

ALAMEDA FITNESS CENTER

NUTRITION HEALTH HISTORY QUESTIONNAIRE

General Information

Name:	Age:	Phone:
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Weight History

Height		Current Weight		Usual Weight	
What is your goal weight or ideal weight?					
Have you lost or gained weight in the past year?				Yes	No
If so, describe?					
What methods have you used to gain or lose weight?					
Are you satisfied with your current weight?				Yes	No
Why or Why Not?					

Please list any medical conditions or diagnoses you may have so we are able to provide the best possible care (i.e. food allergies, heart conditions, diabetes, etc.)

Describe any current forms of exercise and frequency of exercise

Form of Exercise		Form of Exercise	
Average Length of Workout		Average Length of Workout	
Times/week		Times/week	
Form of Exercise		Form of Exercise	
Average Length of Workout		Average Length of Workout	
Times/week		Times/week	

Diet History

How would you describe your current eating habits?		Good		Fair		Poor	
Please explain your choice above.							
How many times do you eat throughout the day?				Meals		Snacks	
Do you avoid any of the following foods? <i>Check any that apply</i>							
<input type="checkbox"/>	Red meat	<input type="checkbox"/>	Fruits	<input type="checkbox"/>	Sweets	<input type="checkbox"/>	Poultry: chicken, turkey
<input type="checkbox"/>	Fried food	<input type="checkbox"/>	Breads	<input type="checkbox"/>	Fast food	<input type="checkbox"/>	Fats/Oils
<input type="checkbox"/>	Vegetables	<input type="checkbox"/>		<input type="checkbox"/>	Fish	<input type="checkbox"/>	Grains: pasta, rice, cereal

	Dairy: milk, cheese or yogurt	
How often do you eat out at fast food or sit down restaurants?		
Which restaurants do you typically eat at?		

Describe your eating patterns for exercising, training or competing

Before Exercise	
During Exercise	
After Exercise	

Fluids--describe the types of fluids you drink each day and approximately how much

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Supplements

Do you use any supplements (vitamins, minerals, protein powders, herbs, energy boosters, energy bars or gels, liquid meals, sport drinks, etc.)

Yes		No	
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If yes, what supplements do you take, how often and in what amounts?

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Prescription and Over-the-Counter Medications

Are you taking any medications, including over-the-counter medications?

Yes		No	
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If yes, please list medications and dose.

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For Females Only

When was your last menstrual period?

How many menstrual periods have you had in the past year?

Have you ever gone >3 months without having a menstrual period (not including pregnancies)

Yes		No	
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If yes, how long did you go without?

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