

Live Smarter Nutrition & Wellness
P.O. Box 24
Morgan, PA 15064
Telephone: (412) 407-2434
Email: livesmarternutrition@gmail.com



NUTRITION ASSESSMENT INTAKE FORM

Date: _____

Name: _____

Email Address: _____

Address – Street: _____

City: _____ State: _____ Zip Code: _____

Preferred telephone: _____ Please indicate: Home Mobile Work

Birth Date: _____ Age: _____ Sex: Male Female

Height: ____ feet ____ inches Profession: _____

Have you previously received nutrition counseling? Yes No

Current Body Weight _____ Highest Adult Weight _____ Lowest Adult Weight _____

Medical History: _____

Current Medications (please include vitamins and other supplements as well):

If desired, please provide the names of any of the following professionals with whom you are working:

Primary care physician: _____

Psychiatrist: _____

Therapist/counselor: _____

Trainer: _____

Other health professionals (include relationship): _____

Goals for nutrition counseling:

Please provide the following insurance information if you wish to submit payment through your insurance company. Your health insurance may or may not cover nutrition counseling services.

Payment/reimbursement depends on your individual coverage and your diagnosis.

Insurance Company: _____ Insurance Plan: _____

Member ID Number: _____ Group Number: _____

Insurance Co. Address: Street: _____

City: _____ State: _____ Zip Code: _____

Insurance Co. Telephone: _____