KICOTAN ACUPUNCTURE
Holistic Healing for Body, Mind & Spirit
📍 37 Swezeytown S Road- Middle Island, New York 11453 📞 516-974-4187

🌐 www.kicotanacupuncture.com 📧 Email: guadalupekicotan@gmail.com

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Nutritional Consultation Intake Form

All information provided is strictly confidential and used solely for your personalized care.

I. Personal Information

Full Name: _____
Date of Birth: _____ **Age:** _____ **Gender:** ☐ M ☐ F ☐ Other: _____
Phone: _____
Email: _____
Address: _____

Occupation: _____
Emergency Contact Name & Phone: _____

II. Health Goals and Concerns

1. **What are your main health goals related to nutrition?**
   (e.g., weight loss, more energy, better digestion, blood sugar balance, etc.)

   _____

2. **What are your specific concerns about your current diet or nutrition?**

   _____

3. **Have you previously worked with a nutritionist or dietitian?**
   ☐ Yes ☐ No
   If yes, what worked and what didn't?

   _____

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III. Medical History

1. **Do you have any of the following health conditions?** (Check all that apply)
   ☐ Diabetes ☐ High Blood Pressure ☐ High Cholesterol ☐ Thyroid Issues
   ☐ Digestive Issues ☐ Autoimmune Condition ☐ Eating Disorder ☐ Other: _____
2. **Please list any allergies or sensitivities (food or environmental):**

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3. **List all current medications, supplements, or herbs you are taking:**

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4. **Do you experience any of the following?** (Check all that apply)
   ☐ Bloating ☐ Constipation ☐ Diarrhea ☐ Gas ☐ Fatigue ☐ Mood Swings
   ☐ Sugar Cravings ☐ Headaches ☐ Trouble Sleeping ☐ Anxiety/Stress

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IV. Diet & Lifestyle

1. **How many meals do you eat per day?**
   ☐ 1 ☐ 2 ☐ 3 ☐ Snacks in between
2. **Do you follow a specific diet?** (e.g., Vegan, Vegetarian, Keto, Gluten-Free)
   ☐ No ☐ Yes – please specify: _____
3. **What do you typically eat in a day?**
   Breakfast: _____
   Lunch: _____
   Dinner: _____
   Snacks: _____
   Drinks (coffee, tea, water, soda, alcohol): _____
4. **How many glasses of water do you drink daily?** _____
5. **How often do you eat out or order takeout?** ☐ Rarely ☐ 1–2x/week ☐ 3+ times/week
6. **Do you cook meals at home?** ☐ Yes ☐ No If yes, how often? _____

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V. Lifestyle Factors

1. **Physical activity:**
   What type of exercise do you do? _____
   How often? ☐ Rarely ☐ 1–2x/week ☐ 3–5x/week ☐ Daily
2. **Stress level:**
   ☐ Low ☐ Moderate ☐ High How do you typically manage stress?

   _____

3. **Sleep:**
   Average hours of sleep per night: _____
   Do you feel rested upon waking? ☐ Yes ☐ No

VI. Additional Information

1. **What motivates you to improve your nutrition at this time?**

   _____

2. **Are there any cultural, religious, or personal preferences we should be aware of when making recommendations?**

   _____

3. **Is there anything else you would like us to know?**

   _____

Consent & Acknowledgment

I understand that the nutritional counseling provided at Kicotan Acupuncture is intended to support my overall wellness and is not a substitute for medical diagnosis or treatment. I confirm that the above information is true to the best of my knowledge.

Signature: _____ **Date:** _____