**NUTRITION INTAKE FORM**

|  |
| --- |
| **First/Last Name:** |
| **Today’s Date:** |
| **Street Address:** |
| **City: State: Zip:** |
| **Phone: Email:** |
| **Height: Weight: Sex: Age: Date of Birth:** |
| **Occupation:**  |
| **Emergency Contact Name/Number:** |
| **OB/GYN or Urologist (Name, Practice):** |
| **Reproductive Endocrinologist (Name, Practice):** |

**Health History**

|  |
| --- |
| **Health Problems for which you are seeking treatment:** |
|  |
| **How long have you had condition:** |
| **Other forms of treatment you have sought?** |
| **Surgeries or major health issues (Year and type):** |
|  |
| **Primary reason for seeking nutrition counseling?** |
|  |
| **Names/Dosages for any medications or supplements you are taking or have taken in the past 2 months?** |
|  |
| **Family Medical History (M=Mother, F-Father, G=Grandparents, S=Sibling, C=Children, Sp=Spouse)** |
|  |
|  |

**Circle any of the following conditions you have experienced:**

**Acne Antibiotic Use (Extended) Constipation Depression/Anxiety Diarrhea Dry Skin Endometriosis Facial Hair Growth Fatigue Feel Cold Feel Hot Fibroids Gas/Bloat Hair Loss Headaches Hot Flashes Hyperthyroid IBS Irritable/Depressed During Menses Leg Cramps**

**Less Than 1 Bowel Movement/Day Menstrual Clots PCOS STD Yeast Infection**

**Reproductive History**

**How many days from one period to the next? \_\_\_\_\_\_\_\_\_\_\_ Date of last period: \_\_\_\_\_\_\_\_\_\_\_**

**How many days do you typically bleed? \_\_\_\_\_\_\_\_\_\_\_ How heavy?** ☐ **Light** ☐ **Moderate** ☐ **Heavy**

**Do you have clotting?** ☐ **Yes** ☐ **No**

**Do you get premenstrual cramping?** ☐ **Yes** ☐ **No**

**Do you get premenstrual low back pain?** ☐ **Yes** ☐ **No**

**Do you abnormal discharge?** ☐ **Yes** ☐ **No**

**Are you pregnant?** ☐ **Yes** ☐ **No How long have you been trying to conceive? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Number & Years of the following:**

**Pregnancies \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Children \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Abortions \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Miscarriages \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**D&Cs \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Complications \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Have you taken oral contraceptives?** ☐ **Yes** ☐ **No When? \_\_\_\_\_\_\_\_\_\_\_\_ How long? \_\_\_\_\_\_\_\_\_\_**

**Have you ever had fertility treatments?** ☐ **No** ☐ **Timed Intercourse** ☐ **IUI** ☐ **IVF**

**If you have gone through in-vitro, how many eggs were retrieved/how many fertilized? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**If male factor infertility, has he had a fertility workup?** ☐ **Yes** ☐ **No Results: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Nutrition Information**

**On a scale of 1-10 (10 being extremely healthful), how do you rate your diet?**

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

 **Please describe any current dietary restrictions? Food Allergies?**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**How many times/week do you eat or drink…**

|  |  |  |  |
| --- | --- | --- | --- |
| Beans/Legumes |  | **Alcohol** |  |
| Butter |  | **Caffeinated Coffee** |  |
| Cheese |  | **Decaf Coffee** |  |
| Chicken/Turkey |  | **Diet Drinks** |  |
| Eggs |  | **Diet Soft Drinks** |  |
| Fish |  | **Fruit Juice** |  |
| Fresh Fruit |  | **Green/ Black Tea** |  |
| Fresh Veggies |  | **Herbal Tea** |  |
| Margarine |  | **Sot Drinks** |  |
| Milk |  | **Sport Drinks** |  |
| Nut Butters |  | **Water** |  |
| Nuts/Seeds |  | **Sugar Substitute** |  |
| Olive Oil |  | **Sweets (desserts, candy)** |  |
| Pork/Ham/Bacon |  | **Tofu/Soy** |  |
| Red Meat |  | **Whole Grains** |  |
| Refined Carbs (crackers, chips, pasta) |  | **Yogurt** |  |

**Please indicate any foods/drinks not listed that you consume regularly:**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**How often do you choose organic fruits and vegetables and grass-fed/cage-free animal products?**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**What foods do you crave? Avoid?**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Do you snack throughout the day?** ☐**Yes** ☐**No If Yes, please describe:**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**How many times/week do you eat breakfast? Please describe your usual breakfast.**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Do you generally cook your own meals?** ☐ **Yes** ☐ **No How Often? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Where do you do most grocery shopping? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**How would you describe most of your meals?**

**Relaxed Rushed In front of the TV Seated at the Table In the Car Alone With Family/Friends**

**Do you feel you eat a wide variety of foods?** ☐ Yes ☐ No ☐ Unsure

**How often do you consume sugar?** ☐ Daily ☐ 3-4x/week ☐ Occasionally ☐ Seldom/Never

**Do you have good energy levels?** ☐ Yes ☐ No ☐ Inconsistent

**Does napping help or make it worse?** ☐ Helps ☐ Worse ☐ Indifferent

**Can you attribute low energy to anything in particular?**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Do you consider yourself?** ☐ Overweight ☐ Underweight ☐ Just Right

**Have you previously used diet or exercise to lose or gain weight?** ☐ Yes ☐ No

**Have you previously used medications or supplements to lose or gain weight?** ☐ Yes ☐ No

**Please specify which of the following are included in your diet:** ☐ Fast Food ☐ Prepared Meals at Home

☐ Fresh Frozen ☐ Canned ☐Boxed/Bagged ☐ Organic ☐ Conventional ☐ Free-range/Grass-fed

**Do you diet frequently/are you currently on a diet? If so, describe.**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Do you, or have you ever used tobacco?** ☐Yes ☐No **If quit, when?** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Do you drink alcohol?**  ☐Yes ☐No

**Sleep and Exercise**

**What time do you go to bed? \_\_\_\_\_\_\_ What time do you fall asleep? \_\_\_\_\_\_\_ What time do you wake up? \_\_\_\_\_\_\_**

**How many hours do you need to sleep to feel rested? \_\_\_\_\_\_\_\_\_\_\_\_\_\_ How many do you get? \_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Do you exercise?** ☐Yes ☐No

**Type & Frequency:** ☐ Walk ☐ Aerobics ☐ Dance ☐ Run ☐ Bicycle ☐ Team Sports ☐ Yoga ☐ Weight Lift

 ☐ Sedentary ☐ Occasional Exercise ☐ Regular Exercise

**Emotional State**

**Rate your current stress level (0-10) in regard to the selections listed below:**

**Job/School: 0 1 2 3 4 5 6 7 8 9 10**

**Divorce/Seperation: 0 1 2 3 4 5 6 7 8 9 10**

**Primary Relationship: 0 1 2 3 4 5 6 7 8 9 10**

**Death: 0 1 2 3 4 5 6 7 8 9 10**

**Family/Parents/Kids: 0 1 2 3 4 5 6 7 8 9 10**

**Financial: 0 1 2 3 4 5 6 7 8 9 10**

**What activities do you engage in to counter stress in your life?**

**Please specify any other information you feel may be helpful:**

By signing, I acknowledge that the primary focus of nutrition sessions at the Wellness Center at Shady Grove Fertility is to provide natural, safe, noninvasive adjunct therapies to promote optimal health and fertility. A Nutritionist does not diagnose nor treat disease, but provides information and nutritional strategies to restore natural balance and health. Your Nutritionist will not encourage you to terminate any previous therapies your doctors have begun, and will gladly cooperate with your medical doctor upon request to support your health concerns. Any recommendations for laboratory tests, diet changes, and nutritional supplements made by your Nutritionist will be to support, not replace, medical treatment you may be receiving from your physician or other health care provider. I acknowledge that the Nutritionist is a Registered Dietitian (RD) and has a minimum of a BS in Nutrition. I accept that no guarantee is made concerning outcomes because of each person's unique biochemical individuality.

**Client Signature**