

# 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 \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

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**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. 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. Fit for life \_\_\_\_\_
- f. Eat Right for Your Type \_\_\_\_\_
- g. South Beach Diet \_\_\_\_\_
- h. The Maker's Diet \_\_\_\_\_
- i. 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 glasses (0-24 ounces)
- b. 4-6 glasses (36-48 ounces)
- c. 7-8 glasses (56-64 ounces)
- d. 8 or more cups (64 ounces plus)
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 like 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 (1 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