



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	<b>1</b>
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	LION
COMBAT C	LUB \
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? If yes, please list: Do you have any allergies or intolerances? \_\_\_\_ Please include all known allergies/intolerances regardless of whether they are food related. Do you have a history of diabetes? If yes, please explain: Do you have any history of high cholesterol? \_\_\_\_\_ If yes, please explain:



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Do you have any history of heart disease? \_\_\_\_\_

If yes, please explain:	
Do you have any history of hypo/hyperthyroidism? If yes, please explain:	
lý.	
Do you have any history of bowel disease (i.e. Crohn's Disease	e, Ulcerative Colitis, Irritable Bowel
Syndrome)?	<b>6</b>
If yes, please explain:	
Have you ever been diagnosed with an eating disorder?	
If yes, please explain:	
The state of the s	
FEMALES ONLY	
At what age did you get your period?	-UB
Do you get regular periods?	
When was your last menstrual period?	
How long did it last?	
Do you take any oral contracentives?	



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## **Health Information**

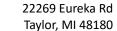
Do you take any vitamins or mineral supplements?  If yes, please list them:
Do you take any type of nutritional supplements (i.e., protein shakes, powders, energy drinks etc.)? If yes, please list:
Are there any foods that you avoid?  If yes, please explain:
Do you follow a certain diet (i.e., vegetarian, pescatarian, vegan, paleo, keto etc.)? If yes, please explain:
Do you drink alcohol?  If yes, on average how many days, how much and what type of alcohol do you consume a week:
Do you drink caffeinated beverages? If yes, please list the beverages and how often you drink these:
Do you smoke (tobacco products)? T T L B T L B T L B T L B T L B T L B T L B T L B T L B T L B T L B T L B T L B T L B T L B T T B T T T T T T
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):
Please rate your stress levels on a scale of 1(bad) to 5(excellent):



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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?  If yes, please explain:		
What is your daily water intake (fl oz)?		
Exercise Information  De your de any eversion?		
Do you do any exercise? If yes, please explain:		
Are you currently working with a trainer or coach?  If yes, what are the goals for these sessions and how often do they take place?		
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TEVULUIIU COMBAT CLUB		







## **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.

<u>Breakfast</u>	(S)		The same of the sa	
Time: Item(s):				
Morning Snack				
Time: Item(s):				
	The Carrier M.			
Lunch Time:	BEV	)LUT	IOA	
Item(s):	<del>-</del> LUM	BAT CL	UB 4	



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Afternoon Snack
Time: Item(s):
<u>Dinner</u>
Time:
Evening Snack Time:
Item(s):
Eating Habits
Do you follow a meal plan?
Do you prepare your own meals? TO LUB
Do you track your macronutrients (i.e. protein, fat, carbohydrates)?
Where do you tend to shop for groceries?
How often do you go out to eat?
How often do you eat fast food/takeout?







Do you have any concerns fitting in meals/snacks based on your current schedule?  If yes, please explain:			
Please	use below for any additional information	you feel would be helpful:	
	BEVOL	UTION	