LiftSmartEatSmart

Initial Nutrition Assessment

|  |  |  |  |
| --- | --- | --- | --- |
| **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 | |

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **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

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **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 |

|  |  |  |
| --- | --- | --- |
| 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