ATHLETIC EDGE SPORTS MEDICINE AESM

121 King St. W., Suite 1100, Toronto, ON, M5H 3T9 Phone ~ 416-800-0800 ~ Fax 416-800-0802

NUTRITION SCREENING QUESTIONNAIRE

Name:	**Date:**
Date of Birth:	**Email address:**
Home/cell number:	**Work phone number:**
Height:	**Weight:**
Lowest weight in last 5 years:	**Highest weight in last 5 years:**
Physician's Name:	**Physician's Tel. Number:**
Physician's Address:	
May your physician be notified of your visit(s) and progress and/or contacted for your health information (i.e. blood pressure, blood sugar etc.)☐ YES ☐NO	

Please complete the following questionnaire. It should take approximately 15 minutes. Please be as honest as possible, as it will help us to serve you better.

1. What are you hoping to accomplish by seeing a Registered Dietitian?

2. What do you believe are your major barriers to achieving success?

3. How do you feel about your weight?

- ☐ **I would like to lose a few pounds**
- ☐ **I believe I have a significant (10 or more lbs) amount of weight to lose**
- ☐ **I am comfortable with my weight**
- ☐ **I would like to gain weight**

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4. Has your weight changed over the last year?

☐ **Yes**

If so, by how much and why?

☐ **No**

5. Have you used any diet or weight loss programs in the past (e.g. low carb, Weight Watchers, Dr. Bernstein)?

☐ **Yes**

Which programs were successful for you? Why?

☐ **No**

6. Have you made any changes to your diet over the last year? Please provide details, including type of change (e.g. increased fibre, vegetables, etc.), and any impact they have had on your health, weight, energy, exercise performance or overall quality of life.

7. Has your activity level changed over the past year?

☐ **Yes**

Please provide details

☐ **No**

8. Please outline your activity for a typical week. Include all sources of activity, including cardiovascular exercise (running, swimming, cycling, stair climber, etc.), weight or resistance training, exercise classes, team sports, walking (include any walking that is part of your commute or daily routine), or other activities. Be sure to include the approximate amount of time that you spend on each activity each week.

9. Do you have any particular fitness goals at this time (e.g. increase muscle / decrease body fat / train for a race or sport event)?

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10. Has your work changed significantly over the last year (e.g. employer or occupation, number of hours per week, amount of travel, etc.)

☐ **Yes**

If so, please provide details:

☐ **No**

11.Has your personal life changed significantly over the last year?

☐ **Yes**

If so, please provide details:

☐ **No**

12. Do you have any medical conditions? (E.g. high cholesterol, high blood sugars, heartburn, constipation, low iron, anemia, osteoarthritis, diabetes, high blood pressure etc.)

13. Have any of these developed or changed over the last year?

14. Please list any supplements that you are taking such as vitamins, minerals, herbs, protein powders, and sports supplements.

15. Are you ALLERGIC to or INTOLERANT to any medication/s? *(Please describe):*

16. Are you ALLERGIC to or INTOLERANT to any food/s? *(Please describe)*

17. Are you presently taking any pills, drugs or medications? (*If yes, please list*)

18. Have you taken prolonged medications in the past? *(If yes, please list):*

19. What are your current living arrangements (e.g. live with spouse or partner, children – include ages, roommate/s, parents, etc.)?

20. Who usually takes care of your shopping and/or meals?

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21. Do you smoke?

☐ **Yes**

How much? (Please provide details)

☐ **No**

22. Do you drink alcohol?

☐ **Yes**

Approximately how many drinks per week?

☐ **No**

23. How often do you eat breakfast in a typical week?

24. Do you skip lunch or dinner?

☐ **Yes**

If so, how many times a week?

☐ **No**

25. On average, how many meals per week do you eat from restaurants, catered meals, fast food or food courts, or ordering in at home or at work (i.e. any meal not prepared by you or a member of your household)?

26. Do you snack during a typical day?

☐ **Yes**

At what times?

What sort of snacks do you normally choose?

☐ **No**

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27. Indicate which of the following topics you are interested in learning about as they relate to your diet and/or health-related goals. Check all that apply.

- ☐ **Eating well in restaurants/while traveling/while on the run**
- ☐ **Recipes and/or meal planning at home**
- ☐ **Strategies to increase metabolism**
- ☐ **Strategies to increase energy**
- ☐ **Strategies to reduce portions/overeating/curb cravings**
- ☐ **Personal protein/carb/fat/calorie needs**
- ☐ **Reading and understanding food labels**
- ☐ **Sports nutrition (what to eat before, during, and after exercise)**
- ☐ **How to set long-term nutrition goals**
- ☐ **Other: _____**

28. How prepared are you to make positive changes to your diet, exercise and lifestyle?

- ☐ **I am very prepared to make changes right now**
- ☐ **I am prepared to follow recommendations if they are flexible and easy to follow**
- ☐ **I may be prepared to make changes in the near future**

Date: _____

Participant's Name: _____

Participant's Signature: _____

Parent/Guardian Signature (if participant under 18 years of age): _____

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Dietitian Notes:

Registered Dietitian Signature: _____