frayed nails
- [ ] Fungus - fingers
- [ ] Fungus - toes
- [ ] Pitting
- [ ] Ragged cuticles
- [ ] Soft nails
- [ ] Thickening of finger nails
- [ ] Thickening of toenails
- [ ] White spots, lines on nails
- [ ] Bad odor in nose
- [ ] Dry cough
- [ ] Productive cough
- [ ] Hay fever in Spring
- [ ] Hay fever in Summer
- [ ] Hay fever in Fall
- [ ] Hay fever in Change of season
- [ ] Hoarseness
- [ ] Nasal stuffiness
- [ ] Nose bleeds
- [ ] Post nasal drip
- [ ] Sinus fullness
- [ ] Sinus infection
- [ ] Sigh frequently, air hunger or trouble catching breath

- [ ] Snoring
- [ ] Sore throat
- [ ] Wheezing
- [ ] Angina/chest pain
- [ ] Breathlessness
- [ ] Heart attack
- [ ] Heart murmur
- [ ] Heart races or palpitations
- [ ] High blood pressure
- [ ] Low blood pressure
- [ ] Poor circulation
- [ ] Arteriosclerosis
- [ ] Swollen ankles, feet
- [ ] Varicose veins
- [ ] Bed wetting
- [ ] Bloody, cloudy and/or darkened urine
- [ ] Dribble after voiding urine (Men)
- [ ] Frequent urination or urgency to urinate (Men)
- [ ] Interruption of the stream during urination (Men)
- [ ] Kidney disease
- [ ] Kidney stone
- [ ] Leaking, incontinence
- [ ] Pain, burning (Urinary)
- [ ] Prostate enlargement
- [ ] Prostate infection
- [ ] Urinary infection
- [ ] Urine has a strong odor
- [ ] Discharge from penis
- [ ] Ejaculation problem
- [ ] Genital pain (Men)
- [ ] Impotence
- [ ] Infection (Men Reproductive System)
- [ ] Lumps in testicles
- [ ] Breast cysts (Female Reproductive System)
- [ ] Breast lumps
- [ ] Breast tenderness
- [ ] Ovarian cyst
- [ ] Endometriosis
- [ ] Fibroids
- [ ] Infertility
- [ ] Vaginal discharge
- [ ] Vaginal odor
- [ ] Vaginal itch
- [ ] Vaginal pain
- [ ] Bleeding between periods
- [ ] Bloating (Premenstrual)
- [ ] Breast tenderness (Premenstrual)
- [ ] Carbohydrate craving (Premenstrual)
- [ ] Chocolate craving (Premenstrual)
- [ ] Constipation (Premenstrual)
- [ ] Decreased sleep (Premenstrual)
- [ ] Diarrhea (Premenstrual)
- [ ] Excess facial hair (Women)
- [ ] Fatigue (Premenstrual)
- [ ] Hot flashes (Women over 35)
- [ ] Increased sleep (Premenstrual)
- [ ] Irritability (Premenstrual)

- [ ] Occasionally skip periods
- [ ] Cramps (Menstrual)
- [ ] Heavy periods (Menstrual)
- [ ] Irregular periods (Menstrual)
- [ ] No periods (Menstrual)
- [ ] Scanty periods (Menstrual)
- [ ] Spotting between (Menstrual)
- [ ] Other (describe):

E. REPRODUCTIVE HEALTH (WOMEN ONLY)

1. Are you pregnant? [ ] Yes [ ] No If so, how many weeks?
2. Are you trying to become pregnant? [ ] Yes [ ] No
3. Have you ever been pregnant? [ ] Yes [ ] No
4. Are you having difficulty conceiving? [ ] Yes [ ] No
5. Number of term births Birth weight of largest baby Smallest baby
6. Did you develop toxemia (high blood pressure)? [ ] Yes [ ] No
7. Have you had other problems with pregnancy? [ ] Yes [ ] No If so, please describe:
8. Do you have any hormonal problems that you know of? Please describe if so:
9. Do you use contraceptive pills? [ ] Yes [ ] No
10. Are your periods regular? [ ] Yes [ ] No
11. Are your periods heavy or painful? [ ] Yes [ ] No
12. Do you suffer from Pre-menstrual syndrome (PMS)? [ ] Yes [ ] No Check the symptoms:

- [ ] Anxiety
- [ ] Fatigue
- [ ] Bloating
- [ ] Other :
- [ ] Irritability
- [ ] Sweet craving
- [ ] Breast tenderness
- [ ] Mood swings
- [ ] Increased appetite
- [ ] Depression

13. Are you in Menopause? Yes No Check the symptoms:

- Irregular periods
- Hot flushes
- Night sweats
- Altered skin
- Acne
- Water retention
- Bloating
- Mood swings
- Depression
- Other
  :

14. Are you taking hormone replacement therapy? Yes No Please describe if so:

F. SUPPLEMENTS AND MEDICATIONS (INCLUDING ANTIBIOTICS)

1. What medications are you taking now? Include non-prescription medications too.

2. List all vitamins, minerals, and other nutritional supplements that you are taking now. If possible, list the form too for ex.: Magnesium Citrate or Magnesium Oxide, Ascorbic Acid or Ascorbyl Palmitate, etc.

3. Are you allergic to any medications? Yes No If yes, please list:

E. EATING HABITS

1. Are you currently following a special diet? Yes No

Diabetic
Dairy-free
Gluten-free
Vegetarian
Vegan
Low cholesterol
Other, please specify:

2. How often do you eat breakfast during the week?

Every Morning 1-3 days Hardly Ever

3. How many meals and snacks do you usually eat per day?

1 meal or less 2-3 meals (no snacks) 2-3 meals + 1-2 snacks >4 meals

If 1 meal or less, why?

4. How many times a week do you eat the following meals away from home?

Breakfast Lunch Dinner

5. How much water do you drink daily?

6. Do you have trouble accessing healthy food?

7. Do you use salt in your cooking, or add it to your food? Yes No Sometimes

8. Do you eat organic food? Yes No Sometimes Type:

9. Please list the three foods you most like:

10. Please list the three foods you most dislike:

11. Do you miss meals? Yes No Sometimes Which:

12. Which of the following ways you prepare food:

- Boil
- Bake
- Grill
- Fry
- Stir fry
- Microwave
- Other, please specify:

13. Do you have symptoms immediately after eating, such as bloating, belching, cramps, hives, sneezing, etc.?

Yes No Sometimes Which:

14. If yes, are these symptoms associated with any particular food or supplement(s)?

Yes No

15. Please name the food or supplement and symptom(s). Example: Milk – gas and diarrhea.

16. Do you feel you have delayed symptoms after eating certain foods (symptoms may be evident after 24 hours or more), such as sinus congestion, muscle aches, etc.?

Yes No

17. Do you feel much worse when you eat:

- high protein foods
- high fat foods
- high carbohydrate foods (potatoes, pastas, breads)
- fried foods
- refined sugar (junk food)
- Other, please specify:

18. Do you feel much better when you eat:

- high protein foods
- high fat foods
- high carbohydrate foods (potatoes, pastas, breads)
- fried foods
- refined sugar (junk food)
- Other, please specify:

19. How often do you have a bowel movement?

- more than 3x/day
- 2-3x/week
- 1-3x/day
- 1x or fewer/week

20. Your stools are? Check all that allow most often.

- hard
- soft
- loose
- difficult to pass
- diarrhea
- thin, long
- alternating between hard and loose/watery
- other, please specify:

21. What color is your stool? Most often.

- medium brown
- very dark or black
- dark brown consistently
- greenish color
- yellow, light brown
- shiny appearance
- blood is visible
- varies a lot
- other, please specify:

22. How often do you experience intestinal gas?

- daily
- occasionally
- excessive
- foul smelling
- little odor
- with pain

23. **Dietary Checklist.** Place a check in the column that describes how often you usually eat each food:

Food/Beverage	Daily	Most days	More than 1x/week	Seasonally	Rarely or never
Whole milk 3.5 %					
Nonfat milk					
Gout milk					
Lactose-free milk					
Almond/Cashew /Coconut Hemp/Oat/Rice / Soy Milk					

Food/Beverage	Daily	Most days	More than 1x/week	Seasonally	Rarely or never
Fruit juice					
Soda					
Lemonade or Kool-Aid					
Sports drinks (Gatorade, etc)					
Tea					
Coffee					
Beer, wine, or hard liquor					
Red meat (beef, lamb, pork)					
Poultry Chicken/Turkey					
Oily fish (salmon, tuna, herring, mackerel, sardines, anchovies)					
Other fish					

Food/Beverage	Daily	Most days	More than 1x/week	Seasonally	Rarely or never
Ham/bacon					
Processed meats (sausages, hamburgers, etc.)					
Yogurt					
Cheese					
Cottage Cheese					
Eggs					
Peanut butter					
Beans (limas, kidneys, etc.)					
Tofu and other soy foods					
Seeds (pumpkin, sesame, sunflower, etc.)					
Nuts (almonds, brazils, cashews etc.)					

Food/Beverage	Daily	Most days	More than 1x/week	Seasonally	Rarely or never
Bread, rolls, bagels					
Cereals (cold or hot)					
Pasta (white, wholewheat, non-wheat)					
Rice (white, wholegrain)					
Fresh fruits					
Canned fruits					
Apples					
Bananas					
Grapes					
Berries					
Peach					
Cherry					

Food/Beverage	Daily	Most days	More than 1x/week	Seasonally	Rarely or never
Apricot					
Pear					
Pineapple					
Plum					
Dried plum					
Raisin					
Orange					
Grapefruit					
Grape juice					
Grapefruit/Orange juice					
Fresh or frozen vegetables					
Canned vegetables					
Broccoli					
Carrot					

Food/Beverage	Daily	Most days	More than 1x/week	Seasonally	Rarely or never
Sweet potatoes					
Green bell pepper					
Tomatoes					
Raw cabbage					
Asparagus					
Beetroot					
Cauliflower					
Corn					
Boiled cabbage					
Celery					
Peas					
Lettuce					
Butter					
Margarine					

Food/Beverage	Daily	Most days	More than 1x/week	Seasonally	Rarely or never
Oils					
Salad dressings, mayonnaise					
Potato or corn chips					
Donuts, pies, pastries					
Biscuits					
Ice cream					
Chocolate					
Cakes					
Canned food					
Fried foods					
Home cooked meals					
Ready meals					
Eat out/Restaurants/ Take aways					

24. How much of the following do you eat/drink in a day:

Food/Beverage	Portions/ Slices	Cups/Mugs/ Glasses	Teaspoons	Other
Fresh fruit				
Vegetables (not potatoes)				
Bread/rolls (white, brown, wholemeal, baguette, rye)				
Sugar				
Tea				
Coffee				
Water (tap, bottled, filtered)				
Alcohol, type _____				
Alcohol, type _____				
Fizzy drinks, type _____				
Fizzy drinks, type _____				

F. ANTHROPOMETRY

1. Please fill in the information about your weight history:

Height: Current weight: Usual weight:

Desired body weight:

2. Have you recently gained or lost weight? If yes, please explain whether it was a gain or loss and what changes led to the change in weight.

3. When did your weight problem begin?

- ☐ Childhood
- ☐ Teenager
- ☐ 10 years ago
- ☐ 20 years ago
- ☐ 30 years ago
- ☐ Throughout life
- ☐ Other, please specify:

4. Is anyone in your family overweight?

- ☐ Mother
- ☐ Father
- ☐ Sibling
- ☐ Grandparent

5. What has been your most successful weight loss diet? Why?

G. FOOD JOURNAL

1. Please record in the attached food journal the foods and beverages that you eat and drink for seven days.
2. Do not change your eating behavior at this time, as the purpose of this food records is to analyze your present eating habits.
3. Include as much information as you can about those foods, by estimating the portion sizes too, for example: 1 cup, 1 piece, 1 handful, 1 tablespoon, 1 teaspoon, etc.
4. Please include information about the used cooking method - baked, fried, boiled, or grilled.
5. Remember to include snacks, desserts/candies, and drinks.
6. Include any added items, for example: tea with 1 tsp. sugar/honey, potato with 2 tsp. butter, etc.
7. Try to record the time you consume the food.

FOOD JOURNAL DAY #____ DATE:_____

Meal/Snack	Time of Day	Foods and Beverages please include portions/amounts eaten	Comments/Symptoms Cooking method
Breakfast			
Morning Snack			
Lunch			
Afternoon Snack			
Dinner			
Evening Snack			
Overnight Snack			

FOOD JOURNAL DAY #____ DATE:_____

Meal/Snack	Time of Day	Foods and Beverages please include portions/amounts eaten	Comments/Symptoms Cooking method
Breakfast			
Morning Snack			
Lunch			
Afternoon Snack			
Dinner			
Evening Snack			
Overnight Snack			

FOOD JOURNAL DAY #____ DATE:_____

Meal/Snack	Time of Day	Foods and Beverages please include portions/amounts eaten	Comments/Symptoms Cooking method
Breakfast			
Morning Snack			
Lunch			
Afternoon Snack			
Dinner			
Evening Snack			
Overnight Snack			

FOOD JOURNAL DAY #____ DATE:_____

Meal/Snack	Time of Day	Foods and Beverages please include portions/amounts eaten	Comments/Symptoms Cooking method
Breakfast			
Morning Snack			
Lunch			
Afternoon Snack			
Dinner			
Evening Snack			
Overnight Snack			

FOOD JOURNAL DAY #____ DATE:_____

Meal/Snack	Time of Day	Foods and Beverages please include portions/amounts eaten	Comments/Symptoms Cooking method
Breakfast			
Morning Snack			
Lunch			
Afternoon Snack			
Dinner			
Evening Snack			
Overnight Snack			

FOOD JOURNAL DAY #____ DATE:_____

Meal/Snack	Time of Day	Foods and Beverages please include portions/amounts eaten	Comments/Symptoms Cooking method
Breakfast			
Morning Snack			
Lunch			
Afternoon Snack			
Dinner			
Evening Snack			
Overnight Snack			

FOOD JOURNAL DAY #____ DATE:_____

Meal/Snack	Time of Day	Foods and Beverages please include portions/amounts eaten	Comments/Symptoms Cooking method
Breakfast			
Morning Snack			
Lunch			
Afternoon Snack			
Dinner			
Evening Snack			
Overnight Snack			

H. ADDITIONAL INFORMATION, PERSONAL SUGGESTIONS

1. Please share any additional information, or interests that I, as your Nutrition Coach should know.

I. CLIENT AGREEMENT

This Nutrition Coaching Agreement (the "Agreement") is entered into on [(date)] between [Celina Salas], (the "Nutrition Coach,") and [ ], (the "Client").

1. Purpose of Coaching/Advising:

The Client is seeking nutrition coaching services [to improve their overall health and well-being, manage specific health concerns, and achieve their nutritional goals.]

The Nutrition Coach [to provide guidance, support, and education in matters related to nutrition, dietary habits, and lifestyle. In no way is Celina Salas authorized or claiming to treat, cure or diagnose.]

2. Scope of Services:

- **Initial Assessment:** The Nutrition Coach will conduct an initial assessment to understand the Client's health history, dietary preferences, lifestyle, and specific goals.
- **Customized Nutrition Plan:** Based on the assessment, the Nutrition Coach will develop a personalized nutrition plan tailored to the Client's unique needs and goals.
- **Nutrition Education:** The Nutrition Coach will provide education on various aspects of nutrition, including macronutrients, micronutrients, portion control, meal planning, and dietary choices.
- **Ongoing Support:** The Nutrition Coach will offer ongoing support, encouragement, and guidance to help the Client implement and sustain their nutrition plan.
- **Goal Setting:** The Client and the Nutrition Coach together will set specific, measurable, and achievable nutrition goals.

3. Coaching/Advising Goals:

The primary goals of this coaching/counseling are as follows:

- Improve overall nutrition and dietary choices;
- Manage specific health concerns, such as weight management, allergies, or chronic conditions;
- Enhance energy levels and overall well-being;
- Develop sustainable and realistic dietary habits;
- Achieve specific nutrition-related goals set by the Client.

4. Confidentiality:

Both the Client and the Nutrition Coach agree to maintain strict confidentiality regarding all personal and health information shared during coaching/advising sessions.

The following exceptions apply:

- Information related to harm to self or others may be disclosed in compliance with applicable laws and regulations;

- Information may be shared with other healthcare professionals involved in the Client's care with the Client's consent.

5. Payment:

The Fee for coaching/advising services is $40 per one hour session. Time for meal planning is billed separately from coaching/advising services. An additional fee is $40 per one hour of meal planning. Payments may be paid with cash, check, credit card, or venmo.

6. Termination:

Either party may terminate this Agreement with written notice. The Client is responsible for fees associated with services provided up to the date of termination.

7. Governing Law:

This Agreement shall be governed by the laws of the state of Arizona.

By signing this Agreement, both parties acknowledge their understanding of its terms and consent to the provision of nutrition coaching/counseling services.

DATE:

DATE:

CLIENT'S FULL NAME (PRINTED):

NUTRITION COACH'S FULL NAME (PRINTED):

CLIENT'S SIGNATURE:

NUTRITION COACH SIGNATURE: