# Rosenthal Chiropractic

## Natural Medicine Clinic

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## NUTRITION & FITNESS QUESTIONNAIRE

**Name**______________________________ **Phone #**______________________________
**Address**________________________________________________________________

**A. Personal Goals**

1. Have you ever received any nutritional counseling? Please specify why.
   a. Yes________________________________________________________________
   b. No

2. What are your reason(s) for seeking nutrition counseling? Circle all that apply.
   a. Coach, trainer, or doctor suggested it.
   b. Enhance performance.
   c. I am curious about nutritional supplements
      Please specify which one(s)_______________________________________
   d. I want to gain weight. How much?________Lbs.
   e. I want to lose weight. How much?________Lbs.
   f. I want to know what foods to eat prior to, during, and after workouts and competition.
   g. I am curious about proper hydration.
   h. I think I may have an eating disorder.
   i. I want to know what foods will help prevent chronic disease.
   j. Other. Please explain.___________________________________________
      ________________________________________________________________
      _______________________________________________________________.

3. Jot down your personal short- and long-range nutrition, lifestyle and fitness goals and how you plan to achieve them.

   Short Term Goals____________________________________________________
   ________________________________________________________________
   ________________________________________________________________

   Action Plan________________________________________________________
   ________________________________________________________________
   ________________________________________________________________

   Long Term Goals____________________________________________________
   ________________________________________________________________
   ________________________________________________________________

   Action Plan________________________________________________________
   ________________________________________________________________
   ________________________________________________________________

## B. Athletic History

1. Sport(s)________________________________________________________________

2. How long have you participated in the sports listed in question #1?___________________
________________________________________________________________________
________________________________________________________________

3. What level of sports activity do you currently participate in? Please specify what sport(s).
   a. Elementary School____________________________________________________
   b. Junior High School___________________________________________________
   c. High School-Varsity__________________________________________________
   d. High School-Junior Varsity, Frosh, or Soph______________________
   e. Varsity collegiate athletics_____________________________________
   f. Intramural Sports_____________________________________________
   g. Club Sport or Traveling Team_____________________________________________
   h. Park District_________________________________________________________
   i. Recreational_________________________________________________________
   j. Elite or Professional Sports___________________________________________

4. Describe a typical training routine for one week. Include all cardio and strength exercises, including those engaged in outside of practice. Attach training program and race schedule if known.
   Monday__________________________________________________________
   Tuesday_________________________________________________________
   Wednesday_____________________________________________________________
   Thursday______________________________________________________________
   Friday________________________________________________________________
   Saturday________________________________________________________
   Sunday_________________________________________________________________

## C. Nutrition History

1. What is your:
   a. PRESENT HEIGHT________ft_________in
   b. CURRENT WEIGHT___________pounds
   c. BODY COMPOSITION (IF KNOWN):______%
   d. DATE OF BIRTH______________________

2. Have you ever been on a weight loss diet?
   a. Yes, I am currently on a weight loss diet.
      What is your goal weight?____________________________________
   b. Yes, I previously was on a weight loss diet.
      How much weight did you lose?_______________________________________
   c. No, I have never been on a weight loss diet.

3. Check the methods you have used in the past or are currently using for weight control. Check all that apply. If applicable, please indicate how often the behavior(s) was used (i.e., twice a week, once a month, etc.).

| **Weight Control Behavior** | **Currently using How often?** | **Used in past How often?** | **Never used** |
|---|---|---|---|
| Self-induced vomiting | | | |
| Diet pills | | | |
| Fasting | | | |
| Diuretics | | | |
| Fluid restriction | | | |
| Laxatives | | | |
| Excessive exercise | | | |
| Other. Please explain. | | | |

4. Have you ever been diagnosed with anorexia nervosa or bulimia nervosa?
   a. Yes
      Which disorder(s)?____________________________________________________
      At what age?_________________________________________________________
      For how long?________________________________________________________
   b. No

5. Have you ever been on a weight gain diet?
   a. Yes, I am currently on a weight gain diet.
      What is your goal weight?_______________________________________
   c. Yes, I previously was on a weight gain diet.
      How much weight did you gain?_______________________________________
      Was this weight gain maintained?________________________________
   d. No, I have never been on a weight gain diet.

6. Check the methods you have used in the past or are currently using for weight gain. Check all that apply. If applicable, please indicate how often the behavior(s) was used (i.e., twice a week, once a month, etc.).

| **Behavior** | **Currently using How often?** | **Used in past How often?** | **Never used** |
|---|---|---|---|
| Supplements (please specify) | | | |
| Steroids | | | |
| Weight gain powders | | | |
| Increased protein intake | | | |
| Weight lifting | | | |
| Increased food intake | | | |
| Decreased cardiovascular exercise | | | |
| Other (please explain) | | | |

7. Have you ever followed any of the following diet plans? Please indicate whether you used this diet in the past or are currently following this diet plan.
   a. Zone Diet (40% carbohydrate, 30% fat, 30% protein)_______________
   b. Atkin's Diet (high protein, low carbohydrate)_____________________________
   c. Vegetarian_______________________________________________________
      What animal products don't you eat?_____________________________________
   d. All liquid diet____________________________________________________
   e. Other (please explain)_______________________________________________

8. Have you ever been advised to follow a specialized/modified diet? Please explain.
   a. Yes
      What type?____________________________________________________________
      For what?_____________________________________________________________
      Recommended by who?___________________________________________________
      Foods avoided_________________________________________________________
      For how long?_________________________________________________________
   b. No

9. Are you affected by food allergies, or have trouble digesting certain foods? Please explain.
   A. Yes
      What food(s)?_________________________________________________________
   B. No

10. Any food dislikes?______________________________________________________

11. How much water do you usually consume on a daily basis?
   a. 0-3 cups
   b. 4-6 cups
   c. 7-8 cups
   d. 8 or more cups

12. On average, how many servings from the following food groups do you consume each day.

   a. Meat, Fish, Poultry, and Alternatives______________________servings/day
      Examples of 1 serving: 3 oz. cooked meat, fish or poultry (about the size of a deck of cards); 1 cup dried beans, ½ cup nuts, 2 TBSP peanut butter; 100 grams tofu

   b. Milk, Yogurt, & Cheese________________________________servings/day
      Examples of 1 serving: 1 cup milk/yogurt, 1.25 oz. natural cheese, 2 oz. processed cheese, ½ cup cottage cheese, ½ cup ice cream/frozen yogurt

   c. Vegetables__________________________________________servings/day
      Examples of 1 serving: 1 cup of leafy greens, ½ cup chopped raw/cooked vegetables, ¾ cup
      vegetable juice, ¾ cup tomato sauce

   d. Fruits______________________________________________servings/day
      Examples of 1 serving: ½ cup fruit juice, 2 small fruits (apricots, plums), ¼ cup raisins, whole medium fruit (apple, peach, banana), ½ cup cherries or grapes

   e. Grain Products_______________________________________servings/day
      Examples of 1 serving: 1 slice bread, 1 medium pancake/waffle, 1 tortilla, 4-6 crackers, ¾ cup cereal, ¾ cup oatmeal/cream of wheat, 1.5 cups popcorn, ½ cup cooked rice, ½ bagel, ½ cup pasta

13. Is your diet low in calcium? You **rarely** drink at least 3 cups of milk daily, or eat at least 3 servings of dairy products to get 1,000-1,200 mg of calcium from dietary sources (1 serving=1 cup milk, 1.25-2 oz. cheese).
    a. Yes
       For how long?
       1. just currently
       2. since I was a child
       3. only during my childhood
       4. my whole life
    b. No

14. Do you regularly consume caffeinated beverages (soft drinks-regular and diet, caffeinated coffee or caffeine-containing drugs-Vivarin, Anacin, Excederin, Dextrim)?
    a. Yes
       For how long?
       1. just currently
       2. since I was a child
       3. only during my childhood
       4. my whole life
    b. No

15. Do you regularly consume alcoholic beverages (2 or more servings per day)?
    a. Yes
    b. No

16. Describe your consumption of sports drinks (i.e., Gatorade, Powerade, All Sport)
    a. Often
    b. Sometimes
    c. Rarely
    d. Never

17. Describe your consumption of sports bars (i.e., Powerbar, Cliff Bar, Met-Rx, Balance)?
    a. Often
    b. Sometimes
    c. Rarely
    d. Never

18. Are you currently taking any nutritional supplements? Please explain.
    a. Yes
       What type(s)?____________________________________________________________
       ____________________________________________________________________
       ____________________________________________________________________
       ____________________________________________________________________
       ____________________________________________________________________
       Dosing pattern____________________________________________________________
       For how long?____________________________________________________________
       For what reason?_________________________________________________
    b. No

19. Circle any medications/drugs you have used. Please specify whether medication/drug was previously used or is currently being used.
    a. Anabolic steroids______________________________________________
    b. Antacids______________________________________________________
    c. Tetracyclin antibiotics______________________________________________
    d. Anticonvulsants______________________________________________
    e. Corticosteroids or glucocorticoids________________________________
    f. Thiazide diuretics_____________________________________________
    g. Estrogen or Hormone Replacement________________________________
    h. Insulin______________________________________________________
    i. Other______________________________________________________

## D. History of athletic injury

1. How would you rate your present fitness? Please explain.
    a. Poor______________________________________________________
    b. Fair______________________________________________________
    c. Good______________________________________________________
    d. Excellent___________________________________________________

2. Have you ever experienced dizziness or mental confusion during a workout or competition?
    a. Yes
       How often does this occur?____________________________________
    b. No

3. Have you ever "hit the wall" during a long training workout or competition?
    a. Yes
       How often does this occur?
    b. No

4. Are you currently being treated for an athletic injury? Please explain.
    a. Knee______________________________________________________
    b. Shoulder___________________________________________________
    c. Hip_______________________________________________________
    d. Foot______________________________________________________
    e. Leg_______________________________________________________
    f. Spine______________________________________________________
    g. Other______________________________________________________

5. Have you ever been treated for an athletic injury? Please explain.
    a. Knee______________________________________________________
    b. Shoulder___________________________________________________
    c. Hip_______________________________________________________
    d. Foot______________________________________________________
    e. Leg_______________________________________________________
    f. Spine______________________________________________________
    g. Other______________________________________________________

6. Have you ever been diagnosed as having low bone mass? Please specify.
    a. Yes, I have been diagnosed with
        1. low bone mass
        2. osteopenia
        3. osteoporosis
       What age?____________________________________________________

b. No, my bone mineral density is normal.
c. I have never had my bone mineral density tested.

7. Have you ever had a stress fracture? Please explain.
   a. Yes
      How many?______________________________________________________
      At what sites?___________________________________________________
      When?__________________________________________________________
   b. No

**E. Hormone-Related Health** *(Females only)*

1. At what age did you begin menstruating?_________________________________

2. Have your menstrual periods ever been irregular or inconsistent? Please explain.
   a. Yes, they are currently irregular
      For how long?___________________________________________________
      How often do you get your period (every other month, every 6 months)?_______
      ______________________________________________________________________
   b. Yes, they were irregular in the past
      At what age?____________________________________________________
      For how long?___________________________________________________
      How so?_____________________________________________________
   c. No, they have never been irregular or inconsistent

3. Has your menstrual cycle been absent for 3 or more consecutive months for reasons other than pregnancy? If yes, please specify for how long.
   a. Yes, my menstrual cycle has currently been absent for_______________months.
   b. Yes, my menstrual cycle was previously absent for__________months.
   c. No, my menstrual cycles have never been absent for 3 or more consecutive months.

4. Please check the appropriate box(s).
   **Previous** yearly menstrual schedule (following menarche or your first menstrual period).
   a. 0-3 menstrual cycles per year
   b. 4-9 menstrual cycles per year
   c. 10+ menstrual cycles per year

   **Current** yearly menstrual schedule
   a. 0-3 menstrual cycles per year
   b. 4-9 menstrual cycles per year
   c. 10+ menstrual cycles per year

5. Have you ever been diagnosed with any menstrual/gynecological problems (i.e., endometriosis)? Please specify.
   a. Yes, I am currently affected with_________________________________
   b. Yes, in the past, I was affected with_______________________________
   c. No, I have never been diagnosed with any menstrual/gynecological problems.

6. Have you ever used oral contraceptives (birth control pills)?
   a. Yes, I am currently taking oral contraceptives.
      For what reason(s)?______________________________________________
   b. Yes, I previously took oral contraceptives.
      At what age(s)?_________________________________________________
      For what reason(s)?______________________________________________
   c. No, I have never used oral contraceptives