Nutritional Assessment

PATIENT INFORMATION: **Date** _____

Name: _____

Address: _____

City: _____ **State:** **Zip:** _____

Phone Number Where You Prefer To Be Reached: _____

E-mail address: _____

Occupation: _____

Present Nutrition/Health Concerns/Goals:

1) _____

2) _____

3) _____

ASSESSMENT DATA:

Sex: _____

Age: _____ **Date of Birth:** _____

Height: _____ **(inches)**

Actual Body Weight: (lbs) _____ **IBW** _____ **%IBW** _____ (Actual/IBW)

Any recent gains or losses? If so how much? _____

What is your activity level? Select one.

- ☐ None
- ☐ 1-2x/Week
- ☐ 3x/Week
- ☐ 5x/Week
- ☐ Daily

_____

How hard (intensity) is your workout? Select one.

- ☐ Light
- ☐ Moderate
- ☐ Heavy

_____

What is the length (duration) of your workout? (Select one)

- ☐ 15 Minutes
- ☐ 20 Minutes
- ☐ 30 Minutes
- ☐ 45 Minutes
- ☐ 60 or more

_____

Is your workout routine an aerobic activity, strength training, or both? _____

Total Daily Energy Expenditure:

Females: 655 + [(9.6ABW)+ (1.7 Ht) - 4.7 Age)] _____

Males: 66 + [(13.7ABW) + (5 Ht) - 6.8 Age)] _____