**Sports Nutrition Assessment Form**

**Name:**

**Birth Date:**

**Age:**

**Today’s Date:**

Please fill out the following information to the best of your knowledge. Certain items may not apply to you (e.g. coach name and address). If they do not, please leave those sections blank.

**Medical Information**

Physician or medical provider:

Name:

Contact:

**Other Health Care Providers** (E.g. physiotherapist, chiropractor, naturopath, athletic therapist, massage therapist):

**Current medications:**

**Medical history:**

Laboratory values: If you have had blood work done recently this is great. Please provide any numbers you have for the indices in the table below.

**Date blood work was taken:**

**Results:**

* CBC (Complete Blood Count):
* OtherNa (Sodium):
* Mg (Magnesium):
* K (Potassium):
* Zn (Zinc):
* Cl (Chloride):
* Vit D (Vitamin D):
* B12 (Vitamin B12):
* Cr (Creatinine):
* Ferritin Glc (Glucose):
* Fe (Iron):
* CO2 (Carbon Dioxide):
* TIBC (Total Iron Binding Capacity):
* Ca (Calcium):
* TSH (Thyroid Stimulating Hormone):

**Additional comments**

**Physical Status**

Height:

Current Weight:

Competition weight (if applicable):

Usual Adult Body Weight:

Highest body weight:  Age:

Lowest body weight:  Age:

**Body composition:**If you have had your body fat and muscle mass estimated by devices such as skinfold callipers, the Bod Pod, or bioimpedance analysis please provide the information below.

**Lean Body Mass:**

**Body Fat:**

**Date measured:**

**Lifestyle/ Sports Information**

In which sports do you participate (list sports and how often you do each sport):

**Coach**

Coach Name:

Coach Contact:

**Injuries:**

**List from newest to oldest**

**Type of injury: Timing for healing or in progress**

1.

2.

3.

4.

5.

**Date injured:**

1.

2.

3.

4.

5.

**Therapy? (E.g. physio):**

1.

2.

3.

4.

5.

**Current training period:**

Training:

Competition:

Recovery:

Comments:

**Typical current training schedule:**

List activity in each day of the week below.

Monday:

Tuesday:

Wednesday:

Thursday:

Friday:

Saturday:

Sunday:

**Diet**

Vitamin and mineral supplements:

Weight loss, herbal or sports supplements:

Food allergies:

Food dislikes:

Describe your daily eating habits:

Alcohol Frequency:

Alcohol Quantity:

Alcohol Type:

**What do you eat and drink (list specific foods/drinks and quantities):**

2-3 hours before workout:

1 hour before workout:

During a workout:

**How often do you eat at restaurants or consume take-out or fast food?**

**How often do you eat snack foods? Type:**

**Describe your typical eating environment (e.g. alone, with a friend or roommate, in car, at desk):**

**What is your primary goal for your nutrition counselling experience overall:**

**What 3 nutrition changes do you think should you make starting today:**

1.

2.

3.

**Preferred strategy for nutrition intervention:**

* Day-to-day meal plan:
* Food choices (e.g. 2 starches, 3 protein) + selections:
* General guidelines (e.g. eat 6 vegetable servings/day):

Other comments: