Sports Nutrition Assessment

Name:_____ Appointment Date:_____

Phone number: _____ Email:_____

Guardian/Parent contact name and info:_____

Primary Care Physician name/phone number:_____

Gender (circle one): M or F Birth date: _____

Weight:_____ Height:_____

What are your sport and/or health goals? _____
_____
_____

Your Personal Medical History (check all that apply):

Diabetes (type I) ____	Anemia or low iron ____	Acid reflux or heartburn ____
Diabetes (type II) ____	Low zinc levels ____	Ulcers ____
Kidney disease ____	Low vitamin B12 levels ____	IBS ____
Diarrhea ____	Low bone density ____	Crohns/IBD ____
Nausea ____	Stress fractures ____	Celiac disease ____
Vomiting ____	Smoker ____	Thyroid disease_____
Constipation ____	Diverticulitus ____	

Injury History (please list): _____
_____

Allergies - food, medications, environmental (please list): _____
_____

Family medical history (please list): _____
_____

Age of first menstrual cycle: ____

Are your cycles regular? Y or N If no, explain:
_____

Your Personal Diet History (check all that apply):

Lactose intolerant ____

Please indicate if you are able to tolerate small amounts of the following:

□ milk □ cheese □ yogurt

Vegetarian (ovo/lacto) ____

Vegan ____

Kosher ____

Iron Deficiency Screening

Do you eat red meat, fish and/or chicken? Y or N If yes, how often?_____

_____

Do you eat cereal, leafy greens and/or beans? Y or N If yes, how what and how often?_____

If female, is your menstrual cycle very heavy? Y or N

Do you feel fatigued or have trouble staying focused during the day? Y or N

Do you ever feel your heart racing when it shouldn't be? Y or N

Do you ever feel dizzy or lightheaded? Y or N

Do you ever feel like your stamina in the pool is poor despite regular training? Y or N

List all supplements and medications you are currently taking (including sport or protein supplements), as well as the amounts:

Supplement or Medication (Include brand name, if applicable)	**Amount**	**Reason for taking**

Indicate frequency of the following dietary habits:

How many:	**Per day**	**Per week**	**Per month**
Times you eat in fast food or sit-down restaurants . List the places you eat most often:_____ _____ _____ _____			
Cups of milk or fortified soy drink you have?			
Cups of juice you drink?			
Cups of soft drinks you drink?			
Cups of coffee or black tea you drink? List anything you add to your coffee or tea and how much (e.g. 2 Tbsp cream and 2 Tbsp sugar).			

	Sunday	***Monday***	***Tuesday***	***Wednesday***	***Thursday***	***Friday***	***Saturday***
Early Morning or Before Breakfast *Workout type:* *Workout intensity:*							
Mid-Morning or After Breakfast *Workout type:* *Workout intensity:*							
Noon *Workout type:* *Workout intensity:*							
Afternoon *Workout type:* *Workout intensity:*							
After Dinner *Workout type:* *Workout intensity:*							

PhysicalActivity

Food Record

Use the forms provided on the next pages to keep track of the food you eat for 3 to 5 days. Then bring the food record with you to your appointment or group session with the dietitian.

Try to be as honest as possible. Don't change your diet just because you are tracking it. This will let us give the most appropriate advice to help you achieve your goals.

Be sure to include as many details about:

- The times you eat at.
- What foods you eat. Include food and candies.
- The fluids you consume. Include water, coffee, tea, juice, pop, and no sugar added drinks.
- The amount of each food (e.g. cups, tablespoons, or ounces).

For example:

Time of Day	Food	Drinks
9:30 am	1½ cups corn flakes 1 scoop whey protein (gives 21 grams of protein) 1 white toast 1 tsp Becel margarine 1 Tbsp strawberry jam	1 cup of 2% milk 2 cups water

If you already use a computer or internet program to track your food, you may bring printed copies of that instead.

Date: _____

What time did you wake up?

Time of Day	Food	Drinks

What time did you go to bed?

Date: _____

What time did you wake up?

Time of Day	Food	Drinks

What time did you go to bed?

Date: _____

What time did you wake up?

Time of Day	Food	Drinks

]What time did you go to bed?

Waiver and Acknowledgement

I, _____, hereby grant permission for SMull Nutrition and its employees, partners, volunteers, instructors, agents or representatives to correspond with my physician(s), coach and/or parent, and other health care professionals to obtain information relevant to my nutrition treatment and counseling. I acknowledge that any information obtained will be held in strict confidence.

I further acknowledge the information provided to me by SMull Nutrition is designed to meet my personal dietary needs. It is NOT suitable for any other individual and will not be transferred, copied or sold to another person.

In order to benefit from the recommendations provided by SMull Nutrition, I realize that it is important for me to inform either my physician or SMull Nutrition of any changes I make in the application of my diet. It is my responsibility to report any side effects or problems immediately and to make the necessary adjustments to my nutrition plan with my physician and/ or SMull Nutrition. I will not hold my physician or SMull Nutrition responsible for any complications that result from my failure to comply with either of the above.

I have agreed to have SMull Nutrition keep records of our visits and to file these in a secure and appropriate place. I have agreed to have SMull Nutrition contact other health care professionals to benefit in my care and to share my personal information. This may be accomplished by letter, phone, fax, or email (per PIPA).

Date: _____

Client's Signature: _____

If under 18 years, Guardian(please print): _____

Guardian Signature: _____