Nutrition Intake Form

New client intake for a dietitian or nutrition practice. Completed before the initial consultation.

ORGANISATION

DATE

Client details

FULL NAME

DATE OF BIRTH

FILE NUMBER

MOBILE

EMAIL

OCCUPATION

REFERRING PRACTITIONER

TREATING GP

Reason for consultation

WHAT WOULD YOU LIKE HELP WITH

REFERRED FOR A SPECIFIC CONDITION

DIAGNOSED BY AND WHEN

Medical background

Diagnosed conditions (tick any that apply)

- [ ] Diabetes
- [ ] Coeliac disease
- [ ] IBS or IBD
- [ ] Reflux
- [ ] Kidney disease
- [ ] Liver disease
- [ ] Cardiovascular
- [ ] Thyroid
- [ ] PCOS
- [ ] Food allergy
- [ ] Food intolerance
- [ ] Eating disorder history

CURRENT MEDICATIONS AND SUPPLEMENTS

ALLERGIES AND INTOLERANCES

RECENT SURGERY OR HOSPITAL ADMISSION

RECENT RELEVANT PATHOLOGY OR TEST RESULTS

Usual intake

Describe a typical day rather than an ideal one. Approximate is fine.

MEAL OR OCCASION	USUAL TIME	WHAT YOU USUALLY HAVE	WHERE / WITH WHOM

MEAL OR OCCASION	USUAL TIME	WHAT YOU USUALLY HAVE	WHERE / WITH WHOM

FLUIDS ACROSS A USUAL DAY

ALCOHOL, IF ANY

CAFFEINE, IF ANY

Habits and context

WHO SHOPS AND COOKS IN YOUR HOUSEHOLD

COOKING CONFIDENCE AND TIME AVAILABLE

BUDGET OR ACCESS CONSTRAINTS

CULTURAL OR RELIGIOUS FOOD PRACTICES

FOODS YOU AVOID, AND WHY

FOODS YOU WOULD NOT WANT TO GIVE UP

USUAL PHYSICAL ACTIVITY

USUAL SLEEP PATTERN

PREVIOUS DIETARY APPROACHES TRIED, AND HOW THEY WENT

> Practitioner note: screen for disordered eating in session using a validated tool before setting any numeric targets. Where a history is disclosed on this form, follow your referral pathway rather than proceeding with a standard plan.

What you want from this

WHAT WOULD MAKE THIS WORTHWHILE FOR YOU

Consent

- [ ] I have read the practice privacy policy and understand how my information is used
- [ ] I understand the fees, rebates and cancellation policy
- [ ] I consent to relevant information being shared with my GP or referring practitioner

CLIENT SIGNATURE	PRINT NAME	DATE