Contact: Christine Moran
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# NUTRITION INTAKE ASSESSMENT

Name: ______________________ Date: ______________

Address: ______________________ City: ______________

Postal Code: ____________ Referred By: ______________

Home Phone: ( ) ____________ Cell Phone: ( ) ______________

Date of Birth/Age: ____________

E-mail: ______________________ Would you like to be added to out mailing list? Y N

1. How did you hear about Christine Moran ❑ Friend ❑ Website ❑ Twitter ❑ Facebook ❑ Advertisement ❑ Blog
2. What are your nutrition goals?
3. How committed are you in achieving your goals? (please circle) 1 2 3 4 5 6 7 8 9 10
4. Have you ever joined a nutrition program before? ❑ Yes ❑ No If yes, which one? _
5. List 3 things you liked about your previous program experience .
6. When was the last time you participated in a regular exercise program?
7. In 6 months, what would you like to improve?
8. Who is included in your support system? ❑ Spouse ❑ Child ❑ Parent ❑ Sibling ❑ No One
9. What are you hoping to receive from your nutrition program?

❑ Improve body composition ❑ Gain muscle ❑ Feel healthier
❑ Hormonal balance ❑ Reduce disease risk ❑ More energy
❑ Lose weight ❑ Medical recovery ❑ Muscle Toning
❑ Other

10. Do you sleep through the night on a regular basis? ❑ Yes ❑ No If no, why?
11. Do you wake up feeling rested? ❑ Yes ❑ No
12. How stressed out are you on a regular basis? please circle (best) 1 2 3 4 5 (worst)
13. Circle any of the following digestive system symptoms you experience:

    Heart Burn Acid Reflux Burping Gas Bloating Constipation Diarrhea

14. Circle the number of daily bowel movements you have: 0 1-2 3-4
15. Circle any of the following symptoms you experience: Headaches Migraines PMS Hot Flashes Aches and Pains Psoriasis

    Eczema Dry Skin Cracking Nails Brittle Hair Cracking Skin Congestion Frequent Colds Seasonal Allergies Mental Fog
    Energy High's and Low's

16 My Medical History:

❑ Diabetes ❑ Cholesterol ❑ High Blood Pressure ❑ Depression ❑ Osteoporosis ❑ Cancer Type: _

❑ Other

❑ List all prescription medications _

❑ List all supplements

17. Do You Smoke ❑ Yes ❑ No
18. How often do you dine out? ❑ Seldom ❑ 1 per week ❑ 2-3 per week ❑ More than 3
19. How frequent do you eat fast foods? ❑ Seldom ❑ 1 per week ❑ 2-4 per week ❑ More than 4

The undersigned hereby acknowledges being informed of Harmony House Wellness privacy policy and hereby to the collection, use and disclosure of the undersigned personal information contained herein in accordance with our privacy policy available **harmonyhousewellness.ca** or upon request

Signature: ______________________ Date: ______________________