IRON QUEEN
FITNESS

Nutrition Assessment Form

First Name _____ Last Name_____

Cell (_____)_____-_____ Email: _____

Age _____ Sex: _____ Birth Date _____/_____/_____

Marital Status_____ Do you have children? Yes No

Are you pregnant? Yes No If yes, due date_____ Age of children_____

Nutrition Readiness Assessment

My food and nutrition-related goals are:

_____

_____

_____

Three things I would like to change about my current health/nutrition lifestyle:

1. _____
   _____
2. _____
   _____
3. _____
   _____

The nutrition/eating habits that are most challenging for me:

_____

_____

In the past, I have tried the following techniques, diets, behaviors, etc. to change my nutrition habits:

_____

_____

_____

On a scale of 1 (not willing) to 5 (very willing), please indicate your readiness/willingness to do the following:

To improve your health, how ready/willing are you to…	1	2	3	4	5
Significantly modify your diet					
Take nutritional supplements each day					
Keep a record of everything you eat each day					

Do you smoke? ☐ Never ☐ In the past ☐ Currently How long?_____

Alcohol use ☐ Never ☐ In the past ☐

Currently Type/amount/frequency_____

Drug use ☐ Never ☐ In the past ☐ Currently ☐ Prefer not to discuss

Type/frequency_____

WEIGHT HISTORY:

Height _____ Current Weight _____ Desired Body Weight _____

DIET HISTORY

Do you follow any special diet or have diet restrictions or limitations for any reason (health, cultural, religious or other)? ☐**Yes** ☐**No If so, please describe** _____

Please list any food allergies, sensitivities or intolerances _____

_____

Who (if not you) primarily cooks your meals? _____

Who (if not you) shops for the food you eat? _____

Where do you shop for food? _____

Do you find cooking difficult? ☐**Yes** ☐**No** **Please** If yes, why? _____

IRON QUEEN
FITNESS

Dietary Information

If you follow a special diet/nutritional program, check the following that apply:

☐Low Fat ☐Low Carb ☐High Protein ☐Low Sodium

☐No Gluten ☐Vegetarian ☐Vegan ☐Diabetic

☐No Dairy ☐No Wheat ☐Weight Loss ☐Other _____

Which meals do you eat regularly, check all that apply:

☐Breakfast ☐Lunch ☐Dinner/ Supper ☐Snacks (time _____ _)

How often do you eat the following?

Food Types	Never	2-3 times/mo.	1 time/week	2-3 times/week	1 times/day	2-3 time/day
Fast food						
Restaurant food						
Vending machine food						
Cafeteria or buffet food						
Frozen meals						
Home-cooked meals						
Leftovers						

Food cravings

_____

Food dislikes

_____

Eating Style: Based on how you eat on a regular basis, please check all that apply:

☐Fast Eater ☐Family member(s) have different tastes

☐Erratic eater ☐Love to eat

☐Emotional eater (stressed, bored, sad, etc.) ☐Eat too much

☐Late night ☐Eat because I have to

☐Time constraints ☐Negative relationship with food

☐Dislike "healthy" food ☐Struggle with eating issues

☐Confused about food/nutrition ☐Poor snack choices

☐Do not plan meals/menus ☐Frequently eat fast food

☐Rely on convenience items