Lisa Thomas RD CDN
NUTRITION COUNSELING

NUTRITION COUNSELING INTAKE FORM

Please provide the following information and bring this form to your first session.

Client Name: _____
(Last) (First) (Middle)

Name(s) of parent(s)/guardian(s) (if under 18 years): _____

_____

Birth Date: _____ /_____ /_____ Age: _____ Gender: □ Male □ Female □ Transgender

Local Address: _____City/State: _____ Zip: _____

Home Address: _____City/State: _____ Zip: _____

Home Phone: ( ) _____May I leave a message? □ Yes □ No

Cell Phone: ( ) _____May I leave a message? □ Yes □ No

E-mail: _____ May I email you? □ Yes □ No
***Please note: Email correspondence is not considered a confidential mode of communication**

Referred by: _____

Name of Primary Care Physician (PCP): _____

Address and Phone of PCP: _____

Emergency Contact: _____

Reason for making Nutrition Counseling Appointment:_____

_____

_____

_____