EAT IT. WEAR IT.

NUTRITION ASSESSMENT FORM

The purpose of this assessment is to inform and educate. It is designed to assess your symptoms that may be due to a nutritional and/or lifestyle imbalance. The services and suggestions are always intended to help with your general feelings of wellness and are in no way meant to diagnose or treat any disease. If you believe that you might have a health problem that requires medical attention, please see your physician. Please complete this assessment and try to send or deliver it to me as soon as possible. All information provided on this form will be kept strictly confidential.

Personal Profile Information

Name:	Gender: ☐ M ☐ F	DOB: / /	Marital Status:
Address:	Phone:		# of Children:
	Email:		
	Occupation:		

Emergency Contact Information

Name:	Relationship:	Phone:

How did you learn of us? _

In order of importance to you, what are your main goals or concerns? _

Fitness Factors: Physical Activity Screening

☐ Yes ☐ No Has your physician ever told you that you have a heart condition?

☐ Yes ☐ No Do you ever experience pain in your chest when you are physically active?

☐ Yes ☐ No In the past month, have you experienced chest pain when not performing physical activity?

☐ Yes ☐ No Do you lose your balance because of dizziness or do you ever lose consciousness?

☐ Yes ☐ No Have you ever had any pain or injuries (ankle, knee, hip, back, shoulder, etc.)?

☐ Yes ☐ No Do you have a bone/joint problem that could be aggravated by a change in your level of physical activity?

☐ Yes ☐ No Have you had any surgeries?

If yes, please explain: _

☐ Yes ☐ No Is your physician currently prescribing medications for your blood pressure or heart condition?

☐ Yes ☐ No Do you know any other reason why you should NOT participate in a physical activity program?

If you answered YES to any of the above questions, EAT IT. WEAR IT requires that you consult with your physician and obtain a completed and signed Physician's Statement & Clearance Form, before participating in any physical assessments or activity of any kind.

Height: ft. in.	Waist Circumference:		Current Weight:	Goal Weight:
RMR:	TEE:	Current Lean %:	Current Body Fat %:	Goal Body Fat %:

Lifestyle/Professional Activity

How would you rate the activity-level of your profession, or what you do during the day (non-exercise related)?

☐ Sedentary ☐ Moderately Active ☐ Active ☐ Very Active

Weekly Exercise Information

Explain in detail what type of resistance exercises, cardio, or sports activities you perform on average during a 7-day period.

Exercise/Activity	Days per Week	Duration

Occupational Questions

☐ Yes ☐ No Do you have an occupation? If so, what type? _____

☐ Yes ☐ No Does your occupation require extended periods of sitting?

☐ Yes ☐ No Does your occupation require extended periods of repetitive movements? If yes, please explain.

☐ Yes ☐ No Does your occupation require you to wear shoes with a heel (dress shoes)?

☐ Yes ☐ No Does your occupation cause you anxiety (mental stress)?

☐ Yes ☐ No Does your occupation require traveling away from home? If yes, please explain.

Recreational Questions

☐ Yes ☐ No Do you partake in any recreational activities (golf, tennis, skiing, other)? If yes, please explain.

☐ Yes ☐ No Do you have any hobbies (reading, gardening, working on cars, other)? If yes, please explain.

General Health History Questions

☐ Yes ☐ No Have you ever experienced a stroke?

☐ Yes ☐ No Do you have asthma or another respiratory condition? If yes please describe.

☐ Yes ☐ No In the past 6-months, have you experienced back pain or discomfort that prevented you from carrying out normal daily activities?

Dietary Factors: Protein

Which **best** describes you? ☐ Sedentary Adult ☐ Exercising Adult ☐ Competitive Athlete

☐ Adult Building Muscle ☐ Teenage Athlete ☐ Athlete Restricting Calories ☐ _____

Body Type

Which of the following statements best describes you?

- ☐ I can eat practically anything I want and I do not gain weight. I find it very hard to gain weight.
- ☐ I can lose or gain weight just by adjusting my activity level and eating habits.
- ☐ I find it difficult to lose weight. I can gain weight easily and have to watch what I eat.

Dietary Factors

How many **meals** do you have per day and when? _____

How many **snacks** do you have per day and when? _____

Do you usually eat meals: ☐ With Family ☐ With Friends ☐ Home Alone ☐ Fast Food ☐ While Multitasking ☐ On the Run ☐ Restaurant ☐ In Front of the TV

What do you usually drink with meals? _____ Average Quantity? _____

Do you feel that there are restrictions on your diet? _____

Are you a meat eater, mostly vegetarian, or vegan? _____

What foods do you crave, if any? _____

Do you avoid certain foods? If so, what are they and why do you avoid them? _____

_____

Do you experience any symptoms after meals? If so, please explain. _____

_____

How many ½ cup servings of each do you typically eat in a day?

____ Fresh Fruit ____Dried Fruit_____Canned Fruit_____Raw Vegetables ____Cooked Vegetables

____ Whole Grains ____Protein Please Specify: _____

____ Dairy Products Please Specify: _____

____ Other Please Specify: _____

How many 1 cup servings of each do you typically drink in a day?

____ Coffee____Tap Water ____Bottled Water_____Fruit Juices_____Vegetable Juice____Fresh Juice

____ Tea ____Herbal Tea_____Whole Milk ____Skim Milk ____1-2% Milk ___Fruit Drinks

____ Beer ____Red Wine ____White Wine ____Soft Drinks ____Diet Soft Drinks_____Hard Liquor

____ Other - Please Specify: _____

How often do you eat these refined foods?

	Never	Rarely	Occasionally	Often
Deli Meats	☐	☐	☐	☐
Fried Foods	☐	☐	☐	☐
Fast Food	☐	☐	☐	☐
Nutra-sweet, etc.	☐	☐	☐	☐
Refined Flour Products	☐	☐	☐	☐
Chips/Salty Snacks	☐	☐	☐	☐
Margarine	☐	☐	☐	☐
Candy/Chocolate	☐	☐	☐	☐

Lifestyle Factors

What time do you usually go to bed?_____ What time do you usually wake up? _____

How do you usually feel when you awaken? _____

What is the level of stress in your life? ☐ Minimal ☐ Average ☐ Considerable ☐ Unbearable

What are the main sources of stress in your life? ☐ Career ☐ Finances ☐ Health ☐ Personal

☐ Unfulfilled Expectations ☐ Relationship ☐ Family ☐ Spiritual ☐ Other _____

Have you experienced any trauma or loss in the last 5 years? _____

How does your stress manifest itself? _____

How do you cope with stress? _____

Do you participate in any spiritual discipline (church, meditation, spiritual group etc.)? _____

Medical History

What are your current medications? _____

What are your reasons for taking them? _____

What vitamins, minerals, herbal and homeopathic remedies do you take? _____

What doses and frequency? _____

Do you have any known allergies or sensitivities? If so, please explain: _____

Have you ever been hospitalized and for what reason? _____

How often do you have a bowel movement? _____

Do you ever experience constipation or diarrhea? _____

Have you noticed a connection to certain food(s) or circumstances? _____

Have you ever had a bone density test? If so, what were the results? _____

Are you pregnant, pre-menopausal, or menopausal? _____

If so, what symptoms do you experience? _____

Do you experience PMS? If so, what symptoms do you experience? _____

Check all those medical conditions that apply:

☐ Heart Disease ☐ Anemia ☐ Lactation ☐ Hypertension ☐ Hypoglycemia

☐ Pancreatic Disease ☐ Diabetes ☐ Asthma ☐ Kidney Disease ☐ Liver Disease

☐ Other: Please Specify _____

Family History Hereditary Diseases (**F** for Father, **M** for Mother, **S** for sibling, **G** for Grandparent, **O** for Other)

____ Mental Illness ____Diabetes____Allergies____Hypertension ____Hypoglycemia

____ Intestinal Disease ____Ulcers ____Asthma ____Heart Disease ____Kidney Dysfunction

____ Kidney Disease ____Arthritis____Cancer, Type? _____

____ Other: Please Specify _____

Symptom Assessment

Indicate how often you've experienced the following, in the last 3 months.	Mild/ Rarely Occurs	Moderate/ Regularly Occurs	Severe/ Occurs Often	N/A
General Fatigue or Weakness	☐	☐	☐	☐
Difficulty Losing Weight	☐	☐	☐	☐
Illness/Infections	☐	☐	☐	☐
High Stress Lifestyle	☐	☐	☐	☐
Smoking	☐	☐	☐	☐
Drink More than 2 Cups of Coffee in a Day	☐	☐	☐	☐
Bad Breath and/or Body Odor	☐	☐	☐	☐
Constipation	☐	☐	☐	☐
Bags Under Eyes	☐	☐	☐	☐
Cravings for Sugar, Bread, or Alcohol	☐	☐	☐	☐
Difficulty Digesting Certain Foods	☐	☐	☐	☐
Used Antibiotics (in the Last 10 Years)	☐	☐	☐	☐
Allergies	☐	☐	☐	☐
Poor Concentration or Memory	☐	☐	☐	☐
Belching or Burping After Meals	☐	☐	☐	☐
Skin/Complexion Problems	☐	☐	☐	☐
Red Meat Consumption	☐	☐	☐	☐
Dairy Product Consumption	☐	☐	☐	☐
Exposure to Toxins/Chemicals	☐	☐	☐	☐
Mood Swings	☐	☐	☐	☐
Depressed and/or Irritable	☐	☐	☐	☐
Brittle Fingernails	☐	☐	☐	☐
Dry, Brittle Hair and/or Split Ends	☐	☐	☐	☐
High Fat/High Cholesterol Diet	☐	☐	☐	☐
Nervousness/Anxiety/Tension/Worry	☐	☐	☐	☐
Insomnia/Restless Sleep	☐	☐	☐	☐
Low Fiber Diet	☐	☐	☐	☐
Muscle Cramps	☐	☐	☐	☐
Sleepy When Sitting Up	☐	☐	☐	☐
Female: Menstrual Cramps	☐	☐	☐	☐
Bronchitis/Asthma/Pneumonia/Emphysema	☐	☐	☐	☐
Cellulite	☐	☐	☐	☐
Cold Hands/Feet	☐	☐	☐	☐
Varicose Veins	☐	☐	☐	☐
Feeling Out of Control	☐	☐	☐	☐
Food/Chemical Sensitivities	☐	☐	☐	☐
Yeast/Fungus Problems	☐	☐	☐	☐
Easily Broken Bones/Osteoporosis	☐	☐	☐	☐
Little to No Exercise	☐	☐	☐	☐
Excessive Mucus	☐	☐	☐	☐
Shortness of Breath Climbing Stairs	☐	☐	☐	☐
Tingling in Lips, Fingers, Arms, Legs	☐	☐	☐	☐

Symptom Assessment Continued

Indicate how often you've experienced the following, in the past 3 months	Mild/ Rarely Occurs	Moderate/ Regularly Occurs	Severe/ Occurs Often	N/A
Chest Pains	☐	☐	☐	☐
Very Rapid or Slow Heart Beat	☐	☐	☐	☐
Painful, Hard, or Thin Bowel Movements	☐	☐	☐	☐
Alternating Constipation/Diarrhea	☐	☐	☐	☐
Bladder Infections	☐	☐	☐	☐
Female: Menopause/Hot Flashes	☐	☐	☐	☐
Female: PMS	☐	☐	☐	☐
Difficulty Urinating	☐	☐	☐	☐
Swollen Glands/Puffy Throat	☐	☐	☐	☐
Lower Abdominal Pain	☐	☐	☐	☐
Frequent Urge to Urinate	☐	☐	☐	☐
Joint Pain	☐	☐	☐	☐
Sinus Inflammation/Discharge	☐	☐	☐	☐
Arthritis	☐	☐	☐	☐
Sudden Weight Gain/Loss	☐	☐	☐	☐
Headaches/Migraines	☐	☐	☐	☐
Female: Taking Birth Control Pills	☐	☐	☐	☐
Lower Back Pain	☐	☐	☐	☐
Dry, Flaky Skin	☐	☐	☐	☐
Drink Less than 6 Glasses of Fluids Per Day	☐	☐	☐	☐
Water Retention	☐	☐	☐	☐
Low Sex Drive	☐	☐	☐	☐
Feeling Heavy/Bloated After Meals	☐	☐	☐	☐
Chronic Cough	☐	☐	☐	☐

Is there anything else you would like to share with us regarding your symptoms? _

Have you ever been placed on any type of nutritional program in the past? ☐ Yes ☐ No
If so, by whom and what did it consist of? _

What were your results? _

Have you ever had your body fat tested? ☐ Yes ☐ No If so, how was it tested and when? _

Are you currently working with a Personal Trainer? ☐ Yes ☐ No If so, who? _

Client Statement:

I understand and acknowledge that the services provided are at all times restricted to consultation on the subject of health matter is intended for general well-being and are not meant for the purposes of medical diagnosis, treatment, or prescribing of medicine for any disease, or any licensed or controlled act which may constitute the practice of medicine. This statement is being signed voluntarily. All information contained in this form will be kept strictly confidential.

Signature:_____Date: _____

Terms & Conditions: Amounts paid under this agreement are nonrefundable. Basic Meal Plans must be picked up within 30-days of completion notification or they are forfeited. If you do not cancel a scheduled session at least 24 hours in advance, the session cost is non-refundable. You will be responsible for the cost of any missed sessions. I have read this agreement thoroughly and understand the terms. My participation in the selected activities and my execution of this agreement are both purely voluntary and I elect to do so despite the risks.

I,_____agree to allow EAT IT. WEAR IT. professionals to design a comprehensive nutrition program for me to enhance my health and fitness goals. I will follow that program to the best of my ability and I will not hold EAT IT. WEAR IT. professionals or any related persons or parties personally liable for any problems, illnesses, or injuries that might occur due to a sudden change in my nutrition, or lifestyle habits. I understand that EAT IT. WEAR IT. professionals are not medical practitioners. This nutrition program does not replace the expert advice or medical treatment of my own private doctor. I have given the EAT IT. WEAR IT. professionals all the necessary information about myself to prevent any possible complications.

Print Name: _____

Signature: _____ Date: _____

FOUR-DAY FOOD JOURNAL

Please be sure to eat as you normally do, then accurately record your dietary intake below. Record your first day over the shadowed example. Please email or text me if you have any questions.

Day 1 - WEEKDAY - ☐ Monday ☐ Tuesday ☐ Wednesday ☐ Thursday ☐ Friday Date:_____			
Time of Day	Type of Food	Quantity	Thoughts & Feelings Before/After
8am	Strawberries	1 Cup	Still/Not hungry
	Orange, Dry Toast	1, 2 Pieces	
	Coffee with Soy Milk	2 Cups, ⅔ Cups	
12:30pm	Canned Tuna	3 Ounces	
	Romaine Lettuce	3 Leaves	
	Tomato	1 Medium	
	Chocolate Chip Cookie	2	
2pm	Apple	1 Large	Fading/Energized
6:30pm	Spaghetti with Meat Sauce	1 Cup, ½ Cup	
	Broccoli	1 Cup	
	Garlic Cheese Bread	2 Slices	
8pm	Vanilla Ice Cream	½ Cup	Guilty/Assured

Day 2 - WEEKDAY - ☐ Monday ☐ Tuesday ☐ Wednesday ☐ Thursday ☐ Friday Date:_____			
Time of Day	Type of Food	Quantity	Thoughts & Feelings Before/After

FOUR-DAY FOOD JOURNAL

Day 3 - WEEKDAY - ☐ Monday ☐ Tuesday ☐ Wednesday ☐ Thursday ☐ Friday Date:_____

Time of Day	Type of Food	Quantity	Thoughts & Feelings Before/After

Day 4 - WEEKEND - ☐ Saturday ☐ Sunday Date:_____

Time of Day	Type of Food	Quantity	Thoughts & Feelings Before/After

WRITE IN: FOOD PREFERENCES, ALLERGIES, AND SENSITIVITIES

FISH • POULTRY (EGGS) • MEAT • MAMMALS

LIKE	DISLIKE

WHOLE GRAINS • STARCHES

LIKE	DISLIKE

VEGETABLES

LIKE	DISLIKE

FRUIT VEGETABLES

LIKE	DISLIKE

FRUITS • NUTS

LIKE	DISLIKE

MISCELLANEOUS • TEXTURAL PREFERENCES • SPICE PREFERENCES

LIKE	DISLIKE

ALLERGIES • SENSITIVITIES
