## CLIENT INFORMATION

Name _____

Address _____

Email _____

Mobile _____ Occupation _____

Date of Birth _____ Age _____ Weight _____ Height _____

**How did you hear about me?**

☐ Search Engine ☐ Facebook ☐ Referral by Friend ☐ Other, please specify _____

**What do you wish to achieve from our sessions together? (please tick all that apply)**

☐ Fat loss ☐ Weight / mass gain ☐ Improve general health

☐ Help with specific health issue ☐ Increase energy ☐ Improve diet / eating habits

☐ Other, please specify _____

**Is there a timeframe you wish to achieve this in?** _____

**If your goal is fat loss, have you tried to lose fat before?** ☐ Yes ☐ No

If yes, how? _____

_____

Were you successful? _____

_____

**What do you consider to be the main challenges you face in respect of losing fat?**

_____

_____

_____

**Are you currently exercising? If so, please describe below**

Type _____

Frequency _____

Duration _____

**Do you smoke or have you ever smoked?** ☐ Yes ☐ No

If yes, how many per day/week? _____

**Do you drink alcohol?** ☐ Yes ☐ No

If yes, what type and how much per day/week? _____

**Do you drink any café type coffees?** ☐ Yes ☐ No

What kind (flat whites/lattes, etc) and how many per week? _____

**Are you a vegetarian or vegan?** ☐ Yes ☐ No

**Do you have any food intolerances/allergies? If so, please list.** ☐ Yes ☐ No

**Are your energy levels:** ☐ High ☐ Moderate ☐ Low

**How would you describe your stress levels?** ☐ High ☐ Moderate ☐ Low

**Women, are you pregnant or trying to conceive?** ☐ Yes ☐ No

## MEDICAL HISTORY AND PRESENT MEDICAL CONDITIONS

**Please tick any conditions you now have, or have had in the past**

- ☐ Diabetes
- ☐ Low blood pressure
- ☐ High blood pressure
- ☐ Under or over active thyroid
- ☐ Fatigue / lack of energy
- ☐ Depression/low mood
- ☐ Digestive disturbances
- ☐ Bloating / gas
- ☐ Constipation
- ☐ Heart disease
- ☐ Sensitivity to cold
- ☐ Diarrhoea
- ☐ Skin disorders
- ☐ Dry skin / hair
- ☐ IBS
- ☐ Anaemia
- ☐ Fluid retention
- ☐ High cholesterol
- ☐ Eating disorder
- ☐ Other, please specify _____

**Women – do you have any of these problems?**

- ☐ Heavy periods
- ☐ PMS
- ☐ Night sweats
- ☐ Moodiness
- ☐ Sugar cravings
- ☐ PCOS

If you have checked any of the above, please explain here:

**Are you breastfeeding?** ☐ Yes ☐ No

**Do you have a pacemaker or other electrical device implanted?** ☐ Yes ☐ No

**Please list any prescribed medications you are taking**

**Please list any over the counter medications or dietary supplements you are now taking**

I have, to the best of my knowledge, given accurate medical history information. If there are any errors or omissions I will advise you as soon as practicable.

_____ Signature

_____ Date

Would you like to receive my monthly newsletters (hints + tips, recipes, etc) ☐ Yes ☐ No

## THREE DAY FOOD DIARY

Please record everything you eat and drink over a three day period, just eating as per normal.
Please include any alcoholic beverages consumed.

| | | | |
|---|---|---|---|
| **Date/Day** | | | |
| **Breakfast** | | | |
| **Snack** | | | |
| **Lunch** | | | |
| **Snack** | | | |
| **Dinner** | | | |
| **Snack** | | | |

Once complete, please email the form to Lynda at lynda@nutritionforlife.co.nz
or print it and bring it to your first appointment.