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Sports Medicine & Rehabilitation

NUTRITION INTAKE FORM

CONTACT INFORMATION

Last Name: _____ First Name: _____

Date of Birth: _____ Age: _____

Sex: ☐Male ☐Female Ethnicity: _____

Occupation: _____

Marital Status: _____ No. of Dependents: _____

Address: _____ Apt. #_____

City: _____ Province:_____

Postal Code: _____ Email: _____

Telephone: (home)_____(work) _____

Telephone: (cell)_____

Preferred form of contact for reminder/follow-up calls:
☐Home ☐Work ☐Email ☐Other – Please specify _____

Emergency Contact Name: _____

Relation: _____Telephone: _____

Name of Medical Doctor: _____

Address: _____

City: _____ Telephone: _____

Were you referred to me, if so by whom so we can thank them? _____

_____

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MAIN HEALTH CONCERN

Please list you main health concerns in order of importance:

1.
2.
3.

What areas would you like to focus on in your first session?

_____

_____

_____

Cardiovascular ☐ High blood pressure ☐ High cholesterol ☐ Heart attack ☐ Stroke ☐ Angina ☐ Heart arrhythmia's	Digestive/ Gastrointestinal ☐ GERD/acid reflux ☐ Ulcers ☐ Crohn's ☐ Colitis ☐ IBD ☐ IBS ☐ Hernia ☐ Diverticulitis	Respiratory ☐ Asthma ☐ COPD (bronchitis, emphysema) ☐ Frequent sinus infections ☐ Environmental allergies	Neurobehavioral ☐ Anxiety ☐ Depression ☐ Frequent migraines ☐ Frequent headaches ☐ Dementia/Alzheimer's ☐ Multiple Sclerosis ☐ ADD/ADHD ☐ Autism spectrum disorder ☐ Seizures ☐ Eating disorder
Genitourinary ☐ Frequent urinary tract infections ☐ Frequent yeast infections ☐ Urinary incontinence ☐ Kidney stones ☐ Prostate ☐ Frequent constipation ☐ Frequent diarrhea ☐ Irregular menses	Endocrinological/ Immunological ☐ Diabetes Type 1 or Type 2? ☐ Autoimmune disease ☐ Thyroid dysfunction High or Low? ☐ Cancer. If yes, where:	Musculoskeletal ☐ Joint pain, stiffness ☐ Arthritis ☐ Osteoporosis ☐ Osteopenia ☐ Fibromyalgia	Other: ☐ Skin conditions (acne, eczema, psoriasis) ☐ Surgery ☐ Accident/injury

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PAST MEDICAL HISTORY

Antibiotic use in the past 5 years?

- ☐ Yes
- ☐ No

Are you seeking treatment from other health care practitioners? (alternative or otherwise). If yes, explain.

_____

LIFESTYLE

STRESS

How would you rate your stress levels?

1 2 3 4 5 6 7 8 9 10

What causes your stress?

_____

How does your stress manifest itself?

_____

_____

Do you use any coping mechanisms? If so, explain.

_____

_____

How would you rate your happiness?

1 2 3 4 5 6 7 8 9 10

What makes you happy?

_____

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How would you rate your energy levels?
1 2 3 4 5 6 7 8 9 10

Do you experience any lulls or highs throughout the day? If so, when?

SLEEP

How many hours of sleep do you get on average?

- ☐ Do you have trouble falling asleep
- ☐ Staying asleep

Do you wake at any specific times?

- ☐ Yes, what time?
- ☐ No

Do you wake feeling rested?

- ☐ Yes
- ☐ No

Do you take naps?

- ☐ Yes
- ☐ No

NUTRITION

Are you following a specific diet or menu plan? Yes if, why?

- ☐ Vegan
- ☐ Vegetarian
- ☐ Paleo
- ☐ Gluten free
- ☐ Other:

Do you avoid certain foods?

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Do you have any adverse reactions to foods? Explain.

_____

_____

How many meals or snacks do you consume per day? _____

How many cups of caffeinated beverages (pop, coffee, tea) do you consume per day? _____

How many alcoholic beverages do you consume per week? _____

Please check any of the following that apply:

☐ Love to eat	☐ Frequent restaurants and fast food meals
☐ Love to cook	☐ Confused about healthy food/nutrition
☐ Emotional eater	☐ Make poor snack choices
☐ Late night eater	☐ Live alone
☐ Struggling with eating issues	☐ Do not have time/knowledge to plan meals and menus
☐ Dislike cooking	☐ Busy schedule
☐ Do not know how to cook	☐ Travel eating
☐ I often forget to eat or skip meals	☐ Fast eater
☐ I am hungry all of the time	☐ Erratic eating patterns
☐ I only eat because I have to	☐ Regularly use artificial sweeteners
☐ Chronic over/under eating	☐ Yo-yo dieter
☐ Relying on convenience foods	☐ Eat out of boredom
☐ Frequent microwave use	
☐ Stress eating	
☐ Distracted eater (in front of TV, at desk, multitasking)	

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3 DAY FOOD LOG

Please complete a three-day food log with any foods and liquids that you consume

DAY 1	DAY 2	DAY 3
Breakfast	Breakfast	Breakfast
Lunch	Lunch	Lunch
Dinner	Dinner	Dinner
Snacks	Snacks	Snacks
BEVERAGES Water: cups Coffee/tea: cups Pop: Juice: Beer/wine/spirits: Other: Supplements:	BEVERAGES Water: cups Coffee/tea: cups Pop: Juice: Beer/wine/spirits: Other: Supplements:	BEVERAGES Water: cups Coffee/tea: cups Pop: Juice: Beer/wine/spirits: Other: Supplements:

TRANSIT TIME TEST-Please complete and return results with paperwork

Swallow 1 heaping tablespoon of whole sesame or flax seeds with water (do not chew). Document time of ingestion. Monitor bowel movements and document time of elimination.

Ingestion: _____ AM/PM *Day/month/year*

Elimination: _____AM/PM *Day/month/year*

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ACKNOWLEDGEMENT AND INFORMED CONSENT

I would like to take this opportunity to welcome you. This paradigm utilizes the principles of holistic nutrition to assist the body's own ability to heal and to improve the quality of life and health through natural means. I will conduct a detailed case history, conduct a physical exam and may utilize specific foods and nutrients as part of the treatment work-up. Some treatments or procedures may include: nutrition, personal training, cooking demonstrations and, lifestyle counseling.

All female patients must inform the doctor if they know or suspect that they are pregnant; as some of the therapies used could present a risk to the pregnancy.

As a client of Shift Happens I have read the information and understand that the form of medical care is based on holistic nutrition and other supportive principles and practices. I also understand that a record will be kept of the health services provided to me. This record will be kept confidential and will not be released to others unless so directed by myself or unless it is required by law.

In order to comply with the regulations as set out in the Personal Information Protection and Electronic Documents Act (PIPEDA), the following policy has been developed. All health care professionals are all trained in the appropriate uses and protection of your information.

I also confirm that I have the ability to accept or reject this care of my own free will and choice and that I am not an agent of any private, local, county, provincial, or federal agency attempting to gather information without so stating. I accept full responsibility for any fees incurred during care and treatment.

Full Name (please print):_____

Signature: _____ Date: _____

Witness _____ Date: _____

Print parent/guardian's name _____

Signature of parent/guardian _____