Fitness Center Nutrition Assessment  
Department of Recreational Services  
Georgia State University

Name: ___________________________ Date: ____________

Age: _____ Gender: _____ DOB: _____ Height: _____ Weight: ________

Goal Weight: _____

Phone: _____ - _______ GSU email: __________________

☐ Freshman ☐ Sophomore ☐ Junior ☐ Senior
☐ Graduate Student ☐ Faculty ☐ Staff ☐ Other: ____________

Have you ever worked with a dietitian? ☐ Yes, where? ____________ ☐ No
Have you worked with a GSU personal trainer? ☐ Yes, when __________ ☐ No

Describe any current medical condition(s) you may have:
________________________________________

How long have you had this condition? _______________________

Describe any significant past medical history or surgeries:
____________________________________________________________________________

When was your last cholesterol test and what was the result?
____________________________________________________________________________

When was your last blood pressure check and what was your reading?
____________________________________________________________________________

Do you have a family history of any of the following: high blood pressure, diabetes, heart disease, or high cholesterol? If yes please describe.
____________________________________________________________________________

List current treatment and/or medications (name/dose): ________________
____________________________________________________________________________

List current supplements (vitamins, mineral as well as any protein drinks or bars):
____________________________________________________________________________

Have you changed your diet to lose weight? If so, describe:
____________________________________________________________________________

Office Use Only
Referral Needed:
Have you experienced any recent weight change? If yes, how much have you gained/lost and how fast?
______________________________________________________________________

Have you been prescribed a specific diet by a physician or other health professional? If so, please describe (approximate date and length of time):
______________________________________________________________________
______________________________________________________________________

Please consider the following questions or statements:

It’s hard for me to stop eating when full.
_____ Often   _____ Sometimes   _____ Rarely   _____ Never

I go through long periods of time without eating.
_____ Often   _____ Sometimes   _____ Rarely   _____ Never

I eat to avoid dealing with problems.
_____ Often   _____ Sometimes   _____ Rarely   _____ Never

I have determined that there are “safe” foods that are okay for me to eat and “bad” foods that I refuse to eat.

☐ Yes   ☐ No

Have you ever had or been diagnosed with an eating disorder?  ☐ Yes   ☐ No
If yes, what eating disorder was it and when were you diagnosed? ____________________________
______________________________________________________________________

Do you any food allergies/intolerances?  ☐ Yes   ☐ No
If yes, please describe:
______________________________________________________________________

Physical Activity Profile: Do you currently exercise?  ☐ Yes   ☐ No
Type of exercise? ______________________________________________________
How often? ___________________________________________________________
How long? ______________ (min/hr)

Barriers to exercise:
☐ Lack of time   ☐ Cost   ☐ Lack of energy
☐ Illness/Injury   ☐ Lack of motivation   ☐ Do not feel comfortable

List 3 goals you now hope to achieve while working with the nutritionist.
1. ________________________________________________________________
2. ________________________________________________________________
3. ________________________________________________________________
Eating Pattern History:
Who shops/prepares food at your home?__________________________________________________

I cook: □ Always □ Most of the time □ Sometimes □ Never

I prepare my food: □ Mixed □ Broiled/baked □ Fried

I eat on campus: □ < 1x/week □ 1x/week □ 2 – 3x/week □ >3x/week

Where: __________________________________________________

I eat out: □ < 1x/week □ 1x/week □ 2 – 3x/week □ >3x/week

I eat: □ Every 3 – 4 hours during the day □ 3x/day □ 2x/day □ varies

I skip meals: □ Always □ Often □ Sometimes □ Rarely □ Never

I skip this meal most often: □ None □ Breakfast □ Lunch □ Dinner

I have alcoholic beverages: □ Never □ <1x/week □ 1-3x/week □ >3x/week □

Daily
   How many per week: _____liquor _____beer _____wine

How many 8-ounce cups of water do you drink in a day?_____

List foods you enjoy and eat regularly in the spaces provided below:
   A. Dairy (Includes milk (skim, 1%, 2%), yogurt, puddings made with milk):

   B. Fruit:

   C. Non-Starchy Vegetables (everything but corn, potatoes, beans, and peas):

   D. Grains (bread, cereal, rice, pasta, crackers, granola, corn, potatoes, beans, peas):

   E. Protein (Eggs, cheese, fish, chicken, beef, pork, tofu, meat analogues):

   F. Fat (Oils, nuts, peanut butter, avocado, salad dressings, sour cream, margarine):

List any foods you dislike or will not eat/cannot eat (i.e. food allergies):

_____________________________________

_____________________________________

Office Use Only
Referral Needed:
1 Day Food Record (Weekday)

Please fill out the table below to the best of your ability. Aim at being accurate and descriptive with types and amounts of food eaten. List all beverages, including water and alcoholic beverages drunk throughout the day. An example is provided for you.

<table>
<thead>
<tr>
<th>Time</th>
<th>Food Item/ Beverages</th>
<th>Amount Eaten</th>
<th>Brand/Type</th>
<th>How Prepared</th>
<th>Location</th>
</tr>
</thead>
<tbody>
<tr>
<td>Example: 8:00 AM</td>
<td>Egg Whites Cheese Toast Margarine OJ</td>
<td>3 1 Slice 2 Slices 1 tsp 1 C</td>
<td>N/A 2% Reduced Fat Whole Wheat I cant believe its not butter Regular OJ</td>
<td>Pan-fried Toasted</td>
<td>Home</td>
</tr>
</tbody>
</table>
# 1 Day Food Record (Weekend)

Please fill out the table below to the best of your ability. Aim at being accurate and descriptive with types and amounts of food eaten. List all beverages, including water, drunk throughout the day. An example is provided for you.

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Please read the statements below regarding Nutrition Services provided at the Georgia State University Student Recreation Center. Please also sign and date.

The nutrition services offered at the Georgia State University Student Recreation Center are intended to provide general nutrition recommendations based on the nutritional needs of the client and within the scope of practice of the nutrition practitioner.

We reserve the right to make referrals out rather than provide services to clients when the issues exceed the scope of available services and/or scope of practice of the practitioner, as determined in the sole discretion of the nutrition practitioner.

Client Signature: ____________________________  Date: _____________________