



## SPORTS NUTRITION CLINIC Nutrition Assessment Form

Please fill out this questionnaire prior to your appointment. This information will contribute to the development of a sports nutrition program based on your needs and current lifestyle habits. Please feel free to include any additional information that you feel might be relevant to your current situation.

Included with this material is also a 3-day food record. For three days before your clinic visit, please record everything you eat and drink, including all snacks and beverages. If possible, try to choose two (2) weekdays and one (1) weekend day when recording. Estimate the amount (i.e. ounces, cups, etc.) of food and drink that you consume.

Name \_\_\_\_\_

1. Intentions and goals for this consultation \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

2. Age \_\_\_\_\_ 3. Date of Birth \_\_\_\_\_

4. Height \_\_\_\_\_ 5. Current Weight \_\_\_\_\_

6. What do you think is your "ideal" weight? \_\_\_\_\_

7. Have you ever had your body composition measured?  Yes  No

If yes, how was it measured and what were your results? \_\_\_\_\_  
\_\_\_\_\_

8. Please provide information about your past medical history. Check those that may apply.

- |   |   |  |
|---|---|--|
| <input type="checkbox"/> Diabetes               | <input type="checkbox"/> Cardiovascular Disease | <input type="checkbox"/> Kidney Disease        |
| <input type="checkbox"/> Irregular Menstruation | <input type="checkbox"/> High Cholesterol       | <input type="checkbox"/> Cancer                |
| <input type="checkbox"/> Digestive Disorder     | <input type="checkbox"/> Pulmonary Disorder     | <input type="checkbox"/> Orthopedic Conditions |
| <input type="checkbox"/> Neurological Condition | <input type="checkbox"/> Osteoporosis           | <input type="checkbox"/> Rheumatologic         |
| <input type="checkbox"/> Other _____            |   |  |

9. Do you have any food allergies or intolerances?  Yes  No

If yes, please list \_\_\_\_\_

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

If yes, please list all supplements \_\_\_\_\_

11. Are you currently on any medication?  Yes  No

If yes, please list all medication \_\_\_\_\_

12. Please list your current exercise/physical activity patterns: \_\_\_\_\_

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

13. How do you personally view your health and current lifestyle patterns? \_\_\_\_\_

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