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### Sports Nutrition Data Collection Form

Name: \_\_\_\_\_ Date: \_\_\_\_\_

Address: \_\_\_\_\_  
\_\_\_\_\_

Phone: (day) \_\_\_\_\_ (evening) \_\_\_\_\_ (cell) \_\_\_\_\_

E-Mail: \_\_\_\_\_

Occupation: \_\_\_\_\_

Normal work hours: \_\_\_\_\_

Age: \_\_\_\_\_ Height: \_\_\_\_\_ (cm) \_\_\_\_\_ Weight: \_\_\_\_\_ (Kg) \_\_\_\_\_

BMI \_\_\_\_\_ Shaded areas are for office use.

Male/Female

Weight goal: \_\_\_\_\_

$M = 66 + (13.7 * \text{kg}) + (5 * \text{cm}) - (6.8 * \text{years})$

$F = 655 + (9.6 * \text{kg}) + (1.7 * \text{cm}) - (4.7 * \text{years})$

\_\_\_\_\_ \* \_\_\_\_\_ = \_\_\_\_\_  
Measured Resting Energy Expenditure    Activity Factor    Total Calories

\_\_\_\_\_  
Calories to maintain / lose / gain weight

#### Personal Meal Plan Daily Totals

\_\_\_\_\_ Starch \_\_\_\_\_ g Carbohydrate \_\_\_\_\_ %  
\_\_\_\_\_ Vegetable \_\_\_\_\_  
\_\_\_\_\_ Fruit \_\_\_\_\_ g Protein \_\_\_\_\_ %  
\_\_\_\_\_ Milk \_\_\_\_\_  
\_\_\_\_\_ Meat (Protein) \_\_\_\_\_ g Fat \_\_\_\_\_ %  
\_\_\_\_\_ Fat \_\_\_\_\_

## Nutrition Summary Sheet

Sport played \_\_\_\_\_

Reason for nutrition  
counseling \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Weight History: Please indicate past weight gain/loss cycle(s).  
(e.g. Gained 15 lbs. over 5 years. Lost 5 lbs. in past 2 months.)

Medical History: (e.g. kidney stones, high blood pressure, thyroid condition,  
diabetes, heart disease etc.)

Indicate laboratory values if known:

Chol \_\_\_\_\_

Glucose \_\_\_\_\_

MCV \_\_\_\_\_

Triglyceride \_\_\_\_\_

HDL \_\_\_\_\_

Hemoglobin \_\_\_\_\_

LDL \_\_\_\_\_

Medications: List all medications that you currently take (do not include  
supplements in this section)

Have any members of your family had: (Check all that apply)

- Obesity                       Diabetes                       Heart Disease
- Cancer, type\_\_\_\_\_  High Cholesterol     High Blood Pressure
- High Triglyceride             Stroke                       Hypothyroid

Do you have any food allergies or intolerances?     Yes     No

Specify:\_\_\_\_\_

Do you have concerns with:		If yes, explain?
Constipation	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Diarrhea	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Indigestion	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Heartburn	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Gas	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Appetite	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____

Do you consume caffeinated Beverages? (e.g. coffee, tea, energy drinks, Redbull, sports supplement, soda)

Yes     No

Type(s) / how often:

\_\_\_\_\_

\_\_\_\_\_

Do you take any vitamin, mineral, herbal, or food supplements? (e.g. Energy bars, protein drinks, protein bars, meal replacements)

Yes     No

Type(s) / how often:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Who usually does the grocery shopping?

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What do you look for on nutrition labels?

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### Diet History

*The following questions are about your typical eating pattern:*

How many days per week do you eat (Breakfast) \_\_\_\_\_ (Lunch) \_\_\_\_\_  
(Dinner) \_\_\_\_\_

How often do you snack? ( ) Once daily ( ) Twice daily ( ) Three times  
daily ( ) More than three times daily

When do you usually snack?

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What is a typical snack you choose?

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Do you eat out? ( ) Yes ( ) No How often per week?

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Which restaurant (s) do you usually choose?

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Do you drink beer, wine, or mixed drinks (beverages containing alcohol)?

( ) Yes ( ) No

If yes, indicate type of alcohol containing beverage you drink.

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Number of beverages per week: \_\_\_\_\_

When do you drink? \_\_\_\_\_

Do you smoke?  Yes  No

How many hours of sleep do you get a night? \_\_\_\_\_

Do you eat when you feel: (circle all that apply)

Happy          Lonely  
Sad              Bored  
Stressed      Anxious      Other: \_\_\_\_\_

What foods do you typically eat when you feel this way? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Do you have a concern with:

Binging  Yes  No

Purging  Yes  No

Compulsive Eating  Yes  No

Night time snacking  Yes  No

Social eating (parties etc.)  Yes  No

Describe your concerns identified above in further detail \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Where / how do you eat the following meals on a typical day: (Circle all that apply)

Breakfast: At the kitchen table  
Watching TV  
In the car  
Standing up  
At work  
Restaurant/ fast food  
Do not eat breakfast

Lunch: At the kitchen table  
Watching TV  
In the car  
Standing up  
At work  
Restaurant/ fast food  
Do not eat lunch

Dinner: At the kitchen table  
Watching TV  
In the car  
Standing up  
At work  
Restaurant/ fast food  
Do not eat dinner

Snacks: At the kitchen table  
Watching TV  
In the car  
Standing up  
At work  
Do not eat snacks

Do you eat with others?  Yes  No

Do you cook?  Yes  No

Who usually prepares the food at home?

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What activities / hobbies do you have?

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Are you active in day to day life other than training? ( ) Yes ( ) No

Specify:

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What are your favorite foods?

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What foods do you dislike?

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What would you like to change about your eating habits?

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Do you follow any special diet restrictions (e.g. vegetarianism etc.)?

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## FOOD FREQUENCY QUESTIONNAIRE

How often do you eat the following foods **per week**?

Food	Times Per Week	Food	Times Per Week	Food	Times Per Week
Eggs		Bread		Sweets	
Cheese		Nuts		Ice Cream	
Milk (Specify)		Rice/Pasta		Water	
Yogurt		Beans		Coffee/Tea	
Cottage Cheese		Bacon/Sausage		Carbonated Beverages	
Pizza		Potatoes		Energy Drinks	
Red Meat		Sweet Potatoes		Alcohol	
Chicken/Turkey		Frozen Dinners		Fruit Juice	
Fish		Fried Foods		Vegetables	
Soy Products		Restaurants		Corn, Peas, Lima Beans	
Luncheon Meat		Fast Food/Take out		Dietary Supplements	
Hotdogs		Salty Snacks		Ethnic Foods (Explain)	
Oatmeal/ oat bran		Margarine/Butter		Other:	

### 24-Hour Recall

Please indicate what you eat and drink on a "typical day."

	Time of Day	Food eaten (Please describe and include quantity of each item)
<b>Breakfast</b>		
<b>Lunch</b>		
<b>Dinner</b>		
<b>Snacks</b>		

## Training Protocol

Please describe your typical weekly training in the chart below or attach your current training regimen.

	Time of Day	Describe Exercise	Duration	RPE*
Sunday				
Monday				
Tuesday				
Wednesday				
Thursday				
Friday				
Saturday				

\*RPE is Rating of Perceived exertion: One a scale of 1-10 rank your effort where 0=nothing, 1=very weak, 2=weak, 3=moderate, 4=somewhat strong, 5=strong, 7=very strong, 10=very, very strong (maximal)