



By Doria Schneider

Health & Wellness Consultant

Phone: 636-795-1464

CLIENT INTAKE FORM

Please take a few minutes to fill out this form and answer the following questions. I know it's a lot but if you try to answer all questions as completely and honestly as possible and the more details you provide, the better we can tailor our time together to meet your individual needs and goals. **All answers are confidential.**

Please be prepared to describe your eating habits for the past 7 days, and bring this form with you to your first Health & Wellness Consult or if you fill it out online I will have a copy at our meeting. You may also send it to the following email address: doria@beinspirednutrition.com

If you have any questions about completing the form, please call: 636-795-1464

A. PERSONAL INFORMATION

DATE

DATE OF BIRTH

BIOLOGICAL GENDER

FIRST NAME

LAST NAME

HOME ADDRESS

CITY

STATE

ZIP CODE

EMAIL ADDRESS

PHONE NUMBER

EMERGENCY CONTACT

PREFERRED CONTACT METHOD

EMERGENCY PHONE #

MARITAL STATUS

Married

Partnered

OCCUPATION

Single

Divorced

Widowed

CHILDREN

Yes

No

If yes, number of children? Ages?

B. NUTRITION GOALS AND EXPECTATIONS

1. What are your reasons for the consultation? What are your primary concerns?

2. What are your personal nutritional goals? (check all that apply)

- | | | |
|---|--|---|
| <input type="checkbox"/> Want to lose weight | <input type="checkbox"/> Disordered eating concerns | <input type="checkbox"/> Personalized Menu |
| <input type="checkbox"/> Want to gain weight | <input type="checkbox"/> Food allergy or intolerance | <input type="checkbox"/> Recipes |
| <input type="checkbox"/> General healthy eating | <input type="checkbox"/> Low Carb/Keto/Carniv | <input type="checkbox"/> Support and motivation |
| <input type="checkbox"/> Vegetarian/Vegan diet | <input type="checkbox"/> ore | <input type="checkbox"/> Other (please specify) |

3. What eating habits would you like to work on?

4. How committed are you to making changes in your nutrition habits? (Please check)

- 1 2 3 4 5 6 7 8 9 10
-

1 - is not committed at all, 10 - is very committed

5. Have you already had dietary consultations for your current reason or another?

- Yes No If so, when was the last time?

C. LIFESTYLE INFORMATION

1. Do you smoke?

Yes No If yes, how often, how much: _____

2. Are you exposed to second hand smoke regularly?

Yes No

3. Do you drink alcohol?

Yes No If yes, how often, how much: _____

4. What is your job like?

- Mostly sitting Irregular working hours Other (please specify)
 Mostly physically demanding Business trips
 Shift work Travel abroad
 Night duty Domestic

5. Are you currently physically active? Do you do regular exercise?

Yes No If yes, please describe your current physical activity:

Activity	Type/Intensity (Light - Moderate - Vigorous)	# Days/week	Duration (minutes)
Aerobics/Cardio (walking, running, biking, etc.)			
Strength Training (pilates, weight lifting, etc.)			
Sports or Leisure (football, basketball, tennis, swimming etc.)			
Stretching			
Other (describe)			

6. Do you have any exercise limitations? Yes No If yes, please describe:

7. On a scale of 1-10, how would you rate your stress level? (Please check)

1 2 3 4 5 6 7 8 9 10

1 - very low, 10 - very high

8. Do you feel you handle stress in a healthy manner? Yes Most days Seldom

9. Do you believe stress is presently reducing the quality of your life? Yes No

10. Daily stressors:

- Work Social
 Family Other (please specify)
 Finances
 Health

11. List your 3 biggest sources of stress:

a.

b.

c.

12. Average number of hours you sleep per night during the week?

<6 hours 6 to 8 hours 8 to 10 hours 10 or more hours

13. Average number of hours you sleep per night on the weekends?

<6 hours 6 to 8 hours 8 to 10 hours 10 or more hours

14. Do you nap? If so, how many minutes/hours?

15. Do you have trouble falling asleep?

Yes No

16. Are you rested upon waking?

Yes No

17. Do you wake up during the night?

Yes No If yes, how many times?

18. How would you rate the overall quality of sleep?

1 2 3 4 5 6 7 8 9 10

1 - very low, 10 - very high

19. What are your hobbies and leisure activities?

D. PERSONAL AND FAMILY MEDICAL HISTORY

1. Please check any family (parents and siblings) history of the following:

Arthritis, rheumatoid, family member:

Asthma, family member:

Alcoholism, family member:

Alzheimer's disease, family member:

Cancer, family member:

Depression, family member:

Diabetes 1 or 2, family member:

Drug addiction, family member:

Eating disorder, family member:

Food intolerance, family member:

- Genetic disorder, family member:
- Glaucoma, family member:
- Heart disease, family member:
- High blood pressure, family member:
- Infertility, family member:
- Kidney disease, family member:
- Lung disease, family member:
- Mental illness, family member:
- Migraine headaches, family member:
- Neurological disorders, family member:
- Obesity, family member:
- Osteoporosis, family member:
- Stroke, family member:
- Suicide, family member:
- Other, family member:

2. Please list all your past and present medical conditions:

Medical Condition	When	Comments
<i>Gastro-intestinal</i>		
Celiac disease		
Crohn's disease		
Diverticular disease		
Gastric reflux disease		
Irritable bowel (IBS)		

Medical Condition	When	Comments
Lactose intolerance		
Ulcerative Colitis		
Gastric or peptic ulcer		
Respiratory/Pulmonary		
Asthma		
Bronchitis		
Chronic Sinusitis		
Emphysema		
Pneumonia		
Sleep apnea		
Tuberculosis		
Hematology / Blood		
Anemia, type: _____		
Bleeding disorder		
Thalassemia		

Medical Condition	When	Comments
Hepatic / Pancreatic		
Cirrhosis		
Gallbladder disease		
Hepatitis		
Pancreatitis		
Renal		
Chronic kidney disease		
Dialysis		
Kidney failure		
Kidney stones		
Nephritis		
Urinary		
Incontinence		
Urinary Tract Infections		
Other: _____		

Medical Condition	When	Comments
Cancer		
Type: _____		
Type: _____		
Cardiovascular		
Angina/chest pain		
Cardiovascular disease		
Heart valve disease		
High blood pressure		
High cholesterol		
Peripheral artery disease		
Stroke		
Metabolic / Endocrine		
Metabolic syndrome		
Pre-diabetes		
Diabetes, type: _____		

Medical Condition	When	Comments
Hypoglycemia		
Polycystic ovary disease		
Infertility		
Thyroid disease		
For Females		
Currently pregnant		
Irregular / No periods		
Gestational Diabetes		
Peri-menopausal		
Post-menopausal		
For Men		
Benign prostatic hyperplasia		
Prostate cancer		
Infertility		

Medical Condition	When	Comments
Other: _____		
<i>Inflammatory / Autoimmune</i>		
Chronic fatigue		
Fibromyalgia		
Gout		
Lupus SLE		
Rheumatoid Arthritis		
<i>Musculo-skeletal</i>		
Osteopenia		
Osteoporosis		
Osteoarthritis		
<i>Neurological</i>		
Addiction		
ADD/ADHD		
Anxiety		

Medical Condition	When	Comments
Autism		
Depression		
Headaches		
Migraines		
Multiple Sclerosis		
Parkinson's Disease		
Seizures		
Sleep difficulties		
<i>Eating Disorder</i>		
Anorexia		
Binge eating		
Bulimia		
Compulsive overeating		
Other: _____		
Other: _____		

Medical Condition	When	Comments
<i>Dermatological</i>		
Acne		
Eczema		
Rosacea		
Skin rashes		
<i>Allergies, sensitivities</i>		
Foods		
Foods		
Foods		
Foods		
Foods		
<i>Allergies</i>		
Medications		
Medications		
Medications		

Medical Condition	When	Comments
Medications		
Medications		
Allergies		
Environmental		
Environmental		
Environmental		
Environmental		
Environmental		
Other medical condition		
Other: _____		
Other: _____		
Other: _____		
Other: _____		
Other: _____		
Other: _____		

3. Please list any previous injuries, and surgeries (provide the date & your age, if known):

Injuries, surgeries	When	Comments
<i>Injuries</i>		
Back injury		
Broken _____		
Head injury		
Neck injury		
Other: _____		
Other: _____		
Other: _____		
<i>Surgeries</i>		

Injuries, surgeries	When	Comments
Dental Surgery		
Other: _____		
Other: _____		
Other: _____		
Other: _____		
Other: _____		

a.		
b.		
c.		
d.		
e.		
f.		
g.		

Check any of the following that apply to you.

- Cold hands and feet
- Cold intolerance
- Daytime sleepiness
- Difficulty falling asleep
- Early waking
- Fatigue
- Frequent fever
- Flushing
- Heat intolerance
- Night waking
- Nightmares
- Peeling, soft or splitting nails
- Belching or gas within 1 hr. of a meal
- Distaste for meat (not a vegetarian or for moral reasons)
- Bloating after eating
- Only specific foods cause bloating
- Sleepy after eating
- Sensitive to smoke
- Pain between the shoulder blades
- Metallic taste in the mouth
- Bitter taste in mouth, especially after meals
- Wake up without remembering dreams
- Trouble tolerating greasy foods
- Trouble tolerating garlic or onions
- Sensitive to chemicals (perfume, insecticides, exhaust fumes)
- Crave coffee or sugar in the afternoon
- Sweet cravings
- Crave bread or noodles
- Crave salt or salty foods
- Crave greasy or fatty foods
- Lactose intolerant
- Coated tongue
- Bad breath
- Sweat a lot
- Sweat at night
- Feet have a strong odor or sweat easily
- Sweat has strong odor
- Irritable, shaky if miss a meal
- Metallic taste in the mouth
- Frequent thirst
- Frequent urination
- Frequent infections

- Cuts take a long time to heal
- Numbness or tingling in the extremities
- Hypoglycemia
- Ankles swell
- Become cold easily or when others are not
- Depression
- Difficulty losing weight
- Frequent colds or flu
- Become dizzy when standing up suddenly
- Trouble getting out of bed in the morning
- Tend to be a "night" person
- Tendency to worry
- Keyed up, trouble calming down
- Feelings of insecurity
- Clench or grind teeth
- Jaw clicks, pops, locks or makes noise
- Decreased ability to taste or smell
- Get hives
- Taken birth control pills
- Fungus or yeast infections
- Yes No History of anorexia or bulimia
- Anemia that is unresponsive to iron
- Hands tremble
- Calves cramp at night
- Legs cramp after walking, better after rest
- Dark circles under the eyes
- Sense of fullness after meals
- Feel better if you don't eat
- Exercise makes you feel worse
- Fluid retention
- Yes No Yellow in the whites of the eyes
- Yes No Are you a vegan (no dairy, meat, or fish)
- Yes No Aspirin is effective in relieving pain
- Conjunctivitis
- Distorted sense of smell
- Distorted taste
- Ear fullness
- Ear noises
- Ear ringing, buzzing
- Yes No Do you have tinnitus (ringing in your ears)
- Ear pain
- Eye crusting
- Eye pain
- Headache
- Migraine
- Afternoon headaches
- Tension headaches (base of skull)
- Hearing loss
- Hearing problems
- Lid margin redness
- Sensitivity to loud noises

- Trouble seeing at night
- Eyes sensitive to bright light
- Vision problems
- Back muscle spasm
- Calf cramps
- Chest tightness
- Foot cramps
- Joint deformity
- Joint pain
- Joint stiffness
- Joints click or pop
- Muscle pain
- Muscle spasms
- Muscle stiffness
- Muscle twitches around eyes
- Muscle twitches in arms or legs
- Muscle weakness
- Neck muscle spasm
- Yes No Have you ever had a herniated disc
- Tendonitis
- Agoraphobia
- Anxiety
- Difficulty concentrating
- Difficulty with balance
- Difficulty with thinking
- Difficulty with memory
- Difficulty with speech
- Difficulty with judgment
- Dizziness
- Fainting
- Fearfulness
- Irritability
- Light-headedness
- Phobias
- Panic attacks
- Paranoia
- Seizures
- Suicidal thoughts
- Tremor, trembling
- Binge eating
- Bulimia
- Can't gain weight
- Carbohydrate craving
- Carbohydrate intolerance
- Poor appetite
- Alternating constipation/diarrhea
- Anal spasms
- Bad teeth
- Bleeding gums
- Bloating of lower abdomen
- Bloating of whole abdomen
- Burping
- Canker sores
- Cold sores
- Constipation

- Cracking at the corner of lips
- Poor chewing
- Diarrhea
- Difficulty swallowing
- Dry mouth
- Farting
- Gastric reflux
- Gallbladder attacks (past or present)
- Heartburn
- Hemorrhoids
- Intolerance to lactose
- Intolerance to all milk products
- Intolerance to gluten (wheat)
- Intolerance to corn
- Intolerance to eggs
- Intolerance to fatty foods
- Intolerance to yeast
- Liver disease/jaundice yellow eyes or skin)
- Lower abdominal pain
- Mucus in stools
-
-
-
-
-
-
-
-
-
-
-
-
- Periodontal disease
- Sore tongue
- Upper abdominal pain
- Vomiting
- Acne on back
- Acne on chest
- Acne on face
- Acne on shoulders
- Athlete's foot
- Cellulite
- Ears get red
- Bruise easily
- Blush or face turns red for no reason
- Eczema
-
-
- Hives
- itchy skin
- Lackluster skin
- Moles color/size change
- Oily skin
- Pale skin
- Psoriasis
- Rash
- Sensitive to bites
- Shingles
- Skin cancer
- Strong body odor
- Thick calluses

- Vitiligo
- feet itching
- Arms itching
- Ear canals itching
- Eyes itching
- Feet itching
- Hands itching
- Legs itching
- Nipples itching
- Nose itching
- Fingers itching
- Roof of mouth itching
- Scalp itching
- Skin in general itching
- Throat itching
- Dryness of eyes
- Dryness of feet
- Cracking of feet
- Peeling of feet
- Brittle, coarse hair
- Hair breaks or falls out easily
- Increased body hair
- Hands cracking
- Hands peeling
- Mouth, throat dryness
- Dry flaky skin or dandruff
- Enlarged/neck
- Tender/neck
- Enlarged/tender lymph nodes
- Bitten nails
- Brittle nails
- Curve up nails
- Frayed nails
- Fungus - fingers
- Fungus - toes
- Pitting
- Ragged cuticles
- Soft nails
- Thickening of finger nails
- Thickening of toenails
- White spots, lines on nails
- Bad odor in nose
- Dry cough
- Productive cough
- Hay fever in Spring
- Hay fever in Summer
- Hay fever in Fall
- Hay fever in Change of season
- Hoarseness
- Nasal stuffiness
- Nose bleeds
- Post nasal drip
- Sinus fullness
- Sinus infection
- Sigh frequently, air hunger or trouble catching breath

- Snoring
- Sore throat
- Wheezing
- Angina/chest pain
- Breathlessness
- Heart attack
- Heart murmur
- Heart races or palpitations
- High blood pressure
- Low blood pressure
- Poor circulation
- Arteriosclerosis
- Swollen ankles, feet
- Varicose veins
- Kidney disease
- Kidney stone

- Breast cysts (Female Reproductive System)
- Breast lumps
- Breast tenderness
- Ovarian cyst
- Endometriosis
- Fibroids
- Infertility (Premenstrual)

- Occasionally skip periods
- Cramps (Menstrual)
- Heavy periods (Menstrual)
- Irregular periods (Menstrual)
- No periods (Menstrual)
- Scanty periods (Menstrual)
- Spotting between (Menstrual)

Other (describe):

E. REPRODUCTIVE HEALTH (WOMEN ONLY)

1. Are you pregnant? Yes No If so, how many weeks?

2. Are you trying to become pregnant? Yes No

3. Have you ever been pregnant? Yes No

4. Are you having difficulty conceiving? Yes No

5. Number of term births

6. Did you develop toxemia (high blood pressure)? Yes No If so, please describe:

7. Have you had other problems with pregnancy? Yes

8. Do you have any hormonal problems that you know of? Please describe if so:

9. Do you use contraceptive pills? Yes No

10. Are your periods regular? Yes No

11. Are your periods heavy or painful? Yes No

12. Do you suffer from Pre-menstrual syndrome (PMS)? Yes No Check the symptoms:

- | | | | |
|---------------------------------------|---|--|--|
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Fatigue | <input type="checkbox"/> Bloating | <input type="checkbox"/> Other: |
| <input type="checkbox"/> Irritability | <input type="checkbox"/> Sweet craving | <input type="checkbox"/> Breast tenderness | <input style="width: 100px;" type="text"/> |
| <input type="checkbox"/> Mood swings | <input type="checkbox"/> Increased appetite | <input type="checkbox"/> Depression | |

13. Are you in Menopause? Yes No Check the symptoms:

- | | | | |
|--|--|--------------------------------------|---------------------------------|
| <input type="checkbox"/> Irregular periods | <input type="checkbox"/> Altered skin | <input type="checkbox"/> Bloating | <input type="checkbox"/> Other: |
| <input type="checkbox"/> Hot flushes | <input type="checkbox"/> Acne | <input type="checkbox"/> Mood swings | |
| <input type="checkbox"/> Night sweats | <input type="checkbox"/> Water retention | <input type="checkbox"/> Depression | |

14. Are you taking hormone replacement therapy? Yes No Please describe if so:

F. SUPPLEMENTS .

List all vitamins, minerals, and other nutritional supplements that you are taking now. If possible, list the form too for ex.: Magnesium Citrate or Magnesium Oxide, Ascorbic Acid or Ascorbyl Palmitate, etc.

3. Are you allergic to any medications? Yes No If yes, please list:

E. EATING HABITS

1. Are you currently following a special diet? Yes No

Diabetic Vegetarian Other, please specify:

Dairy-free

Vegan

Gluten-free

Low cholesterol

2. How often do you eat breakfast during the week?

Every Morning

1-3 days

Hardly Ever

3. How many meals and snacks do you usually eat per day?

1 meal or less

2-3 meals (no snacks)

2-3 meals + 1-2 snacks

>4 meals

If 1 meal or less, why?

4. How many times a week do you eat the following meals away from home?

Breakfast

Lunch

Dinner

5. How much water do you drink daily?

6. Do you have trouble accessing healthy food?

7. Do you use salt in your cooking, or add it to your food? Yes No Sometimes

8. Do you eat organic food? Yes No Sometimes Type:

9. Please list the three foods you most like:

10. Please list the three foods you most dislike:

11. Do you miss meals? Yes No Sometimes Which:

12. Which of the following ways you prepare food:

- Boil Fry Other, please specify:
- Bake Stir fry
- Grill Microwave

13. Do you have symptoms immediately after eating, such as bloating, belching, cramps, hives, sneezing, etc.?

Yes No Sometimes Which:

14. If yes, are these symptoms associated with any particular food or supplement(s)?

Yes No

15. Please name the food or supplement and symptom(s). Example: Milk – gas and diarrhea.

16. Do you feel you have delayed symptoms after eating certain foods (symptoms may be evident after 24 hours or more), such as sinus congestion, muscle aches, etc.?

Yes No

17. Do you feel much worse when you eat:

- high protein foods fried foods
- high fat foods refined sugar (junk food)
- high carbohydrate foods (potatoes, pastas, breads) Other, please specify:

18. Do you feel much better when you eat:

- high protein foods fried foods
- high fat foods refined sugar (junk food)
- high carbohydrate foods (potatoes, pastas, breads) Other, please specify:



Dietary Checklist. Place a check in the column that describes how often you usually eat each food:

Food/Beverage	Daily	Most days	More than 1x/week	Seasonally	Rarely or never
Whole milk					
Nonfat milk					
Goat milk					
Lactose-free milk					
Almond/Cashew/ Coconut Hemp/Oat/Rice/ Soy Milk					

Food/Beverage	Daily	Most days	More than 1x/week	Seasonally	Rarely or never
Fruit juice					
Soda					
Lemonade or Kool-Aid					
Sports drinks (Gatorade, etc)					
Tea					
Coffee					
Beer, wine, or hard liquor					
Red meat (beef, lamb, pork)					
Poultry Chicken/Turkey					
Oily fish (salmon, tuna, herring, mackerel, sardines, anchovies)					
Other fish					

Food/Beverage	Daily	Most days	More than 1x/week	Seasonally	Rarely or never
Ham/bacon					
Processed meats (sausages, hamburgers, etc.)					
Yogurt					
Cheese					
Cottage Cheese					
Eggs					
Peanut butter					
Beans (limas, kidneys, etc.)					
Tofu and other soy foods					
Seeds (pumpkin, sesame, sunflower, etc.)					
Nuts (almonds, brazils, cashews etc.)					

Food/Beverage	Daily	Most days	More than 1x/week	Seasonally	Rarely or never
Bread, rolls, bagels					
Cereals (cold or hot)					
Pasta (white, wholewheat, non-wheat)					
Rice (white, wholegrain)					
Fresh fruits					
Canned fruits					
Apples					
Bananas					
Grapes					
Berries					
Peach					
Cherry					

Food/Beverage	Daily	Most days	More than 1x/week	Seasonally	Rarely or never
Apricot					
Pear					
Pineapple					
Plum					
Dried plum					
Raisin					
Orange					
Grapefruit					
Grape juice					
Grapefruit/Orange juice					
Fresh or frozen vegetables					
Canned vegetables					
Broccoli					
Carrot					

Food/Beverage	Daily	Most days	More than 1x/week	Seasonally	Rarely or never
Sweet potatoes					
Green bell pepper					
Tomatoes					
Raw cabbage					
Asparagus					
Beetroot					
Cauliflower					
Corn					
Boiled cabbage					
Celery					
Peas					
Lettuce					
Butter					
Margarine					

Food/Beverage	Daily	Most days	More than 1x/week	Seasonally	Rarely or never
Oils					
Salad dressings, mayonnaise					
Potato or corn chips					
Donuts, pies, pastries					
Biscuits					
Ice cream					
Chocolate					
Cakes					
Canned food					
Fried foods					
Home cooked meals					
Ready meals					
Eat out/Restaurants/Take aways					

24. How much of the following do you eat/drink in a day:

Food/Beverage	Portions/ Slices	Cups/Mugs/ Glasses	Teaspoons	Other
Fresh fruit				
Vegetables (not potatoes)				
Bread/rolls (white, brown, wholemeal, baguette, rye)				
Sugar				
Tea				
Coffee				
Water (tap, bottled, filtered)				
Alcohol, type _____				
Alcohol, type _____				
Fizzy drinks, type _____				
Fizzy drinks, type _____				

PHYSICAL INFO

1. Please fill in the information about your weight history:

Height: Current weight: Usual weight:

Desired body weight:

2. Have you recently gained or lost weight? If yes, please explain whether it was a gain or loss and what changes led to the change in weight.

3. When did your weight problem begin?

- Childhood 20 years ago Other, please specify:
 Teenager 30 years ago
 10 years ago Throughout life

4. Is anyone in your family overweight?

- Mother Sibling
 Father Grandparent

5. What has been your most successful weight loss diet? Why?

G. FOOD JOURNAL

1. Please record in the attached food journal the foods and beverages that you eat and drink for seven days.
2. Do not change your eating behavior at this time, as the purpose of this food records is to analyze your present eating habits.
3. Include as much information as you can about those foods, by estimating the portion sizes too, for example: 1 cup, 1 piece, 1 handful, 1 tablespoon, 1 teaspoon, etc.
4. Please include information about the used cooking method - baked, fried, boiled, or grilled.
5. Remember to include snacks, desserts/candies, and drinks.
6. Include any added items, for example: tea with 1 tsp. sugar/honey, potato with 2 tsp. butter, etc.
7. Try to record the time you consume the food.

FOOD JOURNAL DAY # _____ DATE: _____

Meal/Snack	Time of Day	Foods and Beverages please include portions/amounts eaten	Comments/Symptoms/ Cooking method
Breakfast			
Morning Snack			
Lunch			
Afternoon Snack			
Dinner			
Evening Snack			
Overnight Snack			

FOOD JOURNAL DAY # _____ DATE: _____

Meal/Snack	Time of Day	Foods and Beverages please include portions/amounts eaten	Comments/Symptoms/ Cooking method
Breakfast			
Morning Snack			
Lunch			
Afternoon Snack			
Dinner			
Evening Snack			
Overnight Snack			

FOOD JOURNAL DAY # _____ DATE: _____

Meal/Snack	Time of Day	Foods and Beverages please include portions/amounts eaten	Comments/Symptoms/ Cooking method
Breakfast			
Morning Snack			
Lunch			
Afternoon Snack			
Dinner			
Evening Snack			
Overnight Snack			

FOOD JOURNAL DAY # _____ DATE: _____

Meal/Snack	Time of Day	Foods and Beverages please include portions/amounts eaten	Comments/Symptoms/ Cooking method
Breakfast			
Morning Snack			
Lunch			
Afternoon Snack			
Dinner			
Evening Snack			
Overnight Snack			

FOOD JOURNAL DAY # _____ DATE: _____

Meal/Snack	Time of Day	Foods and Beverages please include portions/amounts eaten	Comments/Symptoms/ Cooking method
Breakfast			
Morning Snack			
Lunch			
Afternoon Snack			
Dinner			
Evening Snack			
Overnight Snack			

FOOD JOURNAL DAY # _____ DATE: _____

Meal/Snack	Time of Day	Foods and Beverages please include portions/amounts eaten	Comments/Symptoms/ Cooking method
Breakfast			
Morning Snack			
Lunch			
Afternoon Snack			
Dinner			
Evening Snack			
Overnight Snack			

FOOD JOURNAL DAY # _____ DATE: _____

Meal/Snack	Time of Day	Foods and Beverages please include portions/amounts eaten	Comments/Symptoms/ Cooking method
Breakfast			
Morning Snack			
Lunch			
Afternoon Snack			
Dinner			
Evening Snack			
Overnight Snack			

H. ADDITIONAL INFORMATION, PERSONAL SUGGESTIONS

1. Please share any additional information, or interests that your Health & Wellness Coach should know.



I. CLIENT AGREEMENT

This Health & Wellness Coaching Agreement (the "Agreement") is entered into on _____ between Doria Schneider and _____.

1. Purpose of Coaching/Counseling:

The Client is seeking health & wellness coaching services to improve their overall health and well-being, discuss how they manage specific health concerns, and how they want to achieve their nutritional goals.

2. Scope of Services:

- **Initial Assessment:** Doria will conduct an initial assessment to understand the Client's health history, dietary preferences, lifestyle, and specific goals.
- **Customized Nutrition Plan:** Based on the assessment, Doria will work with you, the client to discuss and customize a personalized meal and menu we plan tailored to your unique needs and goals.
-

3. Coaching Goals:

The primary goals of this health & wellness coaching are as follows:

- Help you the client to improve overall nutrition and dietary choices;
- Help client learn techniques to manage specific concerns
- Enhance energy levels and overall well-being;
- Develop sustainable and realistic habits;
- Achieve specific goals set by the Client.

4. Confidentiality:

Both the Client and Doria agree to maintain strict confidentiality regarding all personal and health information shared during coaching sessions.

5. Payment:

Payment is due at time of service.

6. Governing Law:

This Agreement shall be governed by the laws of [Florida and Sarasota County].

By signing this Agreement, both parties acknowledge their understanding of its terms and consent to the provision of health and wellness coaching services.

DATE:

DATE:

CLIENT'S FULL NAME (PRINTED):

Doria's FULL NAME (PRINTED):

CLIENT'S SIGNATURE:

Doria's SIGNATURE: