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Please complete the following details.

Title \_\_\_\_\_ Last Name \_\_\_\_\_

First Name(s) \_\_\_\_\_ Date of Birth \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Age \_\_\_\_\_

Address \_\_\_\_\_

\_\_\_\_\_  
Postcode \_\_\_\_\_

Mobile \_\_\_\_\_ Home \_\_\_\_\_ Work \_\_\_\_\_

Email \_\_\_\_\_ Occupation \_\_\_\_\_

Hobbies \_\_\_\_\_

Height \_\_\_\_\_ Current Weight \_\_\_\_\_

Ethnicity : \_\_\_\_\_

What is your number one nutrition goal? \_\_\_\_\_

When would you like to achieve this by? \_\_\_\_\_

**ADDITIONAL GOALS (please circle option(s) applicable to you)**

Improve Strength

Improve muscle tone

Reduce stress

Rehabilitate or prevent injury

Gain muscle/weight

Increase energy

Improve sport performance

Combat an illness

Improve eating habits

Weight loss

Improve cardio fitness

Improve sleep

How did you hear about my services? \_\_\_\_\_

## FITNESS HISTORY

Are you presently involved in a regular exercise programme? (If yes please list)

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FREQUENCY \_\_\_\_\_ DURATION \_\_\_\_\_

## MEDICAL HISTORY

Do you have or have had you had any of the following? (please circle option(s) applicable to you)

Type 1 Diabetes	Hormonal imbalances
Type 2 Diabetes	Anxiety or depression
Anaemia	Coronary disease
Eating disorder	Allergies
Stroke	Stomach or intestinal problems
Polycystic ovaries	High or low blood pressure
Cancer, cysts, tumour	Thyroid issues
Blood disease	Immune disorder

If you have ticked yes to any of the above please give details \_\_\_\_\_

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Do you have any other medical conditions? \_\_\_\_\_

Are you currently taking any medications or supplements? If yes, please give details \_\_\_\_\_

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Are you currently pregnant or breastfeeding? Yes/No

Has any blood relative ever had any of the following? (please circle options(s) applicable to you)

Sudden death before 50	Heart disease	Blood diseases (anaemia, leukaemia etc)
Cancer, tumour, cyst	High blood pressure	Diabetes    Epilepsy    Stroke

How would you describe your sleep? \_\_\_\_\_

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## HEALTH AND DIET HISTORY

Do you currently smoke or have you ever smoked? Yes/No

Do you drink alcohol? Yes/No If yes, how much and how often? \_\_\_\_\_

Do you drink coffee or cola's that contain caffeine? Yes/No If yes, how much and how often? \_\_\_\_\_

Do you have any food intolerances or are you vegetarian, vegan or follow any particular eating regime, and are there any foods you refuse to eat? \_\_\_\_\_

How do you consider your current weight? (please circle option applicable to you)

Overweight      Ideal weight      underweight

If your goal is to lose body fat, do you feel you store body fat in one body part more than others?

No/Yes, where? \_\_\_\_\_

In the last 5 years ....

a. What is the most you have weighed? When? \_\_\_\_\_

b. What is the least you have weighed? When? \_\_\_\_\_

What other weight loss techniques have you tried? Please give details \_\_\_\_\_

Are your energy levels? (please circle option applicable to you)

High      Moderate      Low

How would you describe your nutrition habits? (please circle option applicable to you)

Good      Fair      Poor

How good would you characterise your life? (please circle option applicable to you)

Highly stressful      Moderately stressful      Low in stress

Are there any other comments you would like to add regarding your health? \_\_\_\_\_

I do hereby state that I have, to the best of my knowledge and belief, given a correct and accurate medical history report.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

(If you are completing this form online you can sign it at your initial appointment).



# FOOD DIARY

Please record quantities, times and include all teas/coffees/water	DAY 1 (                      )	DAY 2 (                      )	DAY 3 (                      )
<b>BREAKFAST</b> (      )am			
<b>SNACKS</b> (      )am			
<b>LUNCH</b> (      )am/pm			
<b>SNACKS</b> (      )pm			
<b>DINNER</b> (      )pm			
<b>SNACKS</b> (      )pm			

Is this a usual 3 days eating for you? Yes/No

Do you regularly (daily) eat any of the following? (please circle option(s) applicable to you)

Desserts    Fried Foods    Fast Food

Do you regularly use any of the following? (please circle option(s) applicable to you)

Butter    Sugar    Sweeteners    Salt

Do you have any other comments regarding your usual food habits? \_\_\_\_\_

\_\_\_\_\_