FAU STUDENT HEALTH SERVICES
NUTRITION CONSULTATION INTAKE FORM

Name: Student ID/Z# Date / /

Local Address (City, State, Zip Code)

Cell phone # ( ) Type of insurance: _____

Birth Date / / Relationship status:

Sex assigned at birth: ☐ Male ☐ Female ☐ Anything else _____ Preferred name: _____

Gender Identity: (check all that apply)

☐ woman ☐ man ☐ genderqueer ☐ trans woman ☐ trans man ☐ prefer not to say ☐ self identity_____

What pronouns do you use?

☐ she/her/hers ☐ he/him/his ☐ they/them/their ☐ Anything else _____

Ethnicity (please check one): ☐ American Indian/Alaskan Native ☐ White ☐ Hispanic ☐ Asian/Pacific Islander ☐ Black/African American ☐ Prefer not to answer

Are you?

Active duty service member?	☐ Yes ☐ No
Veteran of the U.S. Military?	☐ Yes ☐ No
Dual-enrolled high school student?	☐ Yes ☐ No
FAU staff or faculty member taking courses through Employee Educational Scholarship Program?	☐ Yes ☐ No
FAU staff or faculty member taking courses, but not through Employee Educational Scholarship Program?	☐ Yes ☐ No

PAST MEDICAL HISTORY

ALLERGIES: (Include drug, food and environmental allergies)

CURRENT MEDICATIONS: (include contraceptives, supplements, and over-the-counter preparations; include dose and frequency)

Do you have any medical diagnoses? If yes, please list here:

What are your nutrition-related concerns? *Please check all that apply*:

☐ General balanced eating	☐ Emotional eating	☐ High cholesterol
☐ Nutrition education	☐ Disordered eating	☐ High triglycerides
☐ Desired weight gain	☐ Anemia	☐ Fatigue/low energy
☐ Desired weight loss	☐ Diabetes or pre-diabetes	☐ Nausea/Vomiting
☐ Food intolerances	☐ High blood pressure	☐ Diarrhea/Constipation
☐ Food allergies	☐ Heartburn	☐ Inflammatory Bowel Disease (UC/Crohn's)
☐ Celiac Disease	☐ Vegetarian/Vegan	☐ Sports Nutrition

How comfortable are you with your body image? *On a scale of 1-5 (1 being very uncomfortable and 5 being very comfortable* _____

What are your nutrition-related goals?

1. _____
2. _____
3. _____

Are you currently following a specific diet or nutrition plan? If so, please specify:_____

Do you have a campus meal plan (swipe access to Atlantic Dining Hall)?

☐ Yes
☐ No

What barriers might be keeping you from your nutrition goals?_____

Do you participate in physical activity? If so, please specify how many x/week and for how long.

☐ Yes ☐ No Number of x/ week: _____ Duration: _____

Do you spend an excessive amount of time thinking and/or worrying about food, weight and dieting? *(Select One)*

Never	Rarely	Sometimes	Often	Always
☐	☐	☐	☐	☐

Do feelings about your weight, body and/or body image contribute to feeling: *(Select all that apply)*?

☐ Hopeless ☐ Overwhelmed ☐ Exhausted ☐ Very Sad ☐ Depressed ☐ None

How would you describe your eating habits?

☐ Good ☐ Fair ☐ Poor

On average, how many meals do you eat per day? _____

Where do you eat the majority of your meals?_____

Do you have any cultural/ethnic/religious affiliations that may have an impact on your nutrition?_____

Are you satisfied with your eating patterns? ☐ Yes ☐ No
Do you ever eat in secret? ☐ Yes ☐ No
Does your weight affect the way you feel about yourself? ☐ Yes ☐ No
Have any members of your family suffered with an eating disorder? ☐ Yes ☐ No
Do you currently suffer with or have you ever suffered in the past with an eating disorder? ☐ Yes ☐ No

For the following statements, please say whether the statement was OFTEN true, SOMETIMES true, or NEVER true for you in the last twelve months:

I was worried whether my food would run out before I got money to buy more.

☐ Often true ☐ Sometimes true ☐ Never true

The food that I bought just didn't last and I didn't have money to get more.

☐ Often true ☐ Sometimes true ☐ Never true

Is there anything else you would like to share with me today?_____

_____ _____

Patient Signature Date Provider Signature Date