

Nancy Corwin Malina, MS, CNS

NCM Nutrition, LLC

200 Sunset Park

Ithaca, NY 14850

(703) 507-0522

ncmnutrition.com

Client Intake Form

*General Information*

|  |  |  |  |
| --- | --- | --- | --- |
| Name of Patient: | | Date: | |
| Telephone: Home |  | | Email Address: |
| Work |  | |  |
| Cell |  | |  |
| Mailing Address: |  | |  |
|  |  | |  |
| Gender: M \_\_\_\_ F \_\_\_\_\_ | Age: Birthdate: | |  |
| Height: | Weight: | | BMI: |
| Occupation: | | | Marital Status: | | |

*Current Health Status*

How would you describe your, or the client’s health in general? **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

What are your most important health concerns? Please list in order of importance.

1.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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4. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Other health problems that are concerns:** (please use back of page if more room is needed)

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**Do you have any current medical diagnoses that are not listed above? (Please list): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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**What types treatments have you sought already to help your health problem? Please include alternative therapies or remedies have you tried already to solve this issue? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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**Allergies/Hypersensitivities:** Do you have known allergies or sensitivities to any drugs, foods, animals, herbs or other substances? Please list allergen and the reaction to it: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Medications:** Please list all current pharmaceutical medicines you are currently taking

N*ame Dosage*  *How long have you taken it*?

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

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**Have you been on extended courses of antibiotics?**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Supplements:** Please list all current vitamins, herbs, homeopathic remedies, and supplements you are currently taking

*Name Dosage Brand How long?*

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***Medical Health History***

**Previous Hospitalizations/Surgeries/Serious Illnesses** Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

***Procedures*:** Please list any procedures/surgeries \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

***Daily Activities:***

|  |  |
| --- | --- |
| **Hours per week you work:** | **Does your work require long hours sitting at a computer or desk?**  **Does your work require long periods of time driving?** |
| **Do you exercise regularly?** | **How many hours a day?**  **How many hours a week?**  **What is your favorite form of exercise?** |
| **Do you smoke?**  **Now? In the past?** | **Do you drink alcohol?**  **How much and how often?** |
| **Do you have an activity that brings you joy?** | **How frequently do you engage in this activity?** |

***Sleeping Habits***

|  |  |
| --- | --- |
| **How many hours do you sleep?** | **Do you wake up feeling rested?** |
| **Do you have trouble falling asleep?** | **Do you have trouble staying asleep?** |

***Eating Habits***

|  |
| --- |
| **What are your favorite foods?** |
| **Do you crave foods? Yes\_\_\_\_ No \_\_\_\_ When?**  **Salty\_\_\_ Sweet \_\_\_\_ Pasta/breads \_\_\_\_\_ Chocolate \_\_\_\_\_ Caffeine/coffee\_\_\_\_\_**  **Other foods you crave?** |

|  |  |
| --- | --- |
| **Do you frequently feel thirsty?** | **What beverage do you drink most during the day?** |
| **Do you often feel hungry?** | **Do you eat beyond feeling full?** |
| **Do you eat when you’re not hungry?** | **What and why?** |
| **Are there any foods you will not eat?** | |
| **Do you typically eat breakfast?**  **Do you skip meals?** | |
| **How many times a week do you eat out or bring in take-out food?** | **Do you eat prepared frozen food?**  **Do you eat processed foods?**  **How frequently?** |

***Elimination***

|  |
| --- |
| **How many times per day do you have a bowel movement?** |
| **Do you strain?**  **Do you have frequent constipation or diarrhea?** |

***Indicate if any of these apply to you:***

**Eat too much**

**Erratic eating patterns**

**Eat on the run**

**Travel frequently**

**Emotional eating**

**Late night eating**

**Fast eater**

**Skip meals**

**Afternoon fatigue**

**Frequent colds, illness**

**Poor focus, memory attention**

**Cold intolerance (often cold, slow to warm up)**

**Insomnia**

**Wake up tired, not refreshed**

**Do not plan meals or menus ahead**

**Rely on convenience foods**

**Often eat/drink for business or social occasions**

**Confused about what to eat**

**Bloating or gas after eating**

***Family History***

|  |
| --- |
| Please indicate if you or family members have/have had any of the following: |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | You | Mother | Father | Siblings | Grandparents |
| **Thyroid Problems** |  |  |  |  |  |
| **Pre-Diabetic orDiabetes** |  |  |  |  |  |
| **Tuberculosis** |  |  |  |  |  |
| **Hypoglycemia** |  |  |  |  |  |
| **Stroke** |  |  |  |  |  |
| **Heart Attack** |  |  |  |  |  |
| **Epilepsy/Seizures** |  |  |  |  |  |
| **Cancer** |  |  |  |  |  |
| **Asthma** |  |  |  |  |  |
| **Allergies** |  |  |  |  |  |
| **Anemia** |  |  |  |  |  |
| **Migraines** |  |  |  |  |  |
| **Hepatitis** |  |  |  |  |  |
| **Heart Disease** |  |  |  |  |  |
| **Birth Defect** |  |  |  |  |  |
| **High Blood Pressure** |  |  |  |  |  |
| **Gall Bladder problem** |  |  |  |  |  |
| **Arthritis** |  |  |  |  |  |
| **Alcoholism/Addiction** |  |  |  |  |  |
| **Sexually Transmitted Disease** |  |  |  |  |  |
| **Skin Conditions** |  |  |  |  |  |
| **Metabolic Syndrome** |  |  |  |  |  |

***Trauma***

Have you experienced physical or emotional trauma prior to your current symptoms? –Please include dates if possible.

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

NCM Nutrition, LLC

Nutrition and exercise are intended to promote general health and wellness and are not intended to replace

a physician’s care or medical intervention. All nutritional assessment, suggestions and consultation on nutrition, diet and exercise are based on your input, and are not intended to diagnose, treat or cure any disease or ailment.

You accept all responsibility for reviewing diet, nutrition, and lifestyle or exercise suggestions with a licensed medical professional before following said suggestions.

Any activity or program may have inherent risks, which may be relative to your state of health, fitness, awareness, care and skill to which you conduct yourself. You agree to inquire about any activities with which you are not familiar, and provide any information, which may limit your participation in suggested activities.

Results and changes in your general health and wellness may vary depending on medical conditions, medications and accuracy in following suggested guidelines.

As your general health and wellness may change with modifications in diet, nutrition, and lifestyle, physician prescribed medications may require modification. It is your responsibility to discuss this with your physician.

**Never reduce or eliminate physician prescribed medications without the direction of your physician or medical care provider.**

Your personal and health information will remain confidential and will not be shared without your consent.

At the discretion of the provider, NCM Nutrition, LLC. reserves the right to refuse services to any individual.

By signing below, you agree to the above terms and conditions for participation in nutritional consultation with Nancy Corwin Malina, MS and NCM Nutrition, LLC.

Print name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_