GRAND RAPIDS
Est. 2006
COUNSELING SERVICES
2400 Eastern Ave SE, Grand Rapids, Michigan 49507
Tel (616) 988-3433 | Fax (313) 899-7087 | Web www.grcounseling.com

Heath and Nutrition Application

Name:______________________________________ (Please print) Age: ______ DOB:________________________

Email: ____________________________________ (Please print) Phone:__________________________ Text? (circle) Yes No

Address: ____

Career: __________________________________ How did you hear about me? ________________________

Why are you seeking nutrition therapy? Check all that apply:

❑Acne ❑Allergies ❑Anxiety ❑Arthritis ❑Brain fog ❑Depression ❑Diabetes – Type I
❑Diabetes – Type II ❑Dry Skin ❑Fatigue ❑Hair Loss ❑Headaches ❑Insomnia
❑Mood swings ❑Poor memory ❑Poor concentration/ADHD ❑Weight loss

Do you currently have any health conditions not indicated above? (circle) Yes No If yes, what?

Have you ever met w/a health professional regarding diet? (circle) Yes No If yes, when and for or how long?

Did something trigger a change in your physical health? (circle) Yes No If yes, what?

Are you currently taking any medications and or supplements: If yes, please list:

Are you willing to take supplements? (circle) Yes No

How much would you say you have spent on your health (including diet programs, lab work, medications surgeries etc.) in the past 12 months?

On a scale of 1-10, 10 being the most satisfied, please answer the following questions:

1. How satisfied are you with your health? 1 2 3 4 5 6 7 8 9 10
2. How satisfied are you with your energy? 1 2 3 4 5 6 7 8 9 10
3. How satisfied are you with your quality of sleep? 1 2 3 4 5 6 7 8 9 10
4. How satisfied are you with your weight/body size? 1 2 3 4 5 6 7 8 9 10
5. How committed are you to making changes to restore health? 1 2 3 4 5 6 7 8 9 10
6. How would you rate your current daily stress? 1 2 3 4 5 6 7 8 9 10

What are the greatest sources of stress? (please list)

Do you engage in regular exercise? (circle) Yes No If yes, please indicate how often and what you do?

How often do make intentional decisions to relax? ___x's/___(week/month/year).

What activities do you do to relax?

Have you ever struggled with an eating disorder? (circle) Yes No If yes, what type, when, and for how long?

Do you drink water daily? (circle) Yes No If yes, how much?

Do you drink caffeine? (circle) Yes No If yes, how much and how often?

Do you use any artificial sweeteners? (circle) Yes No If yes, how much and how often?

Do you smoke? (circle) Yes No If yes, how much and how often?

Do you drink alcohol? (circle) Yes No If yes, how much and how often?

Do you use any illegal substances? (circle) Yes No If yes, please specify which one(s), how much and how often?

Do you have a family history with obesity, diabetes, or cancer? (circle) Yes No If yes, please specify which one(s), and who?

Have you ever made significant changes in your eating habits? (circle) Yes No If yes, please describe what changes, when and for how long?

What are your top 4 favorite foods/drinks and why do you enjoy them so much?

1.

2.

3.

4.

What are your specific goals you would like to achieve through Nutrition Therapy?

What are your beliefs about your relationship to food? Are you in control?

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If you woke up tomorrow and could change any 3 things in your life, what would they be and how would you know the changes had taken place?
1.

2.

3.

What are the top 3 things holding you back from losing weight? (For example, emotional eating, sugar addiction, choosing poor-quality foods, busy life, food pushers who encourage bad habits, fear of failure and fear of success.)
1.

2.

3.

What beliefs/internal dialogs do you have that are holding you back from losing weight/changing your eating habits? (For example, "I've tried before and failed" or "losing weight is too hard" or "I don't deserve to give myself this much time and attention.")
1.

2.

3.

How does being overweight or sick diminish or detract from your happiness and from fulfilling your life's purpose?

How do you see your life changing by learning to nourish and take care of yourself properly?

What positive experiences have I had in the past that resulted from eating well and practicing self-care and nurturing?

What motivates you?

Do you currently have a mental health counselor? (circle) Yes No If yes, how often do you meet?

Would you describe yourself as a type A personality? Why or why not

Do you plan to use your HSA or Flex Spending account to take pay for your nutrition therapy? (circle) Yes No