TIFFANY CHAG
NUTRITION | TRAINING

NUTRITION INTAKE FORM

PERSONAL INFORMATION

TODAY'S DATE: _____/_____/_____

NAME: _____ DATE OF BIRTH: _____/_____/_____ AGE: _____

ADDRESS:

_____

Street Apt #

_____

City State Zip

PHONE #: _____ E-mail: _____

OCCUPATION: _____

GOALS

Provide up to three goals you have related to making positive changes to your current dietary habits.

1.

2.

3.

Why are these goals important to you?

What are the main obstacles that might prevent you from achieving your desired goals?

On a scale of 1 (Poor) to 10 (Excellent), how would you currently rate your overall dietary habits? _____

TCNT

NUTRITION INTAKE FORM

HEALTH SCREEN

Please list any medical conditions and concerns in the space below:

Please list any injuries and hospitalizations in the last 2 years:

MEDICATION AND SUPPLEMENT REVIEW

What medications and supplements are you currently taking? This includes prescriptions, vitamins, minerals, protein powder, electrolytes, CBD/THC, etc. (please list brand and dose)

MEDICATION / SUPPLEMENT	Dose	Years taking	Reason for taking

GENERAL NUTRITION SCREEN

Do you have any food allergies or intolerances? If yes, please list.

Do you currently have any GI (gastrointestinal) issues? If yes, please list. (e.g.: heart burn, reflux, nausea, bloating, gas, diarrhea, constipation, etc.)

Do you struggle with any of the following: regularly skipping meals, significant nighttime snacking, mindless eating, emotional or stress eating, etc.? If yes, please list.

Do you currently, or have you in the past, had a negative relationship with food? If yes, how do you feel about where you are today?

How many times do you eat per day? (meals/snacks)	1 □	2 □	3 □	4 □	5 □	6+ □
How many pieces of fruit do you eat daily?	1-2 □	3-4 □	5-6 □	7-8 □	9-10 □	10+ □
How many servings of veggies do you eat daily?	1-2 □	3-4 □	5-6 □	7-8 □	9-10 □	10+ □
Weekly, how many meals do you eat out?	1-2 □	3-4 □	5-6 □	7-8 □	9-10 □	10+ □
What are your favorite places to eat out?						

Have you ever actively tried to gain or lose weight? Yes □ No □ If yes, please list how below:		
Type of Diet / Eating Program	Date(s) of Diet	Outcome

HYDRATION SCREEN

	How many?	What type?
How many cups or ounces of water do you drink daily? (1 reg Poland springs bottle = 2 cups = 16oz)		
How many caffeinated beverages do you drink daily? (coffee, tea, energy drinks, soda, etc.)		
How many alcoholic beverages do you drink daily (can list weekly intake, if easier)		
What other beverages do you consume?		

SPORTS NUTRITION SCREEN

	Hydration	Fueling
Do you eat or drink anything in particular **before** a workout? Yes □ No □ If yes, please list.		
Do you eat or drink anything in particular **during** a workout? Yes □ No □ If yes, please list.		
Do you eat or drink anything in particular **after** a workout? Yes □ No □ If yes, please list.		

Do you sweat a lot during workouts? Yes □ No □
Does your sweat taste salty or leave salt crystals on your clothing or body after? Yes □ No □
Do you feel you have enough energy during practice and games? Yes □ No □
Do you take any sports performance supplements? Yes □ No □ If yes, please list in the space below:

MOVEMENT SCREEN

Daily Activity

What is your baseline activity level? (Includes work and daily life, excludes workouts)	Not Active □	Lightly Active □	Moderately Active □	Very Active □
On average, how many steps/blocks/miles do you walk a day? (2000 steps = 1 mile = ~20min)	Weekdays:		Weekends:	

Workouts Activity

Please describe your activities:	Duration (per session)	Frequency (per week)	Activities Performed (details appreciated)
Cardiovascular Training			
Resistance Training			
Sport-Specific Training			

Are there any other activities you enjoy doing (skiing, hiking, dancing, gardening, etc.) ?

_____

_____

LIFESTYLE PATTERNS

Stress

On a scale of 1-10 (1 = low) what is your current stress level? _____

Do you do anything to alleviate stress? If so, what? _____

Sleep

On average, how many hours of sleep do you get nightly? Weekday_____ Weekend_____

Are you satisfied with the *quality* of your sleep? Yes □ No □

Tobacco

Do you currently smoke or use tobacco products: Yes □ No □ If yes, for how long? _____

ANTHROPOMETRICS (optional)

Are you satisfied with your current weight and body composition? Yes □ No □

Have you gained or lost a significant amount of weight in the last year? Yes □ No □

Height	Current Body Composition	Ideal Body Composition	Current Body Weight	Ideal Body Weight

MENSTRUAL HISTORY

Do you track the frequency of your period? Yes □ No □

How many days does your period last? _____

Do you have excessive flow? Yes □ No □

Have you ever missed more than 2 periods in a row? Yes □ No □

Have you ever had a stress fracture? Yes □ No □

Do you take birth control or have an IUD? Yes □ No □ If yes, which one? _____

OTHER – Is there anything else you'd like me to know?