LBS Nutrition, LLC
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PATIENT INTAKE FORM

Name_____ Today's Date _____

Birthdate_____ Height_____ Weight_____

Reason for visit: _____

Past medical history: _____

Medications/supplements: _____

Food allergies/intolerances: _____

How often do you eat out?_____ Who cooks?_____ Who shops? _____

Who do you live with? _____

Stress levels (circle one): high moderate low

Food cravings (circle one): sweets salty crunchy

Physical activity? _____

How many hours do you sleep typically? _____

What did you eat yesterday? _____

Motivation level (circle one): high moderate low

Breakfast: _____

_____

Lunch: _____

_____

Dinner: _____

_____

Snacks: _____

_____

Beverages: _____

_____