Megan Kraeger, MS, CNS
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New Client Nutrition Intake Form

Name____ Date_________________

Address____

City_____________________ State_________ Zip_____________

Home #________________Cell#________________ Work#_________________

E-Mail_____________________________

Please indicate your preferred method of contact: __________________________________

Occupation_________________________ Marital Status ________________

Referred By_________________________ Birth Date____________________

Are you pregnant? ☐ Yes ☐No Due Date: _______________________

Age:	Weight:	Height:	Blood Pressure:

Please check all that apply:

☐ Caucasian ☐ African American ☐ Pacific Islander ☐ Mixed Race

☐ Native American ☐ Hispanic/Latino ☐ Asian ☐ Other

Highest level of education:

☐Some high school ☐GED ☐Associates Degree ☐Masters Degree

☐High school diploma ☐Some college ☐Bachelors Degree ☐Doctorate Degree

Primary Care Provider ____________________ Date of last physical exam _____________

Please check any of the following whose care you are under:

☐ Medical doctor (MD) ☐ Psychiatrist/Psychologist ☐ Chiropractor

☐ Osteopath ☐ Physical Therapist ☐ Dentist

Other ____

If you have seen any of the above in the last three months, please describe for what reason (illness, medical condition, accident, physical, etc.) __________________________________

____

Please describe your overall general health _______________________________________

____

____

What nutrition or health concerns would you like to focus on during your visit?

1.
2.
3.

How motivated are you to resolve your health issues?

☐ Extremely motivated doing whatever it takes

☐ Very motivated

☐ Somewhat motivated

Clinical Nutritionist's Notes:

Past and Current Relevant Medical History

Indicate if you have been diagnosed with any of the following conditions and at what age.

	Illness/Disease/Symptom	**Age Diagnosed**	**Describe/Specify**
	Anemia		
	Arthritis		
	Asthma		
	Bronchitis		
	Cancer (specify type)		
	Chronic fatigue syndrome		
	Crohn's Disease or Ulcerative Colitis		
	Depression		
	Diabetes (specify Type I, II, Gestational, Prediabetes)		

	Emphysema		
	Epilepsy, convulsions, seizures		
	Gallstones		
	GERD/Reflux/Heartburn		
	Gout		
	Heart attack/Angina		
	Heart disease		
	Hepatitis		
	Herpes		
	High cholesterol		
	High blood pressure		
	HIV		
	Hypoglycemia		
	Irritable bowel		
	Kidney stones		
	Lyme disease		
	Mononucleosis		
	Multiple Sclerosis		
	Osteoporosis		
	Pneumonia		
	Polycystic Ovarian Syndrome		
	Psychiatric conditions		
	Sinusitis		
	Sleep apnea		
	Stroke		
	Thyroid disease		
	Urinary tract infection		
	Other (describe)		
	Injuries	**Age**	**Describe/Specify**
	Back injury		
	Broken (specify)		
	Head injury		
	Neck injury		

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	Other (describe)		
	Diagnostic Studies	**Age at study**	**Describe/specify**
	Barium enema		
	Bone scan		
	CAT Scan (specify)		
	Chest X-ray		
	Colonoscopy or Sigmoidoscopy		
	EKG		
	NMR/MRI		
	Upper GI Series		
	Other (describe)		

Operations:

	Operation	**Age**	**Comments**
	Appendectomy		
	Dental surgery		
	Gall bladder		
	Hernia		
	Hysterectomy		
	Tonsillectomy		
	Other (describe)		

****Please attach copies of all recent laboratory studies, for example, fasting blood glucose, Vitamin D, lipid panel, etc.**

Please list all allergies including food, medication, cosmetics, or other substances: ___________

____

____

Your birth history: ☐ Vaginal ☐ C-section

Were you breastfed as an infant? ☐Yes ☐No ☐Unsure

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Clinical Nutritionist's Notes:

Medications and Supplements

Please list the medications you are taking. Include prescription and over the counter.

Medication	Date Started	Dosage	Frequency	Reason for Taking
1.				
2.				
3.				
4.				
5.				
6.				
7.				

Please list all vitamins, minerals, and other nutritional supplements that you are taking. Indicate the form (e.g., calcium carbonate vs. calcium lactate), when possible.

Vitamin/Mineral/ Herbal Supplement	Date Started	Dosage	Frequency	Reason for Taking
1.				
2.				
3.				
4.				
5.				
6.				
7.				

Please indicate how often you have taken antibiotics during each life stage:

Life stage	More than 5 times	Less than 5 times
Infancy/childhood		
Teen		
Adult		

Have you had prolonged or regular use of NSAIDs (Advil, Aleve, etc.)?
☐Yes ☐No Comment:

Have you had prolonged or regular use of acid blocking drugs (Zantac, Pepcid, etc.)?
☐Yes ☐No Comment:

Clinical Nutritionist's Notes:

Family History

Please check any health conditions your family members (Mother, Father, Grandparents, Brothers, Sisters) have been affected by and indicate which family member:

Condition	Family Member	Condition	Family Member
Food allergies		Alzheimer's/Dementia	
Non-food Allergies		Mental illness	
Obesity		Depression	
High blood pressure		Anorexia/Bulimia	
Heart disease		Liver disease	
High cholesterol		Alcoholism	
Stroke		Drug use	
Diabetes		Multiple Sclerosis	
Cancer (specify type)		Chronic fatigue	

Please list any other family medical history not listed above: ______________________________
____
____

Clinical Nutritionist's Notes:

Environmental Contributors

Do you have any "silver" dental fillings? ☐Yes ☐No How many?________________
How old are they?______________
Do you have any artificial joints or implants? ☐Yes ☐No
Do you regularly get hair coloring or permanents? ☐Yes ☐No
Do you regularly get acrylic fingernails? ☐Yes ☐No
Have you lived or worked in freshly-painted rooms in the last six months? ☐Yes ☐No

Have you ever lived in a house built before 1978? ☐Yes ☐No
Do you use plastic containers or plastic wrap when you microwave your food? ☐Yes ☐No
Do you use home air fresheners or plug ins? ☐Yes ☐No
Do you regularly eat fish (fresh, canned, frozen)? ☐Yes ☐No How often?_________________
What type of fish? ____

Please check if you have been exposed to any of these in the last 12 months. Check "past" if exposure occurred more than 12 months ago.

Do you have regular exposure at home or work to:	**Yes**	**No**	**?**	**Past**
Peeling or chipping paint				
Gas or propane stove				
Coal or wood stove				
Regular contact with smokers				
Damp basement or crawl space				
Water leaks (ceilings, walls, floors)				
Visible mold				
New Carpet or furniture				
Pesticides or herbicides				
Chemical pest treatment				

Are there animals in your home? ☐Yes ☐No
Type of animals and number ____
Please state all of the home (or work) cleaners you use on a regular basis and for what (ex. Lysol wipes for dusting, Scrubbing Bubbles for shower): _______________________________
____
____

Clinical Nutritionist's Notes:

Dietary Intake

Please state the foods/drinks that apply to your current typical diet. If you have nothing, please state none. Include any condiments, dressings, sweeteners (ex. Mayo, butter, sugar, etc.)
Usual Breakfast: ____
____
____

Usual Lunch: ____
____
____

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Usual Dinner: ____
____
____

Usual Snacks and time: ____
____
____

How many meals and/or snacks do you consume each day? ___________________________
What is the time interval between each meal? ____________________________________
How many glasses of water do you think you drink during a typical day? __________________

Are you following a special diet? ☐ Yes ☐No

☐ Vegetarian ☐ Diabetic ☐ Other (describe)
☐ Vegan ☐ Dietary restricted ______________________________
☐ Low sodium ☐ Low carb ______________________________

Please list any food allergies, sensitivities or intolerances ____________________________
____

Who prepares the majority of your meals? _____________ Who shops for food?___________
Where do you shop for food?____

Please indicate the frequency that you eat the following:

How often do you eat:	Never	2-3x per month	1x per week	2-3x per week	1x per day	2-3x per day
Fast food						
Restaurant food						
Vending machine food						
Cafeteria or buffet food						
Frozen meals						
Home cooked meals						
Leftovers						
Artificial sweeteners, type:						
Meal replacements, type:						

How many servings of fruit do you typically have in a day? ________ Vegetables? ________

Please indicate the beverages you drink, and how often you drink them.

Beverage Type	Daily amount	Weekly amount	Monthly amount
Example: Coffee: ☒reg ☐decaf ☐latte	2- 8 oz. cups	---	---
Water: ☐tap ☐filtered ☐bottled			
Coffee: ☐reg ☐decaf ☐latte			
Tea: What type(s)?____________			
Juice: ☐natural ☐fruit drinks			
Soda: ☐regular ☐diet			

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Milk: ☐whole ☐2% ☐1% ☐skim			
Milk alternative type ____________			
Alcohol: ☐wine ☐beer ☐liquor			
Other: _______________________			

Food cravings: ____
____

Food dislikes: ____
____

The nutrition/eating habits that are most challenging for me: ______________________________
____
____

The nutrition/eating habits that I am most pleased with: __________________________________
____
____

Eating Style: Based on how you eat on a regular basis, please check all that apply:

☐ Fast eater
☐ Erratic eater
☐ Emotional eater (stressed, bored, sad, etc.)
☐ Late night eater
☐ Time constraints
☐ Travel frequently
☐ Do not plan meals/menus
☐ Rely on convenience foods
☐ Family member(s) have different tastes
☐ Dislike "healthy" food
☐ Love to eat
☐ Eat because I have to
☐ Negative relationship with food
☐ Confused about food/nutrition
☐ Poor snack choices
☐ Struggle with eating issues

Bowel Movements

Please fill in the chart below according to your bowel movements:

Frequency		Consistency		Color	
More than 3x/day		Soft and well formed		Medium brown consistently	
1-3x/day		Often float		Very dark or black	
4-6x/week		Difficult to pass		Greenish color	
2-3x/week		Diarrhea		Blood is visible	
1 or fewer x/week		Thin, long or narrow		Varies a lot	
		Small and hard		Dark brown consistently	
		Loose but not watery		Yellow, light brown	
		Contains undigested food		Greasy, shiny appearance	
		Alternating between hard and loose/watery			

Clinical Nutritionist's Notes:

Physical Activity

Using the table, please describe your physical activity.

Activity	Type/Intensity (low-moderate-high)	# Days per week	Duration (minutes)
Cardio/Aerobics (walking, jogging, biking, etc.)			
Strength- training (weight lifting, pilates)			
Stretching/Yoga			
Sports or leisure (describe)			
Other (describe)			

Does anything limit you from being physically active? ______________________________

____

Occupational activity level:
☐ Sedentary: sitting ☐ Moderate: walking
☐ Light: standing ☐ Active: Manual labor

Clinical Nutritionist's Notes:

Social History

Do you have children? ☐ Yes ☐ No Age of children: ______________________________

With whom do you live? (Include parents, children, relatives, and/or friends. Please include ages.) Ex. Jack, husband, age 40

____

____

____

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Indicate daily stressors and rate the level of stress from 1 (extremely low) to 10 (extremely high):

☐Work________ ☐Family________ ☐Social________ ☐Financial________ ☐Health_________

Other stressors____

____

Have you experienced any major losses in life? ☐Yes ☐No

If yes, please comment: ____

____

Have you or your family recently experienced any major life changes? ☐Yes ☐No

If yes, please comment: ____

____

Have you lived or traveled outside of the United States? ☐Yes ☐No

If yes, when, and where?____

____

How important is religion (or spirituality) for you and your family's life?

☐Not at all important ☐Somewhat important ☐Extremely important

What helps you unwind?____

____

On average, how many hours of sleep do you get? Weekdays_________ Weekends_________

How much time have you lost from work or school in the past year?

☐0-2 days ☐3-14 days ☐>15 days ☐Not applicable

Do you smoke? ☐Never ☐In the past ☐Currently How long?______________________

Other tobacco use?☐Yes ☐No If yes, please specify: _____________________________

Drug use ☐Never ☐In the past ☐Currently ☐Prefer not to discuss Type/frequency_________

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Organ Systems Review

Please check if these symptoms either occur presently or have occurred in the past 6 months

Head, eyes, nose, ears	**Mild**	**Mod.**	**Severe**	**Digestion**	**Mild**	**Mod.**	**Severe**
Conjunctivitis				Problems with teeth			
Vision problems				Bleeding gums			
Distorted taste				Bloating			
Ear ringing/buzzing				Constipation			
Hearing loss				Diarrhea			
Sensitive to loud noises				Dentures with poor chewing			
Nasal congestion or discharge				Difficulty swallowing			
Headache				Heartburn/Reflux			
Migraine				Dry mouth			
				Bowel pain			
Mood/Nerves				Hemorrhoids			
Anxiety				Flatulence (gas)			
Depression				Indigestion			
Difficulty concentrating				Burping			
Dizziness							
Light-headedness				**Respiratory**			
Irritability				Asthma			
Fainting				Wheezing			
Fearfulness				Bad breath			
Mood swings				Hoarseness			
Panic attacks				Cough- dry			
Seizures				Cough- productive			
				Difficulty breathing			
Skin				Snoring			
Acne on back/shoulders				Sleep apnea			
Acne on chest				Winter stuffiness			
Acne on face				Sore throat			
Athletes foot							
Bruising easily							
Bumps on back of upper arms				**Cardiovascular**			
Dark circles under eyes				Pounding heart			
Eczema				Irregular heartbeat			
Psoriasis				Varicose veins			
Numbness/tingling				Cold hands/feet			
Oily skin				Chest pain			
Dry skin							
Dandruff				**Weight/Eating**			
Open sores on feet				Can’t gain weight			

and legs							
Skin cancer				Can't lose weight			
Cracking at corner of lips				Binge eating			
Canker sores				Bulimia			
Cold sores				Anorexia			
Excessive sweating				Feeling hungry 1-2 hours after eating			
Pale skin				Poor appetite			
				Unintentional weight loss			
Energy/Activity							
Fatigue				**Joint/Muscle**			
Lethargy				Pain/aches in joints			
Hyperactivity				Joint stiffness			
Restlessness				Arthritis			
Daytime sleepiness				Muscle weakness			
Difficulty falling asleep				Pain/aches in muscles			
Difficulty awaking				Calf cramps			
				Back muscle spasm			
Urinary				Muscle spasms			
Bed wetting				Muscle twitches			
Dark urine				Neck pain			
Kidney stone				Low back pain			
Pain/burning							
Leaking/incontinence				**Male reproductive**			
				Infection			
Other				Poor libido (sex drive)			
Nightmares							
Brittle nails				**Female Reproductive**			
Thinning hair				Endometriosis			
Dry hair				Infertility			
Learning disabilities				Poor libido			
Frequent illness				Breast tenderness			
Flushing				Vaginal pain			
Hot flashes				Fibroids			
Excessive ear wax				PMS			
Hay fever				Menstrual:			
Insomnia				Cramps			
Sleep apnea				Heavy periods			
Other: please list				Irregular periods			
				No periods			
				Scanty periods			
				Spotting between			

Other Comments:____

____
____
____

For Women Only
Age at first period________
Have you ever used birth control pills? ☐Yes ☐No If yes, when?________________
Are you in menopause? ☐Yes ☐No If yes, age at last period____________
Are you taking any hormone replacement? ☐Yes ☐No If yes, what type?_______________

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Policies/Procedures and Consents

Please initial under the following Policies/Consents

CANCELLATION POLICY
There is a strict 24-hour cancellation policy for nutrition appointments. If you need to reschedule or cancel your appointment, please contact Megan by phone or email at least 24 hours before your appointment time. Failure to cancel in this time frame will result in a $25 charge.
_______(initials)

INSURANCE INFORMATION
We do not accept any form of health insurance for consultations or supplement purchases. You will be provided with invoices that can be submitted to your insurance company. It is your responsibility to check with your insurance carrier to determine reimbursement eligibility.
_______(initials)

PAYMENT OPTIONS/POLICY
We accept cash, checks and all major credit cards for all services offered and supplements. There is a $25 returned check fee. HSA/FSA credit cards are also accepted for services offered. It is the client's responsibility to determine if the HSA/FSA will cover nutrition services.
_______(initials)

CONSENT FOR BIOIMPEDANCE ANALYSIS (BIA)
I agree to have Megan Kraeger, Certified Nutrition Specialist complete a BIA test. I have read and understand the instructions for the BIA test. I certify I am not pregnant, I do not have a pace maker or defibrillator and I have notified Megan of any metal implants.
_______(initials)