Client intake form

Clinic / dietitian: _____ (add your name or logo here)

This form collects background for a nutrition consultation. It is not medical advice and does not replace a doctor's assessment. Your answers stay private with your dietitian.

1. About you

Field	Answer
Full name	
Age / date of birth	
Sex	
Height (cm)	
Weight (kg)	
Waist (cm)	
City and country	
Preferred language for your plan	
WhatsApp number	
Occupation and work hours	

2. Goals

Main goal: [ ] Weight loss [ ] Weight gain [ ] PCOS [ ] Diabetes [ ] Thyroid [ ] Gut health [ ] Sports [ ] Pregnancy / lactation [ ] Other: _____

What would make this programme a success for you? _____

Have you followed a diet before? What worked and what didn't? _____

3. Diet pattern

[ ] Veg [ ] Egg [ ] Non-veg [ ] Jain [ ] Vegan Fasting days or religious restrictions: _____

Foods you dislike or avoid: _____

Allergies or intolerances (e.g. lactose, gluten, nuts): _____

Who cooks at home? _____ Meals eaten outside per week: _____ Tea / coffee per day: _____

4. A typical day of eating (yesterday)

Time	What you ate or drank	How much

5. Health

Medical conditions (diabetes, BP, thyroid, PCOS, others): _____

Medicines and supplements (name and dose): _____

Digestion: [ ] Bloating [ ] Acidity [ ] Constipation [ ] Loose motions [ ] None

For women: cycle regular? [ ] Yes [ ] No Pregnant or breastfeeding? [ ] Yes [ ] No

Recent lab reports — please attach (HbA1c, lipid profile, thyroid, vitamin D, B12, CBC, others): _____

6. Lifestyle

Activity / exercise (type, days per week, minutes): _____

Sleep (hours, bedtime): _____ Stress level (1–10): _____ Water per day: _____ glasses

Smoking / alcohol: _____

7. Consent

[ ] I confirm the information above is correct and I will tell my dietitian about any change in my health or medicines.

Signature: _____ Date: _____

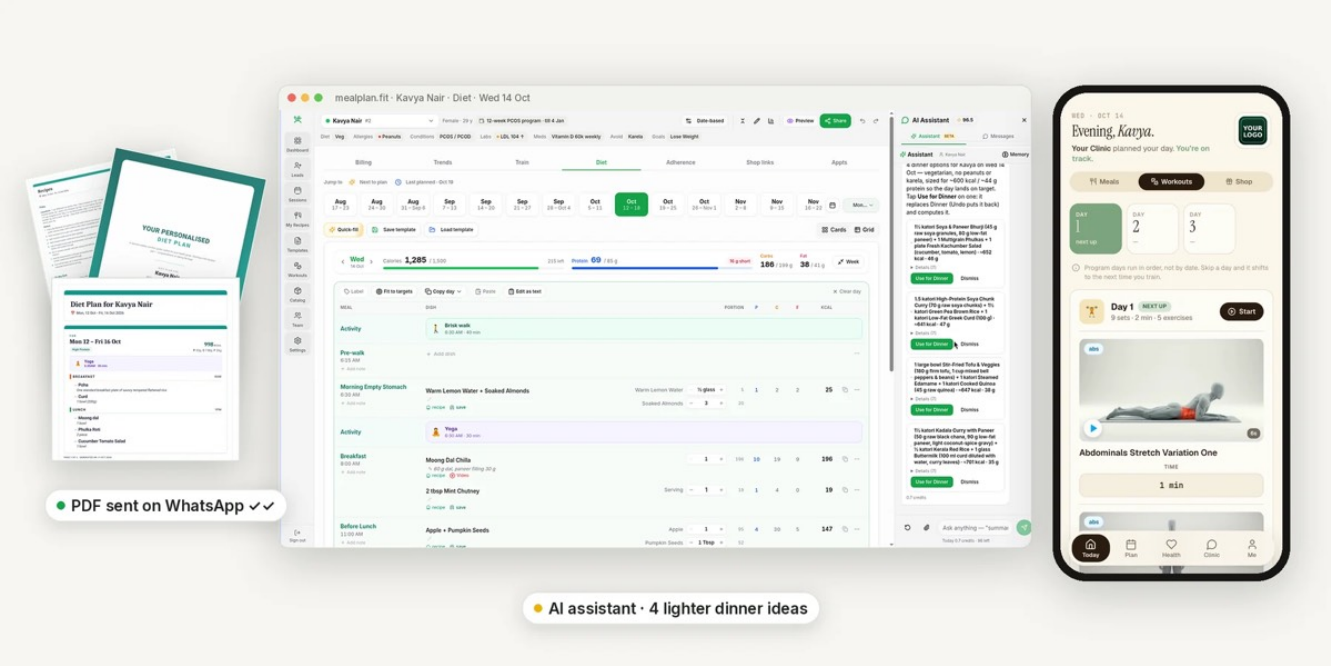
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FOR YOU, THE DIETITIAN · NO NEED TO PRINT THIS PAGE

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- Calories and macros add up as you plan; the AI assistant suggests swaps and you approve
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