Nutrition Intake Form

Client Information

First Name	Last Name	Preferred Name	Patient Identifier (If known)
Gender	Preferred Pronouns	Date of Birth	Marital Status

Address	City	State	Zip Code
Email	Preferred Phone Number		

Emergency Contact

Full Name	Relationship	
Home Phone	Cell Phone	Work phone
Full Name	Relationship	
Home Phone	Cell Phone	Work phone

Insurance Information

Insurance Carrier	Insurance Plan	Contact Number
Policy Number	Group Number	Social Security Number

Referrals and Adjunctive Care

Are you currently under medical care? ☐ Yes ☐ No For? _____

Primary Care Physician	Address	Contact Number

Health Concerns/Symptoms

Describe your health/nutrition concerns

When did you first start having these concerns?

What are your health or nutrition-related goals for today and for your long-term health?