InTouch Wellness

Nutrition & Lifestyle Workbook

Initial Consultation

Helping adults age healthier through science-based nutrition and lifestyle education.

Welcome!

Thank you for choosing to work with me. This workbook helps me understand your health history, lifestyle, eating habits, and goals so I can create a personalized plan for you. There are no right or wrong answers. Please answer honestly and completely. Estimated completion time: 20–30 minutes.

I believe healthy aging isn't about finding a quick fix. It's about understanding the body and the individual, addressing the root contributors to chronic disease, and making informed choices that support vitality throughout life. Together, we can identify achievable nutrition and lifestyle adjustments to reduce chronic inflammation and improve overall well-being and longevity.

My goal is not to put you on a diet or ask you to become a different person. Instead, we'll develop a personalized plan that fits your lifestyle and helps you make realistic, sustainable changes.

Let’s begin!

Karin

1. About You

Name: _____
Preferred Name (if different): _____

Date: _____ Date of Birth: _____

Address: _____

Phone: _____ Email: _____

Preferred contact method: _____

Emergency Contact: _____

Primary Care Provider: _____

How did you hear about my practice? _____

Is there anything else you would like me to know about you?

_____
_____
_____

2. Your Health Story

Tell me what prompted you to schedule this appointment?

_____

_____

What are your three biggest health concerns?

1. _____
2. _____
3. _____

What would success look like in six months?

_____

_____

What would you most like my help with?

_____

_____

What has worked well for you in the past, when you've tried to improve your health?

_____

_____

What has made it difficult to maintain those changes?

_____

_____

What do you think is contributing most to your current health concerns? ☐ Stress ☐ Aging ☐ Menopause ☐ Poor food choices ☐ Lack of exercise ☐ Poor sleep ☐ Medical condition ☐ Medications ☐ I'm not sure

What do you believe is currently the biggest obstacle to improving your health?

_____

_____

Is there anything else you'd like me to know about your health goals or concerns?

_____

_____

_____

3. Medical History

Diagnoses (circle):

High Blood Pressure, High Cholesterol, Diabetes/Prediabetes, Heart Disease, Thyroid Disorder, Arthritis, Osteoporosis, IBS, GERD, Autoimmune Disease, Cancer, Depression, Anxiety

Other: _____

Current Medications:

_____
_____
_____

Current Supplements:

_____
_____
_____

Allergies:

_____
_____

Have you experienced any significant illnesses/injuries that have affected your health?

_____
_____
_____

Surgeries/Hospitalizations:

_____
_____

Family History (circle if applicable):

Heart Disease Diabetes High Blood Pressure High Cholesterol Cancer Dementia
Autoimmune Disease Other _____

Do you have recent lab work available? ☐ Yes ☐ No

Would you be willing to share the results of these tests if available? ☐ Yes ☐ No

Is there anything else you would like me to know about your medical history?

_____
_____
_____

4. Weight & Lifestyle

Weight: Current Weight _____ Goal Weight _____

Highest Adult Weight _____ Lowest Adult Weight _____ Waist (optional) _____

Sleep: Hours/night _____ Quality (1-10): _____
1 = Very poor (rarely restful) 5 = Fair 10 = Excellent (wake refreshed most mornings)
Do you usually wake feeling refreshed? ☐ Yes ☐ No

What is your average stress level (1-10)? _____
1 = Very little stress 5 = Moderate stress 10 = Overwhelming stress affecting daily life
What are the biggest sources of stress?

_____

Movement: Which activities do you currently do? ☐ Walking ☐ Golf ☐ Gardening ☐ Yoga ☐ Cycling ☐ Swimming ☐ Stretching ☐ Strength training ☐ Pickleball ☐ Tennis ☐ Pilates ☐ Jogging ☐ Kayaking ☐ Other _____

How many days/week are you active? _____ **How many average daily steps?** _____

How many hours a day do you spend sitting? _____

Fluids: Average daily water: _____ cups/day
Coffee: _____ cups/day
Alcohol: _____ drinks/week

Tobacco: ☐ Never ☐ Former ☐ Current

When did you last feel your healthiest?

_____

_____

If applicable, what do you think caused your weight to change?

_____

_____

Who supports your health goals? ☐ Spouse ☐ Family ☐ Friends ☐ Exercise partner

☐ No one ☐ Other

Is there anything else you would like me to know about your lifestyle, sleep, stress, or physical activity?

_____

_____

_____

5. Nutrition & Eating Habits

Meals

Typical Breakfast:

_____

_____

Typical Lunch:

_____

_____

Typical Dinner:

_____

_____

Typical Snacks:

_____

How many restaurant meals/week? _____ **How many fast food meals/week?** _____

Do you usually eat ☐ 3 meals/day ☐ 2 meals/day ☐ 1 meal/day ☐ I graze all day ☐ It varies

Who prepares most meals at home? _____

Who does the grocery shopping? _____

How confident do you feel about making healthy meals? (1-10): _____
1 = Not confident at all 5 = Moderately confident 10 = Extremely confident

Explain: _____

What are your favorite healthy foods?

_____

What foods do you avoid or dislike?

_____

Do you have any cultural, religious, or personal food preferences that I should know about?

_____

_____

Is there anything else you would like me to know about your eating habits?

_____

_____

_____

6. Eating Behaviors & Cravings

Which best describes your appetite?

☐ Always hungry ☐ Usually hungry ☐ Average ☐ Rarely hungry ☐ I forget to eat

Check all that apply:

☐ Skip breakfast ☐ Eat quickly ☐ Eat while watching TV ☐ Eat because I'm anxious
☐ Eat because I'm stressed ☐ Eat because I'm bored ☐ Eat because I'm tired
☐ Snack after dinner ☐ Crave sweets ☐ Crave bread ☐ Crave salty foods
☐ Eat when I'm not hungry ☐ Feel out of control around certain foods ☐ Reward myself with food ☐ Eat while working ☐ Eat late at night

Which food cravings are hardest to resist? ☐ Chocolate ☐ Ice cream ☐ Bread ☐ Chips
☐ Cookies ☐ Pizza ☐ Pasta ☐ Fast food ☐ Salty snacks ☐ Other _____

What usually triggers your cravings? ☐ Stress ☐ Fatigue ☐ Boredom ☐ Watching TV
☐ Evening ☐ Social situations ☐ Habit ☐ Other _____

When are cravings strongest?

☐ Morning ☐ Afternoon ☐ Evening ☐ After Dinner ☐ During Stress ☐ When Tired

Is there anything else you would like me to know about your relationship with food?

_____
_____
_____

7. Gut Health

Bowel movements: Less than 1/day ☐ 1/day ☐ 2/day ☐ 3+/day ☐

Bristol Stool Guide:
1 Hard pellets (constipation)
2 Firm, lumpy stool
3 Sausage with cracks
4 Smooth, soft stool (Ideal)
5 Soft blobs
6 Mushy stool
7 Watery stool
Usual type: ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7

Digestive symptoms:
☐ Gas ☐ Bloating ☐ Heartburn ☐ Constipation ☐ Diarrhea ☐ IBS ☐ Food intolerances
☐ Other _____

Have you taken any antibiotics in the past year? ☐ Yes ☐ No

Do you take probiotics? ☐ Yes ☐ No

Have you been told you have: ☐ Diverticulosis ☐ Diverticulitis ☐ Ulcerative colitis ☐ Celiac disease ☐ Crohn's disease ☐ Fatty liver

Have you ever had: ☐ Colonoscopy ☐ Endoscopy ☐ Stool Testing ☐Food Sensitivity Testing ☐ Gallbladder removed

Have you recently experienced: ☐ Unintentional weight loss ☐ Blood in stool ☐ Black stools ☐ Difficulty swallowing ☐ Persistent vomiting ☐ Severe abdominal pain ☐ None of the above

Is there anything else you would like me to know about your digestion or gut health?

_____
_____
_____

8. Goals & Readiness

How important is improving your health? (1-10): _____
1 = Not important right now 5 = Somewhat important 10 = One of my highest priorities

How confident are you that you can make lifestyle changes? (1-10): _____
1 = Not confident at all 5 = Moderately confident 10 = Extremely confident

What do you think will be your biggest challenge?

_____

_____

What strengths will help you succeed?

_____

_____

Which of these would have the biggest impact on your life? (check up to three): ☐ Lose weight ☐ More energy ☐ Better digestion ☐ Better sleep ☐ Reduce inflammation ☐ Lower cholesterol ☐ Lower blood sugar ☐ Improve mobility ☐ Healthy aging ☐ Other _____

Which ONE goal would make the biggest difference in your life right now?

_____

On a scale of 1–10, how committed are you to making changes over the next month? _____

1 = Not ready to make changes **5** = Willing to try a few changes **10** = Ready to fully commit

Is there anything else you would like me to know about your goals and readiness?

_____

_____

Why is improving your health important to you? ☐ I want more energy ☐ I want to stay independent ☐ I want to keep traveling ☐ I want to play with my grandchildren ☐ I want to feel better ☐ I want to prevent future health problems ☐ I want to reduce medications ☐ Other _____

What is one thing that you would like me to understand about you that I have not asked?

_____

_____

_____

Client Signature _____ Date _____

9. Privacy & Consent

I understand that nutrition counseling is intended to support my health and does not replace medical diagnosis or treatment. I understand I should continue to work with my healthcare providers regarding medical conditions and medications.

I acknowledge that my personal information will be kept confidential in accordance with applicable privacy laws and office policies. I will receive or have access to the practice's Notice of Privacy Practices if required.

I consent to receive nutrition and lifestyle counseling.

Client Signature _____ Date _____

Practitioner Signature _____ Date _____

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Bring to Your Appointment

☐ Recent lab results
☐ Medication list
☐ Supplement list
☐ Food diary (if requested)
☐ Questions you'd like to discuss