



Dietary Coaching Intake Form

There are no right or wrong answers to these questions. Please answer them honestly and in as much detail as possible. It is our goal to find a meal plan that works for your individual needs and the below information will help us understand what tools you will need to be successful.

1. Create a diet journal that includes at least 3 days of all food and beverages consumed. Please send your journal and completed intake form to the office via fax (410-266-9110) or email (greenhealinginc@gmail.com) at least 3-5 days before your scheduled consult.
2. About how many ounces of water do you drink per day? _____ oz
3. What is your typical intake of beverages other than water?

4. What is your typical intake of alcoholic beverages? _____ drinks/week
5. Do you use artificial sweeteners? Yes No If yes, which ones?

6. Please list any added sugars you regularly use. For example, honey, maple syrup, agave nectar, coconut sugar, turbinado sugar, table sugar, etc.

7. Do you have a particular grocery store(s) where you shop (Whole Foods, Safeway, Trader Joes, etc.)? _____
8. If you cook or prepare meals at home, list some of the different kitchen tools you have/use. (food processor, blender, stovetop, etc.)

9. Beside yourself, is there anyone else for whom you regularly prepare food/cook (partner, children, roommate)?

10. Please list any known food allergies for yourself or anyone for whom you regularly prepare food.

11. Do you have any digestive discomfort after meals? Yes No If yes, please be specific about symptoms and foods; bloating, gas, pain, cramping, etc. Have you determined which foods cause this discomfort? If so, please list them and the accompanying symptoms.

12. Do you tend to eat until you are full? Yes No

13. What is the average amount of time after eating your evening meal before you go to sleep?

14. Do you wake up hungry? Yes No

15. Please briefly outline the structure of your day related to food. For example; where are your meals typically eaten, how much time do you have for each meal and meal preparation, do you eat 3 solid meals or graze throughout the day, etc.?

16. Please list in as much detail as possible your primary reasons for eating or skipping meals. For example; hunger, food cravings, stress, boredom, depression, anxiety, general love of food, etc. Most people will have a variety of reasons why they eat or skip meals, so please list as many reasons as possible in the order they come to your mind.

17. Please outline your typical sleep patterns. What time you go to bed, what time you wake up, any difficulty falling asleep or staying asleep.

18. How are your energy levels throughout the day? Are there particular times of day when your energy levels are high or low?

19. How would you rate your typical stress levels?

20. Please list your typical activity level including exercise and general movement throughout the day. Try to be specific with type of exercise, frequency, length, intensity, and time of day.

21. Please give some examples of what you consider a healthy diet. For example, plant-based, low-carb, low-fat, avoidance/inclusion of specific foods, etc.

22. Please briefly describe your childhood diet. Many people develop core beliefs around food from patterns that were established at a young age.

23. Which foods do you tend to crave the most (salty, sweet, carbs, crunchy, etc.)?

24. Please list as many food preferences as possible.

a. Likes: _____

b. Dislikes: _____

25. Do you have any weight loss goals? Yes No If yes, please give a rough estimate of how much weight you are interested in losing. _____ lbs.

26. In as much detail as possible, list your general dietary goals. If you are already following a specific diet to address a health concern, please describe.
