HEALTH ASSESSMENT QUESTIONNAIRE

AND

NUTRITION POLICIES

Benchmark Nutrition, LLC Nutrition Policies

Welcome! I look forward to working with you to achieve your goals. The following policies are established to help facilitate a positive working relationship. Please feel free to comment or ask questions. Nutrition consultations can be conducted at your home, work, by phone, over the internet or at another private location.

Appointments

Appointments may be made by calling (205) 538-2005 or emailing Brandon at info@benchmarknutrition.com. Prior to all initial appointments a Health Assessment Questionnaire must be filled out. You can acquire a Health Assessment Questionnaire by registering at www.benchmarknutrition.com, by mail, or emailing Brandon at info@benchmarknutrition.com

Confidentiality

Our sessions are held in strict confidence. A release form will be used to obtain permission to speak to your physician, personal trainer, or other allied health care professional.

Payment

Payment is “fee for service” and due in full at the time the services are provided or may be paid for in advance. Credit/Debit cards (via: www.benchmarknutrition.com), Cash, or Check is acceptable methods of payment. All payments are to be made **payable to Benchmark Nutrition**. All payments are non-refundable and any unused sessions at the end of 12 months, from the date of purchase, will no longer be usable. Travel charges that may apply: 1) Mileage – mileage reimbursement based on current IRS rate, 2) Time – for round trip distances equal to or greater than 1 hour will be charged for the first hour and for every 15 minutes thereafter.

Cancellations

Notice is required for all cancellations. Because I have set aside a specific time to meet with you, a 24-hour notice is required for all cancellations. With such notice I am able to schedule someone else in your time slot. You will be charged 50% of the service fee for any cancellations less than 24-hours from your scheduled appointment. Cancellations without notice will be charged 100% of the service fee. Please contact Brandon Booth, MS, RD (205-538-2005) or email Brandon at info@benchmarknutrition.com at your earliest opportunity to cancel your session and reschedule for a later date. I appreciate your cooperation in this regard.

Account information to use for services, cancellations, and broken appointments (you will be notified before a transaction is made):

A) Credit/Debit Card #:____

B) Exp. Date:____

Signature:____

Please sign and date after you have read and understood the sports nutrition policies contained within this document:

Client Name (print)____

Client Signature___________________________________ **Date**__________________

Release Form

Please fill-out and sign this release form which enables me to contact your physician(s), personal trainer, and/or therapist.

I ________________________________ (print your name), authorize Brandon Booth, MS, RD, consulting dietitian, to contact, obtain, and/or release information concerning my nutrition therapy to the following physicians/personal trainers/therapists/registered dietitian:

Name________________________________ Phone(s)______________________________

Address____

Name________________________________ Phone(s)______________________________

Address____

Name________________________________ Phone(s)______________________________

Address____

Name________________________________ Phone(s)______________________________

Address____

Client Printed Name__________________________________

Signature_______________________________________ **Date**_________________________

Health Assessment Client Questionnaire

Name:____ Date: ________________________

Address:____

Background Information

Age: ___________ Birth date:________________ Preferred phone number: __________________________

E-mail: ________________________________ Occupation/Sport:________________________________

Work/Training hours: _______________________ Marital status:__________________________________

Highest level of education: ____

Please list the people in your household and their relationships to you:_______________________________

____

Referred by:____

General Health Information

Physician's name:_____________________________ Physician's phone:____________________________

Physician's address:____

Date of most recent physical exam:______________ Date of most recent blood test:___________________

How do you rate your health? ______ Poor ______ Fair ______Good ______Excellent

Height:_____________ Weight: _____________ Desired Wt:____________

Review of Systems (circle all that you currently have or are concerned about)

Respiratory

Shortness of breath

Emphysema

Disturbed sleep

Coughing

Snoring

Sleep apnea

Asthma or wheezing

Daytime sleepiness

History of pneumonia, chronic bronchitis, or COPD

Cardiovascular

High blood pressure

Heart murmur

Ankle or feet swelling

Heart disease/heart attack

Irregular heartbeat or palpitations

Varicose veins

Congestive heart failure

Chest pain or discomfort

Blood clots or clotting disorders

Sickle Cell Anemia/Trait

Gastrointestinal

Nausea/vomiting	Ulcer disease	Diarrhea
Abdominal/stomach pain	Rectal bleeding or blood in stools	Gallbladder disease/gallstones
Heartburn/acid reflux	Hemorrhoids	Celiac disease
Belching/burping	Constipation	Hernia

Genitourinary

Difficulty urinating	Inability to empty bladder fully	Sexual problems
Urinary incontinence (leaking urine)	Recurrent urinary tract infections (UTIs)	Abnormal menstrual periods
Enlarged prostate	Infertility	

Musculoskeletal

Aching muscles or joints	Lower back pain/disc problems	Arthritis

Endocrine

Diabetes mellitus	Thyroid disease (specify)	High triglycerides
High cholesterol	Gout	High or Low blood sugar

Skin and Hair

Skin sores or infections (boils, ulcers, skin fold irritations)	Chronic rashes or dermatitis or eczema	Excessive facial/body hair (women only)
Bruises easily		

Other

Low energy level	Obsessive-compulsive disorder (OCD)	Binge Eating
Depression	Bipolar disorder	Bulimia
Psychological or psychiatric care	Anemia	Anorexia

Cancer (list type):____

Other serious medical conditions (list types):____

Do you have a family history of any of the following? (Circle all that apply)

High blood pressure, high blood cholesterol, diabetes, thyroid disease, obesity, heart disease, cancer, other (list):

____

List the types of surgeries you have had: ____

____

How often do you use tobacco?________________ How often do you drink alcohol?______________________

Do you grocery shop?____________ Do you cook for yourself?___________ How often?__________________

What types of foods do you prepare?____

____

How many times per week do you eat out?____

What types of restaurants do you visit? ____

____

____

Are you allergic to any foods?______________ If so, please list them.

____

____

How many hours of sleep do you average per night?__________ Is your sleep restful? Yes No

On a scale from 1 (low stress) to 5 (high stress), how would you rate your daily stress level?

1 2 3 4 5

How do you cope with stress in your daily life?____

____

Please list any religious practices that affect your health care or diet:

____

On a scale of 1 (not ready) to 5 (very ready), how ready are you to make lifestyle changes?

1 2 3 4 5

On a scale of 1 (not at all confident) to 5 (very confident), how confident are you to make lifestyle changes?

1 2 3 4 5

List all prescription and over-the-counter medications that you currently take (including the dosages):

____

____

____

List all vitamins, minerals, supplements, and herbs that you take:

____

____

____

What makes it hard for you to achieve & maintain your goals (i.e. lose weight and keep it off; cook)?

____

____

____

Physical Activity

What is the most physically active thing you do in an average day? ______________________________

____

What, if any, regular exercises do you do? How often and for how long do you participate?

____

____

____

Do you know of any reason(s) why you should not do physical activity? If yes, please explain the reasons.

____

____

Nutrition Information

What one or two things would you like to change about your diet? ______________________________

____

Please list any diet(s) you are currently on or have been on in the past:_________________________

____

In the following charts, describe when and what you usually eat in a typical day. (Skip a space or draw a line to separate you meals (i.e. Breakfast, Lunch, Dinners, Snacks). Two weekdays and one weekend day is preferred.

Keeping A Food Diary

Instructions:

The information in your food diary will help you and your Registered Dietitian design an eating program to meet your needs. Food diaries are meant to be used for a week, but studies have shown that keeping track of what you eat for 3 days (2 weekdays & 1 weekend), even 1 day, can help you make changes in your diet. DO NOT change your eating habits while keeping your food diary.

- Write the date for each day
- Circle which day of the week it is (i.e.: Monday (M), Thursday (Th), etc)
- Circle if the meals for that day were Typical of how you eat; if it was Less Than what you normally eat; or if it was More Than what you normally eat.

** **Don't depend on your memory at the end of the day. Record your eating as you go****

Food/Preparation:

In this column write down the type of food you ate and how it was prepared. Be as specific and provide as much detail as possible:

- Coffee? Did it have: cream, sugar, and/or milk in it? Is so, half & half, regular cream? 1%, 2% milk?
- Tea: sweet or unsweet?
- Was it baked, grilled, fried, or steamed?
- Fresh, frozen, or canned vegetables/fruits/other?
- If you eat bread, is it white, wheat, whole wheat, rye, honey wheat, multigrain, or double fiber? If you drink milk, is it whole, 2%, 1%, skim, soy, lactose free, or rice?

If you know the exact amount of the condiments, gravies, sauces, etc list them in separate rows from the main dish.

Don’t forget to put all fluids consumed: coffee, water, soda, juice, sport drinks, milk, etc.

Time:

The time of day you ate the food.

Serving Size:

Indicate the amount of the particular food item you ate. Estimate the volume (1/2 Cup, 2 Tablespoons), weight (2 ounces), and/or the number of items (22 grapes) of that food.

Reason:

Indicate the reason for eating. Were you tired, energetic, depressed, happy, sad, hungry, bored, etc?

Place:

Where did you eat this meal? At home on the couch, at your desk at work, in your car, at the kitchen table, a restaurant, etc.

Calories/Carbs/Pro/Fat: You do not have to fill this portion out.

Try to skip a space between each meal (Breakfast/Lunch/Dinner) & snack or draw a line to separate them.

FOR A 3 DAY FOOD LOG PLEASE PRINT OUT 2 ADDITIONAL COPIES OF THE FOOD DIARY (PAGE 9)

Food Diary

Name:________________________________ Date:_________________ Day: S M T W Th F Sa

Food/Preparation	Time	Serving Size	*Reason/ Place	Calories	CHO	PRO	FAT

Daily Activity (type and duration)	Comments
Water (check one box for each 8-ounce glass)	

*Reason: Tired, Stressed, Celebration, Sad, Happy, Hungry, Bored, Craving, etc. Place: Home, Work, Car, Restaurant, etc

Benchmark Nutrition, LLC www.benchmarknutrition.com 205-538-2005

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