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:

- ❒ General nutrition/better eating habits
- ❒ Diet for weight loss
- ❒ Diet for weight gain
- ❒ Sports nutrition
- ❒ Eating Disorder
- ❒ Anemia
- ❒ Constipation
- ❒ High Cholesterol
- ❒ Hypertension (high blood pressure)
- ❒ Hypoglycemia (low blood sugar)
- ❒ Other (specify):____

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?

____

Current medications:____

Vitamins/minerals/herbal supplements: ____

Reasons for taking: ____

Please turn the page over and continue ⟶

Exercise:
Do you exercise?___________If not, why? ____

Types 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 HRC 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:_____