LiftSmartEatSmart

Initial Nutrition Assessment

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| **Demographic Information and Medical History** |
| Date:  | Age:  | DOB:  | Gender:  |
| Name: | Primary MD: | Accompanying member: | Member Relationship: |
| Past Medical History: |
| Family History: |
| Medications: |
| Supplementations: |
| Food Allergies/Intolerances: |
| Dietary Restrictions: |
| Who Prepares Most of your Meals: * Self-prepared
* Family
* Spouse/Partner
* Take-out
 |
| Smoke/Tabaco use:* Yes
* No
* If yes, How Often:
 |
| Preferred Language: |
| Dentition: | * Missing or damaged teeth
* Dentures
* Chewing difficulty
* Swallowing difficulty
 |

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| **Anthropometrics Data, Physical Activity, Laboratory Data** |
| BW: | UBW: | IBW: | LBW: | HBW: |
| Diet History:* Yo-yo diet
* Binge diet
* Eating disorder
* Other:
 |
| Lab Date: | TSH | Chol | Glu | Trig | HbA1c |
| Exercise Frequency: | * Sedentary
 | * 1-2 times/week
 | * 3-4 times/week
 | * +4 times/week
 |
| Type of Exercise: |

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| **Diet Education Assessment** |
| Goal Plans:1.2.3.4. |

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| 24 Hour Recall |
| Breakfast: |  | Awake Time: |
| Lunch: |  | Breakfast Time: |
| Dinner: |  | Lunch Time: |
| Snack: |  | Dinner Time: |
| Drinks (oz./glasses): |  | Snack Time: |
| Water (oz./glasses): |  | Bed Time: |

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| Notes |
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Nutrition Follow-up Progress Report

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| **Demographic Information and Medical History** |
| Date: | Last RD Visit: | Last MD Visit: | Age: | Gender: |
| Name: | DOB: |
| Body Weight: | Gain/Loss: | BMI: | Blood Pressure: |
| Any medical conditions now or in the past: | * Yes
* No
* If yes, explain. Be specific:
 |

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| **24 Hour Recall** |
| Breakfast: |  | Awake Time: |
| Lunch: |  | Breakfast Time: |
| Dinner: |  | Lunch Time: |
| Snack: |  | Dinner Time: |
| Drinks (oz./glasses): |  | Snack Time: |
| Water (oz./glasses): |  | Bed Time: |

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| --- |
| New Lab Data and Medications/Supplements |
| Lab Date: | * TSH:
* Glu:
* Chol:
* HDL:
* LDL:
* BUN:
* Trig:
* HbA1c:
* Other:
 |
| Changes in Medications/Supplements: | * Yes
 | * No
 |

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| Goals |
| * Met first goal
 | * Still working on it
 | * Meeting objectives
 |
| Comments/Changes in Diet Prescriptions, Exercise/Goals/Plans:1.2.3.4.5. |

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Goal Sheet

Name: Date:

Nutrition Goals:

1.

2.

3.

Exercise Goals

1.

2.

3.

Next Nutrition Appointment

Date: Time:



Diet Elimination- Food Diary

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| DAY | FOOD | QUANTITY | FEELING | SYMPTOMS |
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Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

To Whom It May Concern:

This letter is to certify that \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ has been seen by Wilson Sanchez, Eat Smart & Move More Director. He/She should be excused for \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_(dates). For any questions feel free to contact us at 646-209-8934 or [www.liftsmartfitness.com](http://www.liftsmartfitness.com)

Thank you,

Wilson Sanchez, CSCS, NSCA-CPT

Nutrition & Exercise Coach