



MyHealth Care Centre
317 Queen St South
Streetsville, ON
905.593.5000

Look Better.
Feel Better.
Live Better.

NUTRITION INTAKE

Name:

Date:

Please fill out as much information as you can. The more we know about you in terms of your nutrition & lifestyle goals and habits, the better we can put you on a program that works best for you, long-term!

GENERAL HEALTH & LIFESTYLE:

- What are your main health and nutrition concerns?
- What results would you like to accomplish from your nutrition sessions?
- Have you ever been diagnosed with a major ailment related to your main health concern?
- Have you ever been hospitalized? If so, why?
- What is your general level of stress (circle one): minimal average considerable unbearable
- What are your main sources of stress (circle all that apply): work family finances marriage health personal spiritual personal unfulfilled expectations
- What happens to you when you're stressed?
- Have you experienced any major trauma or loss in the last 5 years?
- How many hours / day do you sleep?
- How many hours / day do you work?
- Do you have any hobbies? What are they?
- Are you currently taking any prescription medications or supplements (please list)?
- How often do you currently exercise? What type?
- How often do you have a bowel movement?
- Do you have to strain to have a bowel movement? Yes No Occasionally
- Are bowel movements urgent and/or painful? Yes No Occasionally
- Do you consciously try to avoid any particular food(s)? If so, what and why?
- Do you have any known allergies / sensitivities (food or environmental)?
- Females: are you or could you be pregnant?



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Do any of the following occur in your family (Mother: M, Father: F, Grandparent: G, Sibling: S)

- | | | |
|--------------------------|-------------------------|--------------------|
| ___ Heart Disease | ___ Diabetes | ___ Allergies |
| ___ High Blood Pressure | ___ Arthritis | ___ Mental Illness |
| ___ Intestinal Disease | ___ Osteoporosis | ___ Alcoholism |
| ___ Kidney Dysfunction | ___ Ulcers | ___ Asthma |
| ___ Gall Bladder Disease | ___ Cancer, type: _____ | |
| ___ Other (please list): | | |

NUTRITION HABITS:

How many times / day do you eat:

- Main Meals _____ Times of day: _____
- Snacks _____ Times of day: _____

Please list as many examples as you can of foods you have for meals & snacks on a typical day:

- Breakfast:

- Lunch:

- Dinner:

- Snacks:

How many of each do you typically have per day:

- | | |
|--|---|
| ___ Fruit (specify fresh, dried, canned) | ___ Vegetables (specify raw, steamed, baked, fried) |
| ___ Whole Grains (specify type) | ___ Protein (specify type) |
| ___ Dairy products (specify type) | ___ Other (specify) |



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How many cups of the following you drink per day:

- | | | |
|--|--|---|
| <input type="checkbox"/> Bottled or Spring Water | <input type="checkbox"/> Tap water | <input type="checkbox"/> Milk (1% or 2%) |
| <input type="checkbox"/> Fresh fruit juice | <input type="checkbox"/> Beer | <input type="checkbox"/> Milk (skim) |
| <input type="checkbox"/> Prepared fruit juice | <input type="checkbox"/> Red Wine | <input type="checkbox"/> White Wine |
| <input type="checkbox"/> Other alcoholic | <input type="checkbox"/> Soft Drinks (regular) | <input type="checkbox"/> Soft Drinks (diet) |
| <input type="checkbox"/> Herbal tea | <input type="checkbox"/> Coffee | <input type="checkbox"/> Other (specify) |

How often do you use the following (1: rarely, 2: regularly, 3: often):

- | | |
|---|---|
| <input type="checkbox"/> Microwave | <input type="checkbox"/> Luncheon meats |
| <input type="checkbox"/> Nutrasweet / Aspartame | <input type="checkbox"/> Fried foods |
| <input type="checkbox"/> Cigarettes / cigars | <input type="checkbox"/> Fast food |
| <input type="checkbox"/> Candy / gum | <input type="checkbox"/> Margarine |

Do you experience symptoms if meals are missed?

Do you experience any sudden and strong cravings?

For what?

Do you experience any of the following after meals?

- Bloating
- Heartburn
- Irregular bowel movements
- Acid reflux
- Vomiting
- Burping/belching
- Other?

If yes, can you correlate any of these symptoms with a particular type of food?

I understand and acknowledge that the services provided are restricted to consultation for general well-being and nutritional advice only, and are not meant for the purposes of medical diagnosis or treatment / prevention of past, current or future medical conditions.

Signed: _____

Dated: _____