Welcome Letter

I work with all different clients for various needs; mostly relating relationship with food, body, and self. This is not a quick fix approach but rather we work in collaboration to create a roadmap for your journey. Nutrition therapy not only involves addressing what you eat, but also how you think and feel about food and your body. This is not a one size fits all approach. I strive to understand your needs, preferences, and goals to offer realistic and personalized support for your food, nutrition, and body concerns. By integrating nutrition therapy, I hope to create a relationship built on trust so that we can honestly and openly communicate with one another.

Because our habits are deeply engrained, making changes that will last a lifetime occurs in stages and often takes time. Be patient. People often wonder how many times we'll need to meet. That entirely depends on the purpose of our meeting, your goals, your readiness to change, what support systems you have in place, and many other factors. We will always revisit our plan and goals at each meeting.

All information disclosed, discussed, and/or documented is strictly confidential. I strive to create a safe and judge-free space.

New Client Intake Form-

All information received on this form will be treated as strictly confidential. Please fill out the form completely and accurately. This information is essential to helping the nutrition therapist to develop a wellness program that addresses your needs, goals and interests and is safe and effective.

NEW Client REGISTRATION

Name Last, First: _____

Referred By (Doctor, friend, internet search, etc.): _____

Address: _____Apt:_____

City:_____ State:_____ Zip Code:_____

Date of Birth: _____ Sex: _____ Male _____Female

Primary Phone: _____Email:_____

Primary Physician (first and last name): _____

Physician Address & Phone #: _____

May we contact your physician regarding your appointment? _____

In case of emergency contact: _____ Phone#: _____

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Nutrition/Health Questionnaire

Name:

Reason for consultation: _____

What do you hope to achieve in our collaboration together? _____

_____

_____

Health and Medical History: Please indicate all that apply with a C (current) or P (past) in box to left

	Food allergies / intolerances		Diabetes
	Eating disorder		GI condition
	Other:		

Please name any medications, vitamins, botanicals, probiotics and any other supplements you use.

_____

Lifestyle:

Rate your health (check those that apply)

☐ **Excellent** ☐ **Good** ☐ **Fair** ☐ **Poor**

Rate your current perceived level of stress on a scale of 1-10: _____

Sleeping habits (Total and Quality):

On a scale of 1-10, 10 being the highest, how much support do you need when making lifestyle changes?

Do you have a strong support system?

Have you ever been advised by your physician to follow a special diet? (i.e. low salt/cholesterol, no sugar, etc):

☐ Yes ☐ No What changes did you make at that time?

What types of social media do you use?

How do you feel social media affects you?

Weight History:

Average weight for the past 2 to 3 years?

Weight you feel most comfortable _____ When were you last at that weight? _____

Highest Adult Weight? _____ Age: _____

Lowest Adult Weight? _____ Age: _____

Have you lost or gained weight recently? _____

How much? _____ Time frame? _____

Do you weigh yourself currently? If yes, how frequently _____

Please check how you currently feel about your body.

☐ Strongly dislike ☐ dislike ☐ slightly satisfied ☐ satisfied ☐ very satisfied

Eating Patterns:

How many meals a day do you eat?

Do you skip meals?

If yes, which ones do you skip and why?

What are your snacking habits (i.e. frequency, time of day, foods you choose)?

How many meals per week do you eat at a restaurant?

Which restaurants do you normally choose?

How does your meal and snack pattern vary on the weekend vs. during the week?

When you feel overwhelmed or life gets busy, do you neglect your eating habits?

____ yes ____ no

If yes, please describe:

Do you feel that your life/schedule conflicts with nourishing your body in the way you'd like to?

____yes _____ no

If yes, please describe:

Do you eat and multi-task (i.e. read, watch TV, drive) ___ yes ___ no

If yes, please describe:

Where do you eat your meals?

Do you feel you eat particularly fast or slow?

Please describe:

Do you cook? ☐ yes ☐ no

Do you like to cook? ___ yes ___ no

Who does the grocery shopping? _____

Who prepares the food at home? _____

Do you read food and nutrition labels? ☐ yes ☐ no

What do you look for on the labels?

Do you travel and/or entertain for business? ☐ yes ___ no

How often?

What foods do you love?

What foods do you dislike?

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Are there any foods that feel like trigger foods for you?

Are there any foods that feel “safe” to you?

Does your diet have a lot of variety or does it tend to be the same from day to day?

What do you think would make the most difference in your overall quality of life and/or health?

I value our time together and want you to feel valued and heard. Tell me foods and/or beverages that are most important to you and would want to stay incorporated to your diet.

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Please write a brief summary of any information that will be helpful to me regarding your health history, or in your own words tell me your story.

I have been given and read through HIPAA Notice of Privacy Practices

HIPAA Notice of Privacy Practices is visible in our offices and available at

www.meredithmagninird.com

Printed Name of Client_____

Signature _____ Date_____

Signature of parent or guardian (if <18yrs of age)

_____ Date_____