Karumba Naturals

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CLIENT INTAKE FORM

Please fill out this questionnaire before your appointment. This information will contribute to the development of a nutrition plan based on your needs and current lifestyle habits.

Name: _____

Age: _____ Birthdate: _____ Mobile #: _____

Email: _____

Height: _____ Current Weight: _____ Ideal Weight: _____

Where are you today? Briefly describe any problems/ailments you may be experiencing.

_____

_____

What do you hope to achieve during our time together?

_____

What are your long term health goals?

_____

What makes you happy? _____

How do you respond to feelings of sadness? _____

List any medications you are on: *(leave blank if it does apply)*

Medication Name	Dosage	Frequency	Reason

Do you take any vitamin, mineral or herbal supplements? ☐ Yes ☐ No

If yes, please list all supplements: _____

How do you rate your level of physical activity?

☐ Sedentary (very inactive) ☐ Somewhat Inactive ☐ Average ☐ Somewhat Active
☐ Extremely Active

On a scale of 1-10 (1 being the lowest level of stress), how would you rate your level of stress? _____

Describe your diet. What does a typical day of eating look like? What is your relationship with food?

_____

_____

_____

On average, how much water do you drink a day? _____

Alcohol Consumption: ☐ Often ☐ Never ☐ Occasionally

Smoking: ☐ Often ☐ Never ☐ Occasionally

How are you currently feeling? _____