JimWhite
FITNESS & NUTRITION STUDIOS

Nutrition Assessment Form

Name:_______________________________ Phone:____________________________ Date:____________

Sex: ___Male ___Female Age:_______ Height:_______ Weight:_______ Goal Weight:_______

Weight Loss Goals and History

How would you describe your body today?

◊Loose ◊Strong ◊ Flabby ◊Other:____________

◊Skinny ◊Weak ◊Toned

Why?

Do you gain or lose weight easily? Please explain.

Have you ever followed a particular diet? (Atkins, South Beach, Zone, Jenny Craig, etc.)

◊Yes ◊No Please explain: ____

Do you usually regain your lost weight after being on a diet?

◊Yes ◊No Please explain: ____

Please give a time line of your past weight fluctuations: < -->

Specifically describe your short/long term goals and expectations that you would like to accomplish through your nutrition & fitness program:

30 days: ____

3 months:____

6 months:____

Eating Habits

What are your current vices? (i.e. chocolate, ice cream, caffeine, beer, salt, sugar, etc.) Please be specific.

Please list any food allergies you have:

Please list your usual food intake and times of your meals below:

Breakfast ____am

Snack ____am

Lunch ____am/pm

Snack ____pm

Snack ____pm

Dinner ____pm

Where do your usually eat your meals? ◊Home ◊Work ◊Restaurant ◊In front of TV

Please list any restaurants you visit on a regular basis. Please specify how often you dine at each restaurant.

1.______________________ ___x per week

2.______________________ ___x per week

3.______________________ ___x per week

4.__________________ ___x per week

5.__________________ ___x per week

6.__________________ ___x per week

Please list: Food Dislikes

Please list any dietary supplements you are currently taking? (i.e. vitamins, weight loss supplements, protein shakes, etc)

Describe your usual daily beverage intake? Please be specific.

◊ I do drink alcoholic beverages

◊ I do not drink alcoholic beverages

How many alcoholic beverages do you consume per week? ___________

Who does the grocery shopping for your household? ◊Me ◊Spouse ◊Other:______________

Do you eat any specific foods before, during, and after workouts? Please specify.

Before

During

After

Lifestyle Patterns

	Yes	No
Are you aware of your caloric intake on a daily basis?	◊	◊
Are you a compulsive eater?	◊	◊
Are you and extremist?	◊	◊
Are you a binge eater?	◊	◊
Do you mood eat?	◊	◊
Do you celebrate with food?	◊	◊
Do you think of food as a reward?	◊	◊
Do you eat at consistent times each day?	◊	◊
Do you ever feel "over full" or uncomfortable after a meal?	◊	◊
Do you ever eat in the middle of the night?	◊	◊
Are you hungry shortly after eating?	◊	◊
Do you get sleepy or lethargic during the day?	◊	◊
Do you get a full 7-8 hours of sleep per night?	◊	◊
Have you ever been diagnosed with an eating disorder?	◊	◊

Rate on a scale of 1 (worst) to 10 (best):

Your overall mood/outlook: ______

Your relationship with food: _____

Your overall energy:______

Your relationships: _____

Your overall stress level:_____

Physical Activity

In the past year, how often have you engaged in physical activity?

◊Regularly (3-4x/week)

◊Semi-regularly (1-2x/week)

◊Sporadic (1-2x/month)

◊None

List types of physical activity you consider to be "fun".

What are your personal barriers to exercising? (i.e. hate going to the gym, no motivation, etc.)

Support Systems

Do you feel you have any negative energy built up towards others in your life regarding weight loss, diet and/or exercise? Please explain.

Is your family and loved ones encouraging you in your pursuit of a healthier lifestyle? Please elaborate.

Do your family or friends that are engaged in regular physical activity? How will your healthier decisions affect these relationships?

Occupation/Leisure

What is your present occupation?

What are your main job duties? Are you sedentary for the most part of your day? Please explain.

Medical History

Physician's Name: ____ Phone:______________________

Are you taking any medication or drugs? If so, please list medication, dose and reason:

____
____
____

Does your physician know you are participating in this exercise program? ◊Y ◊N

Please indicate if you have a history or are currently diagnosed with any of the following conditions:

	YES	NO	Explanation
Heart problems, chest pain, or stroke	◊	◊	
Increased blood cholesterol and/or blood pressure	◊	◊	
Recent surgery (within last 12 months) or previous injuries	◊	◊	
Preganacy (within last 3 months)	◊	◊	
Respiratory problems, asthma	◊	◊	
Muscle, joint or back disorders	◊	◊	
Osteoporosis	◊	◊	
Diabetes or thyroid condition	◊	◊	

	Yes	No
Obesity (more than 20% over ideal body weight)	◊	◊
Cigarette Smoking	◊	◊
Alcohol abuse	◊	◊
Hernia	◊	◊
Difficulty with physical exercise	◊	◊
Advice from physician not to exercise	◊	◊
Do you have HDL levels greater than 60	◊	◊
History of heart problems	◊	◊

Any other chronic disease: _________________________

Please explain any "yes" answers below and continue on back if necessary.

Comments:____
____
____

Part Two: Family History

Has your mother, father, or sibling suffered form (Please select all that apply)

◊ Heart attack or surgery prior to age 55

◊ High cholesterol

◊ Stroke prior to age 50

◊ Diabetes

◊ Congenital Heart disease or left ventricular hypertrophy

◊ Obesity

◊ Hypertension

◊ Asthma

◊ Osteoporosis

◊ Leukemia or cancer prior to age 60

Part Three: Lifestyle History

◊ Are you a cigarette smoker? If so how many per day? __________

◊ Previously a cigarette smoker? If so, when did you quit? ___/___/___

How many years have you smoked or did you smoke before quitting?______________

Do/Did you smoke ◊ Cigarettes ◊ Cigars ◊ Pipe

Stressors

On a scale of 1-10 (10 = incredibly stressed out), how is your stress on a daily basis?