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# Sports Nutrition Data Collection Form

Name: _____ Date: _____

Address: _____
_____

Phone: (day) _____ (evening) _____ (cell) _____
E-Mail: _____
Occupation: _____
Normal work hours: _____

Age: _____ Height: _____ (cm) _____ Weight: _____ (Kg) _____
BMI_____ Shaded areas are for office use.

Male/Female Weight goal: _____

M=66 + (13.7*___kg) + (5*___cm) - (6.8*years)
F=655 + (9.6*___kg) + (1.7*___cm) - (4.7*years)

_____ * _____ = _____
Measured Resting Energy Expenditure | Activity Factor | Total Calories

_____
Calories to maintain / lose / gain weight

## Personal Meal Plan Daily Totals

_____ Starch _____ g Carbohydrate _____ %
_____ Vegetable
_____ Fruit _____ g Protein _____ %
_____ Milk
_____ Meat (Protein) _____ g Fat _____ %
_____ Fat

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## Nutrition Summary Sheet

Sport played_____

Reason for nutrition
counseling_____
_____
_____
_____

Weight History: Please indicate past weight gain/loss cycle(s).
(e.g. Gained 15 lbs. over 5 years. Lost 5 lbs. in past 2 months.)

Medical History: (e.g. kidney stones, high blood pressure, thyroid condition, diabetes, heart disease etc.)

Indicate laboratory values if known:

Chol _____ Glucose_____
MCV_____ Triglyceride_____
HDL_____ Hemoglobin_____
LDL_____

Medications: List all medications that you currently take (do not include supplements in this section)

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Have any members of your family had: (Check all that apply)

( ) Obesity ( ) Diabetes ( ) Heart Disease

( ) Cancer, type_____ ( ) High Cholesterol ( ) High Blood Pressure

( ) High Triglyceride ( ) Stroke ( ) Hypothyroid

Do you have any food allergies or intolerances? ( ) Yes ( ) No

Specify:_____

Do you have concerns with: If yes, explain?

Constipation ( ) Yes ( ) No _____
Diarrhea ( ) Yes ( ) No _____
Indigestion ( ) Yes ( ) No _____
Heartburn ( ) Yes ( ) No _____
Gas ( ) Yes ( ) No _____
Appetite ( ) Yes ( ) No _____

Do you consume caffeinated Beverages? (e.g. coffee, tea, energy drinks, Redbull, sports supplement, soda)

( ) Yes ( ) No

Type(s) / how often:

_____

_____

Do you take any vitamin, mineral, herbal, or food supplements? (e.g. Energy bars, protein drinks, protein bars, meal replacements)

( ) Yes ( ) No

Type(s) / how often:

_____

_____

_____

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Who usually does the grocery shopping?

_____

What do you look for on nutrition labels?

_____

_____

_____

## Diet History

*The following questions are about your typical eating pattern:*

How many days per week do you eat (Breakfast) _____ (Lunch) _____ (Dinner) _____

How often do you snack? ( ) Once daily ( ) Twice daily ( ) Three times daily ( ) More than three times daily

When do you usually snack?

_____

What is a typical snack you choose?

_____

Do you eat out? ( ) Yes ( ) No How often per week?

_____

Which restaurant (s) do you usually choose?

_____

Do you drink beer, wine, or mixed drinks (beverages containing alcohol)?

( ) Yes ( ) No

If yes, indicate type of alcohol containing beverage you drink.

_____

Number of beverages per week: _____

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When do you drink? _____

Do you smoke? ( ) Yes ( ) No

How many hours of sleep do you get a night? _____

Do you eat when you feel: (circle all that apply)

Happy Lonely
Sad Bored
Stressed Anxious Other:_____

What foods do you typically eat when you feel this way?_____
_____
_____
_____

Do you have a concern with:

Binging ( ) Yes ( ) No

Purging ( ) Yes ( ) No

Compulsive Eating ( ) Yes ( ) No

Night time snacking ( ) Yes ( ) No

Social eating (parties etc.) ( ) Yes ( ) No

Describe your concerns identified above in further detail_____
_____
_____
_____
_____
_____
_____
_____

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Where / how do you eat the following meals on a typical day: (Circle all that apply)

Breakfast: At the kitchen table
Watching TV
In the car
Standing up
At work
Restaurant/ fast food
Do not eat breakfast

Lunch: At the kitchen table
Watching TV
In the car
Standing up
At work
Restaurant/ fast food
Do not eat lunch

Dinner: At the kitchen table
Watching TV
In the car
Standing up
At work
Restaurant/ fast food
Do not eat dinner

Snacks: At the kitchen table
Watching TV
In the car
Standing up
At work
Do not eat snacks

Do you eat with others? ( ) Yes ( ) No

Do you cook? ( ) Yes ( ) No

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Who usually prepares the food at home?

_____

What activities / hobbies do you have?

_____

_____

_____

Are you active in day to day life other than training? ( ) Yes ( ) No

Specify:

_____

_____

_____

What are your favorite foods?

_____

_____

What foods do you dislike?

_____

_____

What would you like to change about your eating habits?

_____

_____

_____

_____

Do you follow any special diet restrictions (e.g. vegetarianism etc.)?

_____

_____

_____

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# FOOD FREQUENCY QUESTIONAIRE

How often do you eat the following foods **per week**?

| Food | Times Per Week | Food | Times Per Week | Food | Times Per Week |
|---|---|---|---|---|---|
| Eggs | | Bread | | Sweets | |
| Cheese | | Nuts | | Ice Cream | |
| Milk (Specify) | | Rice/Pasta | | Water | |
| Yogurt | | Beans | | Coffee/Tea | |
| Cottage Cheese | | Bacon/Sausage | | Carbonated Beverages | |
| Pizza | | Potatoes | | Energy Drinks | |
| Red Meat | | Sweet Potatoes | | Alcohol | |
| Chicken/Turkey | | Frozen Dinners | | Fruit Juice | |
| Fish | | Fried Foods | | Vegetables | |
| Soy Products | | Restaurants | | Corn, Peas, Lima Beans | |
| Luncheon Meat | | Fast Food/Take out | | Dietary Supplements | |
| Hotdogs | | Salty Snacks | | Ethnic Foods (Explain) | |
| Oatmeal/ oat bran | | Margarine/Butter | | Other: | |

## 24-Hour Recall

Please indicate what you eat and drink on a "typical day."

| | Time of Day | Food eaten (Please describe and include quantity of each item) |
|---|---|---|
| **Breakfast** | | |
| **Lunch** | | |
| **Dinner** | | |
| **Snacks** | | |

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## Training Protocol

Please describe your typical weekly training in the chart below or attach your current training regimen.

| | Time of Day | Describe Exercise | Duration | RPE* |
|---|---|---|---|---|
| Sunday | | | | |
| Monday | | | | |
| Tuesday | | | | |
| Wednesday | | | | |
| Thursday | | | | |
| Friday | | | | |
| Saturday | | | | |

*RPE is Rating of Perceived exertion: One a scale of 1-10 rank your effort where 0=nothing, 1=very weak, 2=weak, 3=moderate, 4=somewhat strong, 5=strong, 7=very strong, 10=very, very strong (maximal)

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