22269 Eureka Rd
Taylor, MI 48180
Telephone: 313-221-9777
Website: www.rccmichigan.com

Nutrition Assessment Form

Full Name: _____ Date of Birth: _____

Phone (Cell/Mobile): _____ Email: _____

Age: _____

Height and Weight History

Height (feet and inches): _____ Current body weight (lbs.): _____

Desired body weight (lbs.): _____

Lowest body weight (lbs.): _____ Year lowest body weight (lbs.): ____

Highest body weight (lbs.): _____ Year highest body weight (lbs.): ____

Nutrition and Fitness Goals

What are your nutrition and fitness goals?

_____

_____

_____

_____

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What have you tried in the past to achieve your nutrition and fitness goals? This includes any diet or exercise program, supplement use, books etc.

_____

_____

_____

_____

Medical History

Are you currently taking any medications? Select
If yes, please list:

_____

Do you have any allergies or intolerances? Select
Please include all known allergies/intolerances regardless of whether they are food related.

_____

_____

_____

Do you have a history of diabetes? Select
If yes, please explain:

_____

_____

_____

Do you have any history of high cholesterol? Select
If yes, please explain:

_____

_____

_____

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Do you have any history of heart disease? Select
If yes, please explain:

_____
_____
_____

Do you have any history of hypo/hyperthyroidism? Select
If yes, please explain:

_____
_____
_____

Do you have any history of bowel disease (i.e. Crohn's Disease, Ulcerative Colitis, Irritable Bowel Syndrome)? Select
If yes, please explain:

_____
_____
_____

Have you ever been diagnosed with an eating disorder? Select
If yes, please explain:

_____
_____
_____

FEMALES ONLY

At what age did you get your period? _____

Do you get regular periods? _____

When was your last menstrual period? _____

How long did it last? _____

Do you take any oral contraceptives? _____

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Health Information

Do you take any vitamins or mineral supplements? Select
If yes, please list them:
_____

Do you take any type of nutritional
supplements (i.e., protein shakes, powders, energy drinks etc.)? Select
If yes, please list:
_____

Are there any foods that you avoid? Select
If yes, please explain:
_____

Do you follow a certain diet (i.e., vegetarian, pescatarian, vegan, paleo, keto etc.)? Select
If yes, please explain:
_____

Do you drink alcohol? Select
If yes, on average how many days, how much and what type of alcohol do you consume a week:
_____

Do you drink caffeinated beverages? Select
If yes, please list the beverages and how often you drink these:
_____

Do you smoke (tobacco products)? Select
If yes, how many cigarettes per day:
_____

On average, how many hours do you sleep on weeknights? _____

On average, how many hours do you sleep on weekends? _____

Please rate your quality of sleep on a scale of 1(bad) to 5(excellent): Select

Please rate your stress levels on a scale of 1(bad) to 5(excellent): Select

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How do you manage your stress?

_____
_____
_____

Have you seen a counselor/therapist in the past
or are you working with someone presently? Select
If yes, please explain:

_____

What is your daily water intake (fl oz)? _____

Exercise Information

Do you do any exercise? Select
If yes, please explain:

_____
_____
_____

Are you currently working with a trainer or coach? Select
If yes, what are the goals for these sessions and how often do they take place?

_____
_____
_____

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Nutrition Log

Please list out what a typical day of eating looks like for you.

Please be very specific, including times, portion sizes and brands (i.e. 1 latte made with whole milk, 45g of oatmeal etc.).

Do not forget to include drinks.

Breakfast

Time: _____
Item(s):_____
_____
_____

Morning Snack

Time: _____
Item(s):_____
_____
_____

Lunch

Time: _____
Item(s):_____
_____
_____

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Afternoon Snack

Time: _____
Item(s):_____
_____
_____

Dinner

Time: _____
Item(s):_____
_____
_____

Evening Snack

Time: _____
Item(s):_____
_____
_____

Eating Habits

Do you follow a meal plan? Select

Do you prepare your own meals? Select

Do you track your macronutrients (i.e. protein, fat, carbohydrates)? Select

Where do you tend to shop for groceries? _____

How often do you go out to eat? _____

How often do you eat fast food/takeout? _____

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Do you have any concerns fitting in meals/snacks based on your current schedule? Select
If yes, please explain:
_____

Please use below for any additional information you feel would be helpful:

_____
_____
_____
_____
_____