Susie Bond, RDN, LDN
NutritionistOnCall@gmail.com 321-327-3793

NEW CLIENT INTAKE FORM

DEMOGRAPHIC INFORMATION

Name: Birthday:
Address:
Preferred phone number:
Email address:
Marital status:
Number of people in household:
Highest level of education:
Occupation:
Typical work/volunteer hours or schedule per week:

How did you hear about Susie Bond?
Reason for visit today:

Primary physician/healthcare provider: Phone:

LAB RESULTS

Please enter your most recent lab results below, if applicable:

Lab Test	Results	Date Taken	Comments/Other Details
Total cholesterol			
LDL-cholesterol			
HDL-cholesterol			
Triglycerides			
A1c			
Hematocrit/hemoglobin			
Blood sugar			
Blood pressure			

WEIGHT HISTORY

Please enter your current weight, height and any other weight-related history you'd like to share.
Weight: lbs Height/length: inches
Any recent weight gain or loss? Amount: Time frame:
Was this weight change intentional/unintentional? Please explain.

Lowest weight: Age:
Highest weight: Age:
Weight at which I feel my best:

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Please share past weight loss/gain attempts, successful or unsuccessful dieting strategies, history of disordered eating, emotions surrounding food/eating, etc.:

MEDICAL HISTORY

Please circle if you have been diagnosed with or currently have any of the following conditions:

Allergies	Fibromyalgia	Lung Disease
Alcohol Abuse	Food allergies or sensitivities	Liver disease
Anemia	Fungal infection (athlete's foot, ringworm, other)	Metabolic Syndrome
Anxiety or Panic Attacks	Gallbladder disease/gallstones	Osteoporosis/osteopenia
Arthritis	Gout	PMS
Asthma	Headaches	Polycystic Ovary Syndrome
Autoimmune Condition	Heart attack/angina	Pneumonia
Back Pain	Heartburn/GERD	Pre-diabetes
Bronchitis	Heart disease	Psychiatric conditions
Cancer	Hepatitis	Sinusitis
Chronic Fatigue Syndrome	High blood lipids (cholesterol, triglycerides)	Sleep apnea
Depression	High blood pressure (hypertension)	Stomach Ulcer
Diabetes (Type I, Type II, Gestational)	Hypoglycemia (low blood sugar)	Stroke
Dry itchy skin, rashes, dermatitis	Intestinal disease	Swollen feet/legs
Eating Disorder (anorexia nervosa, binge eating)	Inflammatory bowel disease (Crohn's Disease or Ulcerative Colitis)	Thyroid disease/condition
Eczema	Irritable bowel syndrome	Urinary tract infection
Epilepsy, convulsions, seizures	Joint Pain/Knee or Hip Replacement	Vitamin D deficiency
Eye disease	Kidney disease/failure or kidney stones	

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Other medical conditions:

Relevant family medical history:

MEDICATION

Current medications:

Vitamins, supplements, herbs, weight loss aids:

PHYSICAL ACTIVITY

Do you participate in regular physical activity/exercise? Please describe.

Do you know of any reason(s) why you should not exercise?

ALCOHOL & SMOKING

Do you do the following?
Smoke Amount per day:
Drink alcohol Type: Drinks per day/week:

DIETARY HABITS

Eating out frequency:

Favorite restaurants:

Who does the food shopping and cooking in your home?

Food allergies or intolerances:

My favorite food(s) are:

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Foods I do not like or generally avoid:

Food(s) I cannot live without:

Are you currently following a specific diet or meal plan?

Are you interested in trying a particular diet?

Is there anything you would like to change about your current diet?

SLEEP

Hours per night:
Do you have any problems sleeping?

YOUR "PERFECT MEAL"

What does this look like?