Dr. B.S Fick
Wellness Clinic

Nutrition Planning for Weight Loss - Patient Intake Form

Purpose: This form helps us understand your current health status, lifestyle, eating habits, and weight loss goals. Please answer honestly and provide as much detail as possible. This information is confidential and will be used to form a complete overview of your current nutritional status.

Date: _____

Section 1: Personal Information

- **Full Name:** _____
- **Date of Birth (DD/MM/YYYY):** ____ / ____ / _____
- **Age:** _____
- **Gender:** [ ] Male [ ] Female [ ] Prefer to self-describe: _____
- **Contact Number:** _____
- **Email Address:** _____
- **Occupation:** _____
- **Who referred you? (Optional):** _____

Section 2: Health & Medical History

- **Current Weight:** _____ kg
- **Height:** _____ cm
- **Goal Weight:** _____ kg
- **Primary reason for wanting to lose weight:** _____
- **Have you tried to lose weight before?** [ ] Yes [ ] No
- Please list any diagnosed medical conditions (check all that apply and provide details if necessary):

[ ] Diabetes (Type 1 / Type 2 / Gestational) _____

[ ] Pre-diabetes / Insulin Resistance

[ ] High Blood Pressure (Hypertension)

[ ] High Cholesterol / Triglycerides

[ ] Heart Disease _____

[ ] Thyroid Condition (Hypo / Hyper) _____

[ ] Polycystic Ovary Syndrome (PCOS)

[ ] Gastrointestinal Issues (e.g., IBS, Crohn's, Celiac, Reflux) _____

[ ] Kidney Disease

[ ] Liver Disease

[ ] Eating Disorder (Past or Present) _____

[ ] Depression / Anxiety / Other Mental Health Condition

[ ] Joint Pain / Arthritis _____

[ ] Sleep Apnoea

[ ] Other: _____

- Do you have any known food allergies or intolerances? (e.g., nuts, dairy, gluten, shellfish)

[ ] Yes [ ] No

- **If Yes, please list them: _____**
- **Are you currently pregnant, planning pregnancy, or breastfeeding?** [ ] Yes [ ] No
- **Please list ALL medications you are currently taking (prescription and over-the-counter), including dosage: _____**
- **Please list ALL supplements you are currently taking (vitamins, minerals, herbs, protein powders, etc.), including dosage: _____**

Section 3: Current Dietary Habits

- **How would you rate your current diet?** [ ] Poor [ ] Fair [ ] Good [ ] Very Good [ ] Excellent
- **How many meals do you typically eat per day?** _____
- **How many snacks do you typically eat per day?** _____
- **On average, how many days per week do you:**
    - Cook meals at home? _____
    - Eat out at restaurants? _____
    - Order takeaways/fast food? _____
- **Who usually prepares the meals in your household?** _____

- **Please describe a typical day's food and beverage intake. Be as specific as possible about types of food, portion sizes (e.g., cups, grams, handfuls), preparation methods (fried, baked, steamed), and times.**
    - **Upon Waking:** _____
    - **Breakfast (Time: _____):**
      _____
      _____
    - **Mid-Morning Snack (Time: _____):**
      _____
      _____
    - **Lunch (Time: _____):**
      _____
      _____
    - **Mid-Afternoon Snack (Time: _____):**
      _____
      _____
    - **Dinner (Time: _____):**
      _____
      _____
    - **Evening Snack (Time: _____):**
      _____
      _____
    - **Beverages (Throughout the day - include water, coffee, tea, juice, soda, alcohol, specify amounts):**
      _____
      _____
      _____
- **How much water do you typically drink per day?** _____ glasses / litres
- **How often do you consume sugary drinks (soda, sweetened juices, energy drinks)?**
  _____
- **How often do you consume alcohol? What types and amounts?**
  _____
- **Do you add salt to your food during cooking or at the table?** [ ] Often [ ] Sometimes [ ] Rarely [ ] Never
- **Do you eat when you are stressed, bored, or emotional?** [ ] Often [ ] Sometimes [ ] Rarely [ ] Never
- **Do you often eat late at night (within 2 hours of bedtime)?** [ ] Yes [ ] No

Section 4: Lifestyle & Activity

- **How many hours of sleep do you typically get per night?** _____ hours
- **How would you rate your sleep quality?** [ ] Poor [ ] Fair [ ] Good [ ] Very Good [ ] Excellent
- **How would you rate your current stress level (1=Low, 10=Very High)?** Select From 1 to 10:____
- **What are your main sources of stress?**
  _____
- **How do you typically manage stress?**
  _____
- **Please describe your current physical activity level:**
  - **Type(s) of activity/exercise:**
    _____
  - **Frequency (days per week):** _____
  - **Duration (minutes per session):** _____
  - **Intensity (e.g., light walk, moderate jog, vigorous workout):**
    _____
- **What type of work do you do? (e.g., Sedentary/Desk Job, Moderately Active, Physically Demanding):** _____
- **Do you smoke or use tobacco products?** [ ] Yes [ ] No
  - If Yes, how much? _____

Section 5: Preferences & Practicalities

- **What are your favourite healthy foods? _____**
  _____
- **Are there any foods you strongly dislike or will not eat (besides allergies/intolerances)?**
  _____
- **Do you follow any specific dietary patterns (e.g., vegetarian, vegan, kosher, halal)?** [ ] Yes [ ] No
  - If Yes, please specify: _____
- **What is your approximate weekly budget for groceries?** _____
- **How much time are you realistically able to dedicate to meal preparation each day?**
  _____
- **How confident are you in your cooking skills?** [ ] Beginner [ ] Intermediate [ ] Advanced
- **What cooking facilities do you have access to? (e.g., full kitchen, microwave only)**
  _____

Section 6: Goals & Motivation

- **Besides weight loss, what other health goals do you have? (e.g., more energy, better sleep, manage condition) _____**
- **On a scale of 1 to 10 (1=Not Ready, 10=Very Ready), how ready are you to make changes to your eating habits? Select From 1 to 10:____**
- **On a scale of 1 to 10 (1=Not Confident, 10=Very Confident), how confident are you in your ability to stick to a new nutrition plan? Select From 1 to 10:____**
- **What do you foresee as potential challenges or barriers to achieving your goals?**
  _____
  _____
- **What kind of support do you think would be most helpful? (e.g., regular check-ins, meal ideas, recipes, accountability) _____**
- **Who makes up your support system at home (partner, family, friends)?**
  _____

Section 7: Consent & Acknowledgement

I understand that the information provided in this form will be used to help understand your eating habits and nutritional status. I certify that the information I have provided is true and accurate to the best of my knowledge.

Patient Signature: _____

Date: _____