**Mini Assessment for Nutrition (15 - 20 minutes)**

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| Name:  DOB:  Contact number:  Email Address: |  |

**ANTHROPOMETRY**

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| Height:  Weight:  Do you weigh yourself regularly (at least once a week)? **Y / N**  Weight history (has your weight increased or decreased?):  Do you have any personal weight or body composition goals? **Y / N**  ⇒ If yes, what are they and why? |

**NUTRITION**

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| Have you had any GIT symptoms in the past two weeks?  ⃞   Constipation       ⃞  Diarrhea       ⃞  Vomiting       ⃞   Nausea      ⃞   Other:  Have you ever had any nutritional deficiencies? **Y / N**  If so, what & when? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

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| Do you follow a particular diet? **Y / N** : \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Do you have any known food allergies or intolerances? **Y / N** : \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Where do you eat most of your meals? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  How frequently do you consume take away / eat out?    **0  1  2  3  4  5  6  7  days/week**  How often do you cook your own meals in a typical week? **ALWAYS / OFTEN / RARELY / NEVER**  Knowledge around serving sizes / AGTH / Macronutrients? |

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| I typically consume \_\_\_\_\_\_ drinks \_\_\_\_\_\_ days/week  Smoker - **Y / N** |

**EXERCISE**

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| How often do you engage in planned physical exercise in a typical week?  **\_\_\_\_\_ days/week**  If active, do you have any specific body composition goals?  Training Session Type/s:  ⃞   Resistance/Weights     ⃞   HIIT     ⃞   Yoga/Pilates     ⃞   Running     ⃞   Cycling  Any food/fluids consumed within 1 hour pre training?: **Y / N**  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Any food/fluids consumed post training?:  **Y / N**              Time frame:  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

**DAILY ROUTINE**

Please briefly describe your daily routine from waking to going to bed:

**SLEEP**

How many hours of sleep (on average) do you achieve per night?\_\_\_\_\_\_\_\_\_\_ If this varies, indicate a range: \_\_\_\_\_\_\_\_\_\_\_

Do you have trouble falling asleep? **Y/N** If yes, are there reasons for this?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How long before bedtime do you stop screen time (i.e. phone, TV)?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_