New Patient Nutrition Form

Patient Name: _____ **Today's Date:** _____

Date of Birth: _____

What are 3 things that you would like to achieve with our meetings together?

1. _____
2. _____
3. _____

What does a typical day of eating look like for you? (*fill in the table below to the best of your ability*)

Meals	Time of Day	What do you eat?
Breakfast		
Snack		
Lunch		
Snack		
Dinner		
Snack		

Do you crave certain foods? What foods do you crave?

Do you drink? _____ If so, how many drinks a week? _____

How is your dental health? (*circle what applies)* Poor, fair, good, no problems

How often do you have bowel movements on average? _____ per week

Do you exercise? _____

- How many days per week?
- How many minutes does each workout session last?

What is the average amount of sleep you get a night? _____

Overall, how stressful is your life on a scale from 1-10? (1 = no stress; 10 = very stressful) _____

Current Supplements:

Supplement	Dosage

Food Allergies:

Food	Reaction