



# Sports Nutrition Assessment

Name: \_\_\_\_\_ Appointment Date: \_\_\_\_\_

Phone number: \_\_\_\_\_ Email: \_\_\_\_\_

Gender (circle one): M or F Birth date: \_\_\_\_\_

Weight: \_\_\_\_\_ Height: \_\_\_\_\_

What are your sport and/or health goals? \_\_\_\_\_

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## **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 _____	
Constipation _____	Diverticulitis _____	

Injury History (please list): \_\_\_\_\_

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Allergies - food, medications, environmental (please list): \_\_\_\_\_

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Family medical history (please list): \_\_\_\_\_

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Age of first menstrual cycle: \_\_\_\_\_ Frequency of menstrual cycle: \_\_\_\_\_

## **Your Personal Diet History (check all that apply):**

Lactose intolerant _____	Vegetarian (ovo/lacto) _____
Please indicate if you are able to tolerate small amounts of the following:	Vegan _____
<input type="checkbox"/> milk <input type="checkbox"/> cheese <input type="checkbox"/> yogurt	Kosher _____

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

<b>Supplement or Medication</b> (Include brand name, if applicable)	<b>Amount</b>	<b>Reason for taking</b>

Indicate frequency of your following dietary habits:

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

	Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
<b>Early Morning or Before Breakfast</b> Workout type: Workout intensity:							
<b>Mid-Morning or After Breakfast</b> Workout type: Workout intensity:							
<b>Noon</b> Workout type: Workout intensity:							
<b>Afternoon</b> Workout type: Workout intensity:							
<b>After Supper</b> Workout type: Workout intensity:							

You may also bring a printed copy of your own training plan.

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 at?

Time of Day	Food	Drinks

What time did you go to bed at?

**Date:** \_\_\_\_\_

What time did you wake up at?

Time of Day	Food	Drinks

What time did you go to bed at?

**Date:** \_\_\_\_\_

What time did you wake up at?

Time of Day	Food	Drinks

What time did you go to bed at?

# Waiver and Acknowledgement

I, \_\_\_\_\_, hereby grant permission for Balance Nutrition Inc. and its employees, partners, volunteers, instructors, agents or representatives to correspond with my physician(s), coach and/or parent, other health care professionals, and employee assistance programs (hereby after known as EAP), or the Workers' Compensation Board (hereby after known as the WCB) to obtain information relevant to my nutrition treatment and counselling. I acknowledge that any information so obtained will be held in strict confidence.

If the nutrition services provided to you have been arranged and paid for as part of my insurance and/or treatment through the WCB or through an EAP, Balance Nutrition Inc. may be required to provide a written report to the WCB about the nutrition treatment and counselling I received from Balance Nutrition Inc.

I further acknowledge the information provided to me by Balance Nutrition Inc. 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 treatment prescribed by Balance Nutrition Inc., I realize that it is important for me to inform either my physician or Balance Nutrition Inc. 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 treatment plan with my physician and/ or Balance Nutrition Inc. I will not hold my physician or Balance Nutrition Inc. responsible for any complications that result from my failure to comply with either of the above.

I have agreed to have my Balance Nutrition Inc. keep records of our visits and to file these in a secure and appropriate place. I have agreed to have Balance Nutrition Inc. 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: \_\_\_\_\_

Witness(please print): \_\_\_\_\_

Witness Signature: \_\_\_\_\_