MATSON HEALTH

YOGA NUTRITION PILATES

Nutrition Intake Form

Insured with Aspen Speciality Insurance Company

Name _____Date_____

Email _____

Please Circle the following:

Male Female Non-Binary Age Range: 18-24 25-35 36-44 45-55 55-65 65-74 75+

General & Medical Information

Stress Allergies Contagious disease Diabetes Back Pain Pregnant Wear Contact lenses

Arthritis Very sensitive to touch or pressure Frequent Headaches Epilepsy or Seizures Insomnia

Osteoporosis Cancer Cardiac or Circulatory problems Bruise easily Joint Swelling Varicose Veins

Anxiety Depression Bipolar Post Traumatic Stress

Smoker? No Yes If yes, what and how often/many_____

Drinker of Alcohol? No Yes If yes, how often and how much _____

Numbness or stabbing pains Where_____

Tension or Soreness Where _____

High Blood Pressure If yes, what medication? _____

Surgery in past 5 years _____

Accident or injuries in past 2 years (broken bones, sprains) Please explain

_____

_____

Pain or issues from older injuries/accidents

_____

_____

Other medical conditions _____

Medications/Supplements _____

_____

_____

_____

What are some of your main nutrition and health goals?

_____

_____

_____

_____

Diet

Veggie Servings per day _____

What kinds? _____

Fruit Servings per day _____

What kinds?

_____

Meat Intake per day _____

What kinds? _____

Water Servings per day _____

Common foods consumed throughout the week? _____

_____

_____

_____

Favorite foods

_____

_____

_____

Once in a while indulgences _____

_____

Do you cook or someone else cooks in your household? How often?

_____

_____

Do you eat out often or not so much? How often? What do you usually order?

_____

_____

_____

_____

What is your relationship like with food? (Do you more often eat with health in mind or eat more for taste? Eat only when hungry, eat when sad/stressed/bored, sometimes forget to eat, etc). Please explain.

_____

_____

_____

_____

_____

_____

_____

Do you exercise? If so, what do you do and how often?

_____

_____

_____

How many hours of sleep to you get?

_____

Do you have any difficulties falling asleep or staying asleep?

_____

_____

Any additional information regarding diet and overall health you would like me to know.

_____

_____

_____

_____

_____

_____

Please read carefully and sign below:

I have answered the previous questions honestly and to the best of my ability. **I** understand that this form is intended to provide my wellness coach with information about my health and diet so that I can co-create a wellness plan for my personalized individual needs through Matson Health, LLC. I understand that services provided by Matson Health, LLC are not to diagnose, cure, prescribe, or treat any health conditions I may have. I understand all the information I shared will be kept strictly confidential and will not be shared with anyone else.

Client Signature Date

_____

Thank you for providing me with this information.

I look forward to working with you and helping you achieve any nutrition and health goals you may have.

Blessings,