studioNUTRITION
a new you is waiting...

New Client Form

Please write or print clearly. All of your information will remain confidential between you and the Nutrition Consultant.

Personal Information

First Name:

_____

Last Name:

_____

Email:

_____

How often do you check email?_____

Home #: _____ Mobile #: _____

Age: _____ Height: _____Birthdate: _____

Current weight: _____

Weight six months ago: _____

One year ago: _____

Would you like your weight to be different? _____ If so, what? _____

Health Information

Please list your main health concerns:

_____

_____

_____

Other concerns and/or goals?

_____

At what point in your life did you feel best?

_____

Any serious illnesses/hospitalizations/injuries?

_____

_____

_____

Any allergies?

_____

_____

List all medications and supplements:

_____

_____

How many hours of sleep do you get each night? _____

What time do you go to bed? _____

How is your digestive health? (circle one)

POOR FAIR EXCELLENT

For women only:

Are you post menopausal? _____

Is your menstrual cycle regular? _____ How many days is your cycle?: _____

Average menstrual flow: (circle one)

LIGHT MEDIUM HEAVY