Nutrition & Wellness Intake Form

Welcome to the SRM Wellness Program! I am looking forward to working with you. This questionnaire will help me learn more about you so that we can make the most of our first session together. Please complete and send back to SRM through the portal.

Name: ____ **Date of Birth**: ____________ **Age**: _______

Health Concerns:
What are your top 1-3 reasons for seeking nutrition and wellness coaching?
1. ____
2. ____
3. ____

Nutrition:
Do you have any food allergies? □ Yes □ No
If so, please list which foods:
____

Do you avoid any foods? □ Yes □ No
If so, please list which foods and why:
____
____

What are your favorite foods?
____
____

Which foods do you dislike?
____
____

Do you skip meals often? □ Yes □ No

Do you regularly have low blood sugar symptoms (irritable, shaky, light-headed, fatigued)? □ Yes □ No

Do you drink caffeinated beverages? □ Yes □ No
If yes, check amounts:
Coffee: □ 1 per day □ 2-4 per day □ >4 per day
Tea: □ 1 per day □ 2-4 per day □ >4 per day
Caffeinated sodas: □ 1 per day □ 2-4 per day □ >4 per day

Check all of the factors that apply to your current lifestyle and eating habits:

□ Fast eater
□ Overeat often
□ Late-night eating
□ Dislike healthy foods
□ Time constraints
□ Travel often
□ Eat out more than 50% of the time
□ Healthy foods not readily available
□ Poor snack choices
□ Significant other or family members don't like healthy foods
□ Significant other or family members have specific dietary needs
□ Love to eat
□ Eat because I have to
□ Have negative relationship to food
□ Emotional eater (eat when sad, lonely, bored)
□ Overeat when stressed
□ Undereat when stressed
□ Don't like cooking
□ Confused about nutrition advice

Digestive Health:

Do you have acid reflux/heartburn? □ Yes □ No

Please fill in the chart below with information about your bowel movements:

Frequency: □ More than 3x per day □ 1-3x per day □ 4-6x per week □ 2-3x per week □ 1 or fewer per week

Consistency: □ Soft and well-formed □ Often float □ Difficult to pass □ Diarrhea

Is there anything else you'd like to share about your digestive health?

____
____

Movement:

Current Movement Routine:

Activity	Type	# of Times Per Week	Time (Minutes)
Cardio			
Strength/Resistance			
Flexibility/Stretching			
Balance			
Sports/Leisure			
Other:			

Is there anything limiting you with movement? □ Yes □ No

If yes, please explain:

____
____

Sleep:

How many hours of sleep do you get a night, on average? ________________________________

Do you have trouble falling asleep? □ Yes □ No

Do you have trouble staying asleep? □ Yes □ No

Do you wake up feeling rested? □ Yes □ No

Do you use sleeping aids? □ Yes □ No
If yes, please explain: ____

Stress:

Please rate your stress levels on a scale from 1-10 and describe which areas of your life you attribute it to (work, family, relationships, finances, health, etc.)

____

____

Does the amount of stress in your life feel unmanageable? □ Yes □ No

Are you interested in discussing stress in our sessions together? □ Yes □ No

Do you use any relaxation techniques? □ Yes □ No

If yes, how often? ____

If yes, what techniques do you use?

□ Meditation □ Breathwork □ Yoga □ Other: ____