Sage Nutrition

NOURISH | MOVE | EMPOWER

Please provide the following information for your initial nutrition consultation.
All information is confidential.

Client Information

FULL NAME: ____ DATE OF BIRTH: ___________________________________

ADDRESS: ____ CITY: ________________ STATE: _______ ZIP: _________________

PHONE: ____________________________ EMAIL: ____

Health Concerns

Please list your main health concerns at the present time
(eating disorder, weight loss/gain, digestion, food intolerance, etc.)

Do you have any complaints about the following? (check all that apply)

□ Appetite □ Constipation □ Acid Reflux □ Diarrhea □ Nausea/Vomiting □ Heart Palpitations
□ Nervousness and/or Irritability □ Food Allergies/Sensitivities □ Acne □ Depression □ Low Energy
□ Headaches □ Dizziness □ Menstrual Discomfort □ Unusual Cravings □ Sensitive Teeth

Health History

HT: ___________ WT: __________

MEDICAL CONDITIONS/DIAGNOSES: ____

CURRENT MEDICATIONS: ____

CURRENT SUPPLEMENTS: ____

PLEASE INDICATE ANY ALLERGIES OR SENSITIVITIES: ____

DO YOU EXERCISE: □ YES □ NO IF YES, HOW MANY DAYS PER WEEK: ______________________________

HOW MANY HOURS OF SLEEP DO YOU GET EACH NIGHT ON AVERAGE? ____

DO YOU DRINK CAFFEINATED BEVERAGES (COFFEE, TEA, SODA)? □ YES □ NO

REFERRED BY: __________________________________