studiorubix find your strength

NUTRITION SCREENING QUESTIONNAIRE

Name: Date:

DOB: M / F (circle) Email:

Phone: (Home) (Mobile)

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 DO NOT want to receive recipes & tips via our newsletter: _____

*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.		
☐ Lack of energy / lethargy	☐ Diarrhoea	☐ Irregular menstrual cycle
☐ Frequent colds or infections	☐ Constipation	☐ Infertility
☐ Slow wound healing	☐ Irregular bowel motions	☐ Dry flaky/rough skin/lips
☐ Headaches / migraines	☐ Bloating	☐ Dizziness
☐ Anxiety / tension	☐ Excessive flatulence	☐ Sensitivity to cold
☐ Low mood	☐ Abdominal cramping	☐ Cold hands/feet
☐ Irritability	☐ Poor appetite	☐ Joint pain or arthritis
☐ Poor memory	☐ Nausea / Vomiting	☐ Excessive thirst
☐ Sleep disturbance	☐ Reflux	☐ Muscle cramps or spasms
☐ Poor concentration	☐ Dehydration e.g. dark urine,	☐ Allergies/intolerances
☐ Other		

Food Recall: Outline a typical day of eating from waking up, to going to bed. You may add info like when you train, work, challenging times with eating. E.g. Breakfast, Lunch, Dinners, Snacks and Fluids, alcohol

Comment on who typically buys your food, who prepares it, where you tend to eat meals, takeaways or other points of interest.

Other **Notes: info that may be relevant to your situation**