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# Nutrition History Form

Name: \_\_\_\_\_ Date: \_\_\_\_\_

Sport: \_\_\_\_\_ Position: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Height: \_\_\_\_\_

Current Weight: \_\_\_\_\_ Desired Weight: \_\_\_\_\_

Contact information: \_\_\_\_\_

How long have you been at your current weight? \_\_\_\_\_

If your weight has changed, please describe what you did to gain or lose weight and indicate how long you have been working on changing your body composition.

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What are your goals? Why are you seeing a sports dietitian?

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Do you cook for yourself? If yes, how often and what types of foods do you prepare?

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Do you grocery shop? \_\_\_\_\_

Do you want to change your eating habits? \_\_\_\_\_

How would you describe your eating habits? (Circle one.)    Good            Fair            Poor

Do you take any vitamin/mineral supplements? \_\_\_\_\_

If so, please list the types of supplements and the amounts the you take.

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Do you take any other dietary supplements (creatine, echinacea, etc)? \_\_\_\_\_

If so, please list the types of supplements and the amounts that you take.

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Are you allergic to any foods? \_\_\_\_\_ If so, please list them.

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How often do you eat out? \_\_\_\_\_ times per week.

What types of restaurants do you visit (pizza, burgers, Chinese, etc)?

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Describe a typical day of training and food intake (times, amounts, and types of foods and fluids consumed; and type, intensity, and duration of training).

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Describe a typical meal that you would eat before competition.

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What do you drink before, during, and after exercise for fluid replacement?

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Do you take any medications? \_\_\_\_\_ If so, please list the medications (both over-the-counter and prescription) that you currently take.

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On the scale below, circle the number that indicates how ready you are to make dietary changes. 1 = not ready and 12 = very ready.

1      2      3      4      5      6      7      8      9      10      11      12