

Name: _____ Date: _____

DOB: _____ M / F (circle) Email: _____

Phone: (Home) _____ (Mobile) _____

Emergency contact (Name): _____ (Phone): _____

Health Care Professional (Name): _____ (Phone): _____

{Do you consent to information being shared with your designated health provider Y / N }

How did you hear about Studio Rubix? _____

Tick here if you want to receive updates via our newsletter: _____

Please sign to indicate that you understand our cancellation policy*: _____

*Cancellations must be made at least 24hrs in advance of the scheduled appointment and between 8am-5pm. Failure to do so will mean you will forfeit the session at full cost.

NUTRITION - BEHAVIOUR CHANGE

What is your main goal relating to nutrition, exercise or wellbeing?

What steps have you already taken to achieve this goal? what has worked and what has not worked.

Have you sought nutrition advice/support in the past? Y / N Whom from?

MEDICAL PROFILE

Please list any medical conditions you currently have, their duration, and any medication you are taking.

Condition: *i.e. high BP*

Duration: *i.e. diagnosed 2005*

Medication: *i.e. Betaloc*

Are you taking any other over-the-counter medications or supplements?

EXERCISE PROFILE

Discuss current level of activity, exercise preferences, training programs you are currently (or plan to) following. If you are competing, outline event details, race duration, expected finishing time etc.

Do you want support on increasing or modifying your current exercise program? Y / N

NUTRITION PROFILE		
Please tick (✓) if you regularly experience any of the following symptoms. Use the additional space to provide any further detail as you wish.		
<input type="checkbox"/> Lack of energy / lethargy	<input type="checkbox"/> Diarrhoea	<input type="checkbox"/> Irregular menstrual cycle
<input type="checkbox"/> Frequent colds or infections	<input type="checkbox"/> Constipation	<input type="checkbox"/> Infertility
<input type="checkbox"/> Slow wound healing	<input type="checkbox"/> Irregular bowel motions	<input type="checkbox"/> Dry flaky/rough skin/lips
<input type="checkbox"/> Headaches / migraines	<input type="checkbox"/> Bloating	<input type="checkbox"/> Dizziness
<input type="checkbox"/> Anxiety / tension	<input type="checkbox"/> Excessive flatulence	<input type="checkbox"/> Sensitivity to cold
<input type="checkbox"/> Low mood	<input type="checkbox"/> Abdominal cramping	<input type="checkbox"/> Cold hands/feet
<input type="checkbox"/> Irritability	<input type="checkbox"/> Poor appetite	<input type="checkbox"/> Joint pain or arthritis
<input type="checkbox"/> Poor memory	<input type="checkbox"/> Nausea / Vomiting	<input type="checkbox"/> Excessive thirst
<input type="checkbox"/> Sleep disturbance	<input type="checkbox"/> Reflux	<input type="checkbox"/> Muscle cramps or spasms
<input type="checkbox"/> Poor concentration	<input type="checkbox"/> Dehydration e.g. dark urine, loose skin	<input type="checkbox"/> Allergies/intolerances
<input type="checkbox"/> Other		

3-DAY FOOD RECORD		
Please complete this as accurately as possible with times of day, estimated or weighed portions, applicable brands, cooking methods and indication of appetite (hunger and fullness) where appropriate.		
DAY 1	DAY 2	DAY 3
BF		
Snack		
L		
Snack		
D		
Snack		
Fluids		
Overall appetite		

