INTAKE FORM

THIS ISN'T A TRADITIONAL INTAKE FORM. I TRULY WANT TO HEAR YOUR STORY, PAST EXPERIENCES, AND YOUR DEEPEST CONCERNS. THIS FORM COVERS A LOT OF THE NITTY GRITTY SO I CAN BEGIN TO PIECE TOGETHER WHAT IS HAPPENING IN YOUR UNIQUE BODY. PLEASE CARVE OUT ABOUT 45 MINUTES OF UNINTERRUPTED TIME TO FILL THIS OUT TO THE BEST OF YOUR ABILITY.I WILL SPEND ABOUT AN HOUR REVIEWING YOUR INTAKE FORM SO WHEN WE HAVE OUR INITIAL CALL WE CAN ADDRESS YOUR BIG CONCERNS AND CREATE A PLAN THAT HAS ATTAINABLE NEXT STEPS TO GET YOU FEELING GOOD AGAIN.

CLIENT'S INFORMATION

FULL NAME:	
DATE OF BIRTH:	AGE: FEMALE / MALE
ADDRESS:	
CITY:	ZIP CODE:
E-MAIL:	PHONE:

EMERGENCY CONTACT

NAME:	
RELATIONSHIP:	PHONE:

HEALTH GOALS

What are you looking to get out of this consult? What's the catalyst now to seek out change? List your top 3 healthcare concerns or goals you are looking to address. Start with highest priority so we know where to dig in.

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IF YOU HAVE ANY RELEVANT LABS FROM THE PAST YEAR, PLEASE INCLUDE THEM AT THE END OF THIS FORM. 20 PAGES MAX.

PAST MEDICAL HISTORY AND DIAGNOSIS

DIAGNOSIS	DATE

HAVE YOU CONSULTED A FUNCTIONAL NUTRITION/HERBALIST/NATUROPATH PRACTITIONER BEFORE?

If yes, what was the outcome? How was the experience? Did you have any concerns with the experience?

DO YOU HAVE ANY HESITATIONS OR CONCERNS ABOUT WORKING WITH A FUNCTIONAL MEDICINE PROVIDER?

If so please list your concerns, I want to understand where you are coming from.

SUPPLEMENTS, VITAMINS, NON-PRESCRIPTION MEDICATIONS AND PRESCRIPTION MEDICATIONS YOU TAKE REGULARLY.

THIS INCLUDES REGULAR USE OF LAXATIVES, PAIN MEDICATIONS, ANTIHISTAMINES, PLANT MEDICINES, ETC. ANYTHING YOU FEEL YOU NEED TO TAKE TO FUNCTION THROUGHOUT YOUR DAY.

NAME	DOSE/DURATION	WHY ARE YOU TAKING IT?	HOW DOES IT MAKE YOU FEEL

PROCEDURES & SURGERIES.

NAME OF PROCEDURE	DATE	WHAT WAS THE OUTCOME/ANY COMPLICATIONS?

HEIGHT & WEIGHT

HEIGHT	CURRENT WEIGHT	DESIRED WEIGHT	DOES YOUR WEIGHT FLUCTUATE?

WHAT IS YOUR RELATIONSHIP WITH YOUR WEIGHT? IF YOU HAVE A DESIRE FOR YOUR WEIGHT TO CHANGE, GAIN OR LOSS, WHAT IS THE REASON?

DIETING.

ARE YOU CURRENTLY DIETING? IF SO DO YOU FEEL IT IS SUCCESFUL?

HAVE YOU DIETED IN THE PAST? IF SO WHY? AND DO YOU FEEL IT WAS SUCCESSFUL?

ARE YOU OPEN TO CHANGING YOUR DIETARY HABITS?

AT WHAT POINT IN YOUR LIFE DID YOU **FEEL** YOUR BEST? WHAT DID THAT LOOK LIKE FOR YOU?

ALLERGIES AND FOOD INTOLERANCES

DO YOU HAVE ANY KNOWN FOOD ALLERGIES? IF SO, HOW DO THE SYMTPOMS MANIFEST?

HAVE YOU NOTICED ANY FOODS THAT HAVE MADE YOU FEEL BETTER OR WORSE? IF SO WHAT WERE THE SYMPTOMS

ANY OTHER ALLERGIES? MOLD, ENVIORNMENTAL, MEDICATIONS,ETC.?

BOOZE AND CIGS.

DO YOU DRINK ALCOHOL? IF SO HOW OFTEN AND WHAT DO YOU DRINK?
DO YOU SMOKE? IF SO, HOW OFTEN AND WHAT DO YOU SMOKE?
ANYTHING THAT WASN'T PREVIOUSLY MENTIONED THAT FITS IN THIS CATEGORY? PLEASE LIST IT HERE. NO JUDGEMNET.
IF YOU DO DRINK/SMOKE/ETC. HOW DO YOU FEEL LIKE IT CONTRIBUTES TO YOUR OVERALL HEALTH? IF NEGATIVELY IS THIS SOMETHING YOU WOULD CONSIDER LIMITING. WHY OR WHY NOT?

ANTIBIOTICS

LIST ANTIBIOTIC TREATMENTS YOU HAVE HAD

ANTIBITOIC NAME	WHEN	DURATION	REASON	ANY SIGNS AFTER TREAMENT?

EXCERSISE

DO YOU EXCERSISE? IF SO WHAT KIND OF EXCERSISE?
HOW OFTEN DO YOU EXCERSISE AND LENGTH OF SESSIONS?
HOW DO YOU FEEL AFTER EXCERSISE? HOW DO YOU FEEL WHEN YOU SKIP EXCERSISE?
ARE YOU WILLING TO CONSIDER CHANGING YOUR EXCERSISE REGIMENT IF NEEDED?

SLEEP

DO YOU FEEL LIKE YOU SLEEP WELL? WHY OR WHY NOT
HOW MANY HOURS OF SLEEP DO YOU GET A NIGHT?
IF YOU SLEEP UNDER 8 HOURS, ARE YOU WILLING TO CONSIDER ADJUSTING YOUR SLEEP ROUTINE?
DO YOU GO TO BED AT THE SAME TIME EACH NIGHT? TELL ME ABOUT YOUR SLEEP ROUTINE
DO YOU HAVE DIFFICULTY FALLING ASLEEP?
DO YOU HAVE DIFFICULTY STAYING ASLEEP? WAKING UP IN THE MIDDLE OF THE NIGHT
DO YOU FEEL LIKE YOU NEED CAFFIENE, STIMULANTS, ENERGY DRINKS, ETC. TO STAY AWAKE DURING THE DAY?
HOW MUCH CAFFIENE DO YOU DRINK PER DAY AND WHAT KIND? COFFEE, TEA, ENERGY DRINKS, SUPPLEMENTS?

BOWEL MOVEMENTS

HOW OFTEN DO YOU HAVE A BOWEL MOVEMENT?
IS IT PAINFUL TO HAVE A BOWEL MOVEMENT?
HOW OFTEN DO YOU HAVE GAS OR BLOATING?
HOW WOULD YOU DESRCRIBE YOUR BOWEL MOVEMENTS? SOFT, LOOSE, HARD, EXPLOSIVE, PAINFUL, STRAINING, CRAMPING, REGULAR, UNDIGESTED FOOD, DIARRHEA, MUCOUS IN STOOL, STREAKS OF RED, CLAY COLORED, BROWN, TARRY, STICKS TO THE TOILET BOWEL,ETC.?

STRESS

DO YOU FEEL STRESSED?
IF SO HOW OFTEN AND WHAT DOES STRESS FEEL LIKE YOUR BODY?
WHAT ARE SOME MAJOR STESSORS IN YOUR LIFE?
DO YOU FEEL LIKE YOUR STRESS IMPACTS YOUR HEALTH? HOW?
DO YOU HAVE SOMEONE TO TALK WITH ABOUT STRESSORS?
DO YOU HAVE ANY COPING TECHNIQUES? IF SO, WHAT AND DO YOU FEEL LIKE THEY ARE HELPFUL?
DO YOU HAVE ANY DAILY STRESS REDUCTION TECHNIQES SUCH AS YOGA, MEDITATION, PRAYER, JOURNALING?
IF YOU DON'T HAVE ANY REGULAR STRESS REDUCTION TECHNIQUES OR A MENTAL HEALTH PROFESSIONAL TO TALK TO, IS THIS SOMETHING YOU WOULD CONSIDER OR YOU FEEL WOULD BE BENEFICIAL FOR YOUR OVERALL HEALTH?
HOW WAS YOUR HOME ENVIORNEMENT GROWING UP? LOUD, QUIET, PEACEFUL, HOSTILE, ANGRY, LOVING, STRESSFUL, ARGUMENTATIVE, EDUCATIONAL, LONELY, SUPPORTIVE?

BODY CARE AND EXPOSURES

DO YOU USE BODY CARE PRODUCTS, COSMETICS, OR PERFUMES? ? IF SO WHAT KIND
DO YOU USE SCENTED LAUNDRY DETERGENTS, DRYER SHEETS?
WHAT DO YOU USE TO CLEAN YOUR HOME?
ANY KNOWN MOLD EXPSOURES, CHEMICAL EXPOSURES, TOXINS,ETC.?

BODY SYSTEMS

COLON

	NEVER	SOMETIMES	ALWAYS
FEELING THAT BOWELS DO NOT EMPTY COMPLETELY	☐	☐	☐
LOWER ABDOMINAL PAIN RELIEVED BY PASSING STOOL OR GAS	☐	☐	☐
ALTERNATING CONSTIPATION AND DIARRHEA	☐	☐	☐
CONSTIPATION/ DECREASED MOTILITY	☐	☐	☐
DIARRHEA/INCREASED MOTILITY	☐	☐	☐
USE LAXATIVES FREQUENTLY	☐	☐	☐
MORE THAN 3 BOWEL MOVEMENTS DAILY	☐	☐	☐
PASS LARGE AMOUNT OF FOUL-SMELLING GAS	☐	☐	☐
A DAY WITHOUT A BOWEL MOVEMENT	☐	☐	☐
FREQUENT BLOATING	☐	☐	☐
ABDOMINAL PAIN AND/OR CRAMPING	☐	☐	☐
ABDOMINAL DISTENTION AFTER CONSUMPTION OF FIBER, STARCHES, AND SUGAR	☐	☐	☐
SUSPICION OF NUTRITIONAL MALABSORPTION	☐	☐	☐
I'VE HAD FOOD POISONING OR TRAVELER'S DIARRHEA IN THE PAST FIVE YEARS	☐	☐	☐
DIAGNOSED WITH CELIAC DISEASE, IRRITABLE BOWEL SYNDROME, DIVERTICULOSIS/ DIVERTICULITIS, OR LEAKY GUT SYNDROME?	☐	☐	☐

STOMACH

	NEVER	SOMETIMES	ALWAYS
EXCESSIVE BELCHING, BURPING, OR BLOATING	☐	☐	☐
GAS IMMEDIATELY FOLLOWING A MEAL	☐	☐	☐
SENSE OF FULLNESS DURING AND AFTER MEALS	☐	☐	☐
DIFFICULTY DIGESTING PROTEINS AND MEATS	☐	☐	☐
UNDIGESTED FOOD FOUND IN STOOLS	☐	☐	☐
FEEL LIKE FOOD SITS IN MY STOMACH	☐	☐	☐
ACID REFLUX/HEARTBURN	☐	☐	☐
I HAVE USED PPIS OR ACID-BLOCKING DRUGS FOR ACID REFLUX	☐	☐	☐
WEAK, CRACKED OR PEELING NAILS	☐	☐	☐
STOMACH PAIN, BURNING, OR ACHING 1-4 HOURS AFTER EATING	☐	☐	☐
FEEL HUNGRY AN HOUR OR TWO AFTER EATING	☐	☐	☐
HEARTBURN WHEN LYING DOWN OR BENDING FORWARD	☐	☐	☐
DIGESTIVE PROBLEMS SUBSIDE WITH REST AND RELAXATION	☐	☐	☐
HEARTBURN DUE TO SPICY FOODS, CHOCOLATE, CITRUS, PEPPERS, ALCOHOL, AND CAFFEINE	☐	☐	☐
KNOWN IRON DEFICIENCY	☐	☐	☐

PANCREAS

	NEVER	SOMETIMES	ALWAYS
PAIN, TENDERNESS, SORENESS THAT RADIATES TO LEFT SHOULDER BLADE	☐	☐	☐
DIFFICULTY DIGESTING ROUGHAGE AND FIBER	☐	☐	☐
NAUSEA AND/OR VOMITING	☐	☐	☐
STOOL UNDIGESTED, FOUL SMELLING, MUCUS LIKE, GREASY, OR POORLY FORMED	☐	☐	☐
FREQUENT LOSS OF APPETITE	☐	☐	☐
A SEVERE, DULL PAIN AROUND THE TOP OF YOUR STOMACH THAT DEVELOPS SUDDENLY	☐	☐	☐

BILIARY

	NEVER	SOMETIMES	ALWAYS
GREASY OR HIGH-FAT FOODS CAUSE DISTRESS	☐	☐	☐
LOWER BOWEL GAS AND/OR BLOATING SEVERAL HOURS AFTER EATING	☐	☐	☐
BITTER METALLIC TASTE IN MOUTH, ESPECIALLY IN THE MORNING	☐	☐	☐
BURPY, FISHY TASTE AFTER CONSUMING FISH OILS	☐	☐	☐
STOOL COLOR ALTERNATES FROM CLAY COLORED TO NORMAL BROWN	☐	☐	☐
DRY OR FLAKY SKIN AND/OR HAIR	☐	☐	☐
HISTORY OF GALLBLADDER ATTACKS OR STONES	☐	☐	☐
GALLBLADDER HAS BEEN REMOVED	☐	☐	☐
AVERSION TO FATS OR FEEL UNABLE TO TOLERATE FATS	☐	☐	☐

SUGAR METABOLISM

	NEVER	SOMETIMES	ALWAYS
IRRITABLE IF MEALS ARE MISSED	☐	☐	☐
INCREASED ENERGY AFTER MEALS	☐	☐	☐
EATING RELIEVES FATIGUE	☐	☐	☐
CRAVING FOR SWEETS IN BETWEEN MEALS	☐	☐	☐
DEPEND ON COFFEE TO KEEP GOING/GET STARTED	☐	☐	☐
LIGHT-HEADED IF MEALS ARE MISSED	☐	☐	☐
HEADACHES WHEN I FORGET TO EAT	☐	☐	☐
FEEL SHAKY, JITTERY, OR HAVE TREMORS	☐	☐	☐
POOR MEMORY, FORGETFUL BETWEEN MEALS	☐	☐	☐
BLURRED VISION	☐	☐	☐
SKIP MEALS BECAUSE I AM TOO BUSY	☐	☐	☐
WEAK, DIZZY, OR SHAKY BECAUSE I HAVEN'T EATEN IN A WHILE	☐	☐	☐
SOMETIMES NEED SUGAR OR CARBS FAST BECAUSE I'M SO HUNGRY	☐	☐	☐
I'M HUNGRY AGAIN AFTER DINNER, BEFORE GOING TO BED	☐	☐	☐
I WAKE UP HUNGRY IN THE MIDDLE OF THE NIGHT	☐	☐	☐

SUGAR METABOLISM, UTILIZATION AND REGULATION

	NEVER	SOMETIMES	ALWAYS
IRRITABLE IF MEALS ARE MISSED	☐	☐	☐
INCREASED ENERGY AFTER MEALS	☐	☐	☐
EATING RELIEVES FATIGUE	☐	☐	☐
CRAVING FOR SWEETS IN BETWEEN MEALS	☐	☐	☐
DEPEND ON COFFEE TO KEEP GOING/GET STARTED	☐	☐	☐
LIGHT-HEADED IF MEALS ARE MISSED	☐	☐	☐
HEADACHES WHEN I FORGET TO EAT	☐	☐	☐
FEEL SHAKY, JITTERY, OR HAVE TREMORS	☐	☐	☐
POOR MEMORY, FORGETFUL BETWEEN MEALS	☐	☐	☐
FATIGUE AFTER MEALS	☐	☐	☐
SKIP MEALS BECAUSE I AM TOO BUSY	☐	☐	☐
WEAK, DIZZY, OR SHAKY BECAUSE I HAVEN'T EATEN IN A WHILE	☐	☐	☐
SOMETIMES NEED SUGAR OR CARBS FAST BECAUSE I'M SO HUNGRY	☐	☐	☐
I'M HUNGRY AGAIN AFTER DINNER, BEFORE GOING TO BED	☐	☐	☐
I WAKE UP HUNGRY IN THE MIDDLE OF THE NIGHT	☐	☐	☐
I SKIP BREAKFAST MORE THAN ONE DAY A WEEK	☐	☐	☐
I HAVE HYPOGLYCEMIA (LOW BLOOD SUGAR)	☐	☐	☐
I HAVE HYPERGLYCEMIA (HIGH BLOOD SUGAR)	☐	☐	☐
CRAVE SWEETS DURING THE DAY	☐	☐	☐
I GET TIRED SHORTLY AFTER I EAT SOMETHING WITH CARBS	☐	☐	☐
EXCESS WEIGHT AROUND THE MIDDLE	☐	☐	☐
DIFFICULTY LOSING WEIGHT	☐	☐	☐
FREQUENT URINATION	☐	☐	☐
INCREASED THIRST AND APPETITE	☐	☐	☐
I HAVE GENERAL FATIGUE	☐	☐	☐
I HAVE CONSTANT HUNGER	☐	☐	☐
BLURRED VISION	☐	☐	☐

ADRENALS

	NEVER	SOMETIMES	ALWAYS
CANNOT FALL ASLEEP	☐	☐	☐
UNDER A HIGH AMOUNT OF STRESS	☐	☐	☐
WEIGHT GAIN WHEN UNDER STRESS	☐	☐	☐
WAKE UP TIRED EVEN AFTER 6 OR MORE HOURS OF SLEEP	☐	☐	☐
I HAVE TROUBLE FALLING ASLEEP; I OFTEN FEEL "TIRED AND WIRED"	☐	☐	☐
I FALL ASLEEP AND THEN WAKE UP A COUPLE OF HOURS LATER	☐	☐	☐
I CRAVE SWEETS, COFFEE, OR CHOCOLATE (OR SALTY FOODS OR CARBS	☐	☐	☐
I FEEL TIRED DURING THE DAY; I OFTEN HIT A SLUMP AT ABOUT 3:00-4:00 IN THE AFTERNOON	☐	☐	☐
I FEEL STRESSED OR OVERWHELMED; I'VE BEEN UNDER STRESS FOR WEEKS (OR MONTHS OR YEARS)	☐	☐	☐
I FEEL ANXIOUS, WORRY A LOT, OR OFTEN THINK SOMETHING "BAD" IS ABOUT TO HAPPEN	☐	☐	☐
I JUMP AT LOUD NOISES	☐	☐	☐
DON'T HAVE ENOUGH TIME OR MOTIVATION TO EXERCISE	☐	☐	☐
I'M FEEL IRRITABLE OFTEN	☐	☐	☐
I'M OVERWEIGHT, ESPECIALLY AROUND MY MIDDLE	☐	☐	☐
SOMETIMES I'M BLUE OR DEPRESSED	☐	☐	☐
I FEEL LIKE I NEVER ACCOMPLISH ENOUGH; I'M OFTEN PUSHING MYSELF TO DO MORE	☐	☐	☐
MY MEMORY IS NOT GREAT; I HAVE TROUBLE WITH MY FOCUS	☐	☐	☐
I GET SICK EASILY; INFECTIONS TEND TO LINGER	☐	☐	☐
CRAVE SALT	☐	☐	☐
SLOW STARTER IN THE MORNING	☐	☐	☐
DIZZINESS WHEN STANDING UP QUICKLY	☐	☐	☐
AFTERNOON HEADACHES	☐	☐	☐
EXHAUSTED AND BURNED OUT	☐	☐	☐
LOW EXERCISE TOLERANCE	☐	☐	☐
MY MOTIVATION AND DRIVE ARE REALLY LOW	☐	☐	☐
NO SEX DRIVE	☐	☐	☐
I'VE BEEN DIAGNOSED WITH CHRONIC FATIGUE SYNDROME OR FIBROMYALGIA	☐	☐	☐

THYROID

	NEVER	SOMETIMES	ALWAYS
TIRED/SLUGGISH/RUN DOWN	☐	☐	☐
FEEL COLD ALL THE TIME —HANDS, FEET, ALL OVER	☐	☐	☐
REQUIRE EXCESSIVE AMOUNTS OF SLEEP TO FUNCTION PROPERLY	☐	☐	☐
GAIN WEIGHT EASILY	☐	☐	☐
DIFFICULT, INFREQUENT BOWEL MOVEMENTS	☐	☐	☐
DEPRESSION/LACK OF MOTIVATION	☐	☐	☐
OUTER THIRD OF EYEBROW THINS	☐	☐	☐
HAIR LOSS OR THINNING OF HAIR	☐	☐	☐
DRYNESS OF SKIN AND/OR SCALP	☐	☐	☐
MY MEMORY AND CONCENTRATION AREN'T WHAT THEY WERE	☐	☐	☐
HEART PALPITATIONS	☐	☐	☐
I'M FEELING BLUE; STRUGGLING WITH DEPRESSION; I'VE LOST MY SENSE OF JOY AND PLEASURE	☐	☐	☐
I HAVE CELIAC DISEASE OR ANOTHER AUTOIMMUNE CONDITION	☐	☐	☐
INCREASED PULSE EVEN AT REST/ HEART ARRYTHMIA'S SUCH AS A.FIB	☐	☐	☐
NERVOUS, ANXIOUS AND EMOTIONAL	☐	☐	☐
INSOMNIA	☐	☐	☐
DIFFICULTY GAINING WEIGHT	☐	☐	☐
MY MUSCLES FEEL FATIGUED AND HEAVY/STRUGGLE TO PUT ON MUSCLE	☐	☐	☐
MY HAIR OR NAILS ARE DRY, COARSE, AND BRITTLE	☐	☐	☐
HIGH CHOLESTEROL	☐	☐	☐
FREQUENT HEADACHES ACCOMPANIED BY PERIPHERAL VISION LOSS	☐	☐	☐
INTOLERANT TO HEAT	☐	☐	☐
INCREASED PERISTALSIS. FREQUENT DIARRHEA	☐	☐	☐
INABILITY TO SIT STILL, ALWAYS NEED TO BE MOVING	☐	☐	☐
IRREGULAR MENSES/HEAVY MENSES	☐	☐	☐
ABSENT MENSES	☐	☐	☐
THICK HAIR	☐	☐	☐

REPRODUCTIVE

☐ PREGNANT	☐ NURSING	☐ FERTILITY CONCERNS
☐ IRREGULAR PERIODS - CAN'T PREDICT CYCLE	☐ HEAVY MENSES	☐ ABSENT/SCANT MENSES
☐ CYCLES LONGER THAN 32 DAYS	☐ CYCLES SHORTER THAN 24 DAYS	☐ HYSTERECTOMY
☐ ENDOMETRIOSIS	☐ PELVIC INFLAMMATORY DISEASE	☐ PMS
☐ MENOPAUSAL	☐ PERIMENOPAUSAL	☐ FACIAL HAIR
IF CURRENTLY PREGNANT, HOW MANY WEEKS?		
PLEASE LIST ANY OTHER REPRODUCTIVE CONCERNS OR PERTINENT INFORMATION		

WALK ME THROUGH A DAY IN THE LIFE.

WHAT TIME DO YOU WAKE UP IN THE MORNING?
DO YOU WAKE EASILY OR FEEL LIKE YOU HAVE TO DRAG YOURSELF OUT OF BED?
WHAT DOES YOUR MORNING ROUTINE LOOK LIKE?
WHAT TIME DO YOU EAT BREAKFAST? DO YOU EVER SKIP BREAKFAST AND WHY?
IF YOU DRINK CAFFEINE, WHAT TIME DO YOU HAVE YOUR FIRST CUP? DO YOU DRINK COFFEE WITH A MEAL OR BY ITSELF?
HOW MANY CUPS OF CAFFEINE DO YOU CONSUME IN A DAY?
AROUND WHAT TIME DO YOU EAT LUNCH? DO YOU EVER SKIP LUNCH AND WHY?
IF YOU ARE EMPLOYED, DO YOU DRIVE TO THE OFFICE OR WORK FROM HOME?
IF YOU ARE A HOMEMAKER, HOW FREQUENTLY DO YOU FIND YOURSELF IN THE CAR?
DO YOU SNACK THROUGHOUT THE DAY?
DO YOU EVER FEEL SHAKY, HANGRY, IRRITABLE IF YOU MISS MEALS?
WHAT TIME DO YOU EAT DINNER? DO YOU EVER SKIP DINNER AND WHY?
ABOUT WHAT PERCENTAGE OF YOUR MEALS ARE HOME COOKED?
ABOUT HOW OFTEN DO YOU EAT OUT AND WHAT KINDS OF MEALS ARE YOU EATING OUT?

FOOD LOG- DAY 1

PLEASE INCLUDE THE TIME AND A DESCRIPTION OF THE MEAL

BREAKFAST	
MORNING SNACK	
LUNCH	
AFTERNOON SNACK	
DINNER	
EVENING SNACK/DESSERT	

FOOD LOG- DAY 2

PLEASE INCLUDE THE TIME AND A DESCRIPTION OF THE MEAL

BREAKFAST	
MORNING SNACK	
LUNCH	
AFTERNOON SNACK	
DINNER	
EVENING SNACK/DESSERT	

FOOD LOG- DAY 3

PLEASE INCLUDE THE TIME AND A DESCRIPTION OF THE MEAL

BREAKFAST	
MORNING SNACK	
LUNCH	
AFTERNOON SNACK	
DINNER	
EVENING SNACK/DESSERT	

FOOD LOG- WEEKEND DAY

PLEASE INCLUDE THE TIME AND A DESCRIPTION OF THE MEAL

BREAKFAST	
MORNING SNACK	
LUNCH	
AFTERNOON SNACK	
DINNER	
EVENING SNACK/DESSERT	

Any additional comments, question, concerns. or anything that was not listed above. Please put here. I want to make sure we have everything covered that you want to discusss.

CLIENT'S SIGNATURE:	
DATE:	DATE: