



*Strictly Confidential*

## The Moore Center – Basic Nutrition Intake Form

**Please complete and return to: Alison Held or Pat Saraggononda**

Full Name: \_\_\_\_\_

Today's Date: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Phone: \_\_\_\_\_

Email: \_\_\_\_\_

1. Please describe your general health goals and any improvements you wish to make:

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2. What if any diagnoses have you been given by a physician? \_\_\_\_\_

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3. Other conditions or symptoms, such as digestion, lethargy, headaches, pain etc. that are bothering you?

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4. How many bowel movements do you have per day? \_\_\_\_\_ Per week average? \_\_\_\_\_

5. Daily stress level? (Please circle) Very High / High / Moderate / Low

6. Do you feel you need to lose weight? \_\_\_\_\_ If yes, how much? \_\_\_\_\_

7. Food dislikes:

8. Food cravings:

9. Please list any food allergies/sensitivities/restrictions you have: \_\_\_\_\_

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10. Do you smoke? \_\_\_\_\_
11. What is your blood type? O \_\_\_ A \_\_\_ B \_\_\_ AB \_\_\_ Don't Know \_\_\_\_\_
12. Activity Level: (check only one)  
 Inactive no regular physical activity with a sit-down job.  
 Light activity no organized physical activity during leisure time.  
 Moderate activity occasionally involved in activities such as weekend golf, tennis, jogging, swimming or cycling.  
 Heavy activity consistent lifting, stair climbing, heavy construction, etc., or regular participation in jogging, swimming, cycling or active sports at least three times per week..  
 Vigorous activity participation in extensive physical exercise for at least 60 minutes per session 4 times per week.
13. What is your usual bedtime? \_\_\_\_\_ When do you usually awaken? \_\_\_\_\_
14. Do you sleep soundly? \_\_\_\_\_
15. List all medications you are currently taking, including prescription, over-the-counter, and vitamin supplements (please feel free to attach another sheet if there is not enough room):

Name of medication/supplement (brand) of time using	Reason for taking	Dose	Frequency & length
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

To be completed during initial session:

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|---|------------------|
| 16. Present Weight: _____                       | Height: _____    |
| 17. Wrist circumference of dominant hand: _____ | % Body Fat _____ |

18. By signing below, you acknowledge that any dietary or supplement suggestions made by Alison Held are entirely nutritional in nature, and are not intended as the diagnosis, cure or treat any disease. You also acknowledge that your physician is your primary health care provider, and is responsible for supervising all changes in diet and nutrient intake that you make.

\_\_\_\_\_  
 Signed Date