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# NUTRITION

CLIENT INTAKE

Large textured area for client intake information.



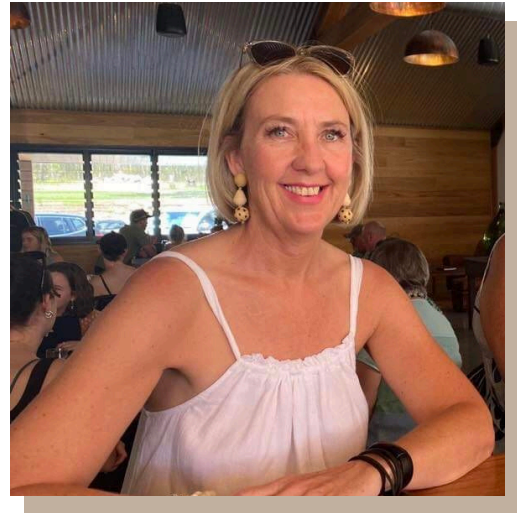
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*your nutritionist*

Hello, and a warm welcome to my nutrition practice! I'm Mandy, a dedicated and passionate Nutritionist, and I'm honoured to be your guide on your journey to better health through nutrition.

For as long as I can remember, I've been fascinated by the profound connection between food and health. Over the years, I've experienced firsthand the transformative power of nourishing my body with wholesome, nutrient-rich foods. This journey ignited a passion within me to share my knowledge and expertise with others, inspiring them to make positive changes in their own lives.



At the heart of my practice lies a deep commitment to empowering individuals to take control of their health and well-being. I believe that everyone deserves access to accurate, science-based nutrition information and personalized guidance tailored to their unique needs and goals. My approach to nutrition is holistic, encompassing not just what you eat, but also how it impacts your lifestyle, habits, and overall quality of life.

Whether you're seeking support for weight management, managing a chronic health condition, or simply striving to adopt healthier eating habits, I'm here to help. Together, we'll embark on a journey of discovery, exploring your individual nutritional needs, preferences, and goals. From creating personalized meal plans to providing ongoing support and accountability, I'll be with you every step of the way, cheering you on and celebrating your successes.

I'm genuinely excited to get to know you and to be a part of your wellness journey. If you're ready to take the first step towards a healthier, happier you, I invite you to reach out to me today. Whether you have questions about my services, want to schedule a consultation, or simply want to chat about your goals, I'm here to listen and support you.

Here's to nourishing your body, nurturing your spirit, and embracing a life filled with wellness and abundance!

Mandy x

Nutritionist

Mandy Tomlinson Pilates & Nutrition



*client intake*

Full Name: \_\_\_\_\_

Date of Birth:     /     / \_\_\_\_\_

Address: \_\_\_\_\_

State: \_\_\_\_\_

Post Code \_\_\_\_\_

Email Address: \_\_\_\_\_

Phone Number: \_\_\_\_\_

Occupation: \_\_\_\_\_

Hours per Week: \_\_\_\_\_

Relationship Status: \_\_\_\_\_

Referred By: \_\_\_\_\_

Preferred Method of Contact:          E-Mail          Text          Phone

When is the best time to reach you?          Morning          Afternoon          Evening

**HEALTH GOALS**

What would you like to achieve during your initial visit?

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

What are your top 3 goals for your health and wellness? Please be specific.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

If you had to achieve one goal within the next 3 months, what would that goal be?

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_



*client intake*

What is/are your biggest challenges reaching your nutrition goals?

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What have you tried in the past to achieve your health goals?

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Do you have any barriers that may impact your ability to follow a nutrition plan?

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On a scale of 1 (not willing) to 5 (very willing), please indicate your readiness and willingness to do the following:

Significantly modify your diet:

—  1 —  2 —  3 —  4 —  5 —  6 —  7 —  8 —  9 —  10 —

Keep a record of everything you eat each day:

—  1 —  2 —  3 —  4 —  5 —  6 —  7 —  8 —  9 —  10 —

*client intake*

Modify your lifestyle (e.g.: work demands, sleep habits, physical activity):

○ 1   ○ 2   ○ 3   ○ 4   ○ 5   ○ 6   ○ 7   ○ 8   ○ 9   ○ 10

Practice relaxation techniques:

○ 1   ○ 2   ○ 3   ○ 4   ○ 5   ○ 6   ○ 7   ○ 8   ○ 9   ○ 10

Engage in regular exercise/physical activity:

○ 1   ○ 2   ○ 3   ○ 4   ○ 5   ○ 6   ○ 7   ○ 8   ○ 9   ○ 10

L I F E S T Y L E

Please describe your typical sleep schedule, including how many hours of sleep.

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Do you experience trouble falling asleep?    Yes    No    Occasionally

Do you awaken feeling rested?    Yes    No    Occasionally

Do you ever experience any lows or highs in your energy levels throughout the day?

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*client intake*

Do you workout? If so, please describe your routine and frequency.

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What are the major causes or factors of your stress?

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On a scale of 1 (extremely low) to 10 (extremely high), how would you describe your:

Stress Levels:

○ 1 — ○ 2 — ○ 3 — ○ 4 — ○ 5 — ○ 6 — ○ 7 — ○ 8 — ○ 9 — ○ 10

Energy Levels:

○ 1 — ○ 2 — ○ 3 — ○ 4 — ○ 5 — ○ 6 — ○ 7 — ○ 8 — ○ 9 — ○ 10

General Happiness:

○ 1 — ○ 2 — ○ 3 — ○ 4 — ○ 5 — ○ 6 — ○ 7 — ○ 8 — ○ 9 — ○ 10

How does your stress manifest itself? (i.e. fatigue, irritability, anxiety, etc.)

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*client intake*

What coping mechanisms do you have?

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**DIET HISTORY**

Do you have any dietary restrictions for personal or religious reasons?

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Do you suffer from any allergies, sensitivities or intolerances?

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How much time do you spend cooking or preparing meals each day?

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Do you find cooking difficult? Please explain.

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*client intake*

Which meals do you eat regularly?  Breakfast  Lunch  Dinner  Snacks

Do you experience any symptoms if meals are missed? Please explain.

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How often do you have a bowel movement?

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If you take laxatives, what type/brand do you use? How often?

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How would you describe your stools?  Hard  Soft  Loose

Please indicate how often you experience the following symptoms:

Heartburn	<input type="checkbox"/>	Often	<input type="checkbox"/>	Sometimes	<input type="checkbox"/>	Rarely
Gas	<input type="checkbox"/>	Often	<input type="checkbox"/>	Sometimes	<input type="checkbox"/>	Rarely
Bloating	<input type="checkbox"/>	Often	<input type="checkbox"/>	Sometimes	<input type="checkbox"/>	Rarely
Stomach Pain	<input type="checkbox"/>	Often	<input type="checkbox"/>	Sometimes	<input type="checkbox"/>	Rarely
Nausea or Vomiting	<input type="checkbox"/>	Often	<input type="checkbox"/>	Sometimes	<input type="checkbox"/>	Rarely
Diarrhea	<input type="checkbox"/>	Often	<input type="checkbox"/>	Sometimes	<input type="checkbox"/>	Rarely
Constipation	<input type="checkbox"/>	Often	<input type="checkbox"/>	Sometimes	<input type="checkbox"/>	Rarely



*client intake*

**MEDICAL HISTORY**

Please indicate whether you or any relatives have been diagnosed with any medical condition.

Illness/Disease	Self-Age Diagnosed	Family Member & Age Diagnosed	Description



*client intake*

REPRODUCTIVE HEALTH (FEMALES ONLY)

Do you have any hormonal issues that you know of? If so, please explain:

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Please indicate any symptoms of PMS you experience:

Cramping	<input type="checkbox"/>	Often	<input type="checkbox"/>	Sometimes	<input type="checkbox"/>	Rarely
Bloating	<input type="checkbox"/>	Often	<input type="checkbox"/>	Sometimes	<input type="checkbox"/>	Rarely
Headaches	<input type="checkbox"/>	Often	<input type="checkbox"/>	Sometimes	<input type="checkbox"/>	Rarely
Mood Changes	<input type="checkbox"/>	Often	<input type="checkbox"/>	Sometimes	<input type="checkbox"/>	Rarely
Breast Tenderness	<input type="checkbox"/>	Often	<input type="checkbox"/>	Sometimes	<input type="checkbox"/>	Rarely
Irritability	<input type="checkbox"/>	Often	<input type="checkbox"/>	Sometimes	<input type="checkbox"/>	Rarely
Cravings	<input type="checkbox"/>	Often	<input type="checkbox"/>	Sometimes	<input type="checkbox"/>	Rarely

\_\_\_\_\_  
Client's Signature

\_\_\_\_\_  
Date



*confidentiality*

I, \_\_\_\_\_, understand and acknowledge that the information I share with Mandy Tomlinson Nutrition is confidential. I recognise the importance of maintaining the privacy and security of my personal health information.

I understand that all information shared with Mandy during consultations and interactions, including my personal health information, medical history, dietary habits, and lifestyle choices, will be treated as confidential.

I understand that Mandy will take reasonable measures to ensure the privacy and security of my information, including storing it securely and limiting access to authorised personnel only.

I understand that Mandy will not disclose or share my information with third parties without my explicit consent, except as required by law or professional obligation.

I understand that Mandy will retain my records and information for the duration required by law or professional standards and will dispose of them securely when no longer needed.

I understand that I have the right to access my own health information, request amendments or corrections to my records, and withdraw consent for the use or disclosure of my information.

I understand that in the event of a data breach or unauthorized disclosure of my information, Mandy will promptly notify me and take appropriate steps to mitigate any potential harm.

By signing below, I acknowledge that I have read, understood, and agree to the terms of this confidentiality agreement.

\_\_\_\_\_  
Client's Signature

\_\_\_\_\_  
Date

*contact me*

## LOCATION

21 Denison Street Gloucester NSW

## BUSINESS HOURS

Monday Wednesday Thursday Friday Saturday

## HOW TO REACH ME

Feel free to give me a call during office hours. If I am unable to answer, please leave a detailed message, and I will return your call as soon as possible.

You can also reach me via email. I strive to respond promptly to all inquiries, and I will address your questions or concerns with care and attention.

If you would like to schedule a consultation or learn more about my services, please let me know your preferred date and time. I will do my best to accommodate your schedule and provide the information you need.

## STAY CONNECTED

Stay updated and connect with me through my social media channels:



[www.mandytomlinsonpilates.com](http://www.mandytomlinsonpilates.com)



Mandy Tomlinson Pilates



mandy\_tomlinson\_pilates