

OFFICE USE ONLY

Counselor Name: _____ Appt. Date: _____ Appt. Time: _____ Receptionist: _____

Informed Counselor of Appointment: In person Phone Voice Message Initials: _____ Date: _____ Time: _____

CSULB NUTRITION COUNSELING - CONFIDENTIAL INTAKE FORM

Name: _____ Today's Date: _____

Student ID# _____ Cell Phone: _____

Occupation: _____ Date of Birth: _____

Gender: Male Female Transgender Age: _____ Height: _____ Weight: _____

Referred by: Self-referred Clinician Instructor Friend Other, please specify: _____

Reason for visit:

- | | |
|---|---|
| <input type="checkbox"/> General nutrition/better eating habits | <input type="checkbox"/> Anemia |
| <input type="checkbox"/> Diet for weight loss | <input type="checkbox"/> Constipation |
| <input type="checkbox"/> Diet for weight gain | <input type="checkbox"/> High Cholesterol |
| <input type="checkbox"/> Sports nutrition | <input type="checkbox"/> Hypertension (high blood pressure) |
| <input type="checkbox"/> Disordered eating | <input type="checkbox"/> Hypoglycemia (low blood sugar) |

Other (specify): _____

Do you have any specific questions for the counselor that would help them to better prepare for your session?

Are you under a clinician's care for a condition or illness? _____ If yes, for which condition/illness?

Do you have certain dietary practices (i.e. vegan, vegetarian, gluten-free, etc.)? _____

Have you been diagnosed by a clinician for a nutrition-related problem (such as anemia, high cholesterol, hypoglycemia, gastrointestinal problem, thyroid disorder, etc.)? _____

If yes, please specify: _____

If you believe you have a nutrition-related problem or metabolic disorder, you must see a clinician for an accurate diagnosis.

What if anything, have you done previously to manage your nutrition-related concerns?

Please turn the page over and continue →

Current medications: _____

Vitamins/minerals/herbal supplements: _____

Reasons for taking: _____

Exercise:

Do you exercise? _____ If not, why? _____

Type of Exercise	How Often? (times per wk.)	For how long? (hrs./mins.)
_____	_____	_____

Average time spent sitting (i.e., screen time, work, and commute)? _____

Average hours of sleep per night? _____

Typical daily stress level: (circle one) High Average Low
Ability to manage stress: (circle one) Excellent Okay Poor

Food Choice Inventory:

Do you have any ethnically specific food preferences (i.e., Chinese, Filipino, Mexican, etc.)?

Yes No If yes, specify: _____

Food dislikes: _____

Food allergies/intolerances: _____

Meal Planning:

Who plans your meals? _____ Who cooks? _____

Who shops? _____ Is a list used? _____

Dining Out:

How often do you eat out/week? _____ Do you eat at:

Fast food restaurants? Yes No Times per week: _____

Other Restaurants? Yes No Times per week: _____

Other people's homes? Yes No Times per week: _____

Beverages:

Do you drink alcohol? _____ What type? _____ Weekly amount? _____

Do you drink coffee/tea drinks, i.e. Frappuccino, Mocha, etc? _____ Daily amount? _____

Do you drink water? _____ Daily amount? _____

Do you drink soda? _____ Daily amount? _____ Regular: _____ Diet: _____

What other beverages? _____ Daily amount? _____

Return form to the WHP receptionist upon completion. Thank you!

Please note: For your scheduled appointment, please arrive on time. If you are more than 15 minutes late, your appointment will be cancelled. If you are a "No Show" for your appointment, you will only be allowed to reschedule the appointment one more time.

Initials: _____