Client Intake Form

Name: ____________________________________	Date: ______________________
Address: __________________________________	E-mail: ____________________________________
Phone number: ____________________________	Referred By: _______________________________

Birth Date: ________ Height (inches): _____ Weight (lbs): _____ Blood Type: ____ Wt. History: ______

Labs: Glucose _____ Albumin _____ Cholesterol ____ Triglycerides ____ Hemoglobin _____

Goal (s) for this consultation: ____

Current health/ nutrition concerns ____

Medical history ____

List all medications and supplements (vitamins/ minerals, herbs, nutritional supplements, etc.) _____________

____

List all food allergies, food sensitivities and food dislikes ____

Current diet (vegetarian, diabetic, etc.) ____

What percentage of your meals are home-cooked? ____

Anything else you would like to add about your current diet, history or relationship to food? _______________

____

How often do you exercise? ____

How often do you have a bowel movement? ____

If applicable, how often do you consume alcohol? ____

How do you handle stress? ____

Current Eating Patterns:

Breakfast	Snacks
Lunch	Beverages
Dinner	Other

EON CONSULTING

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