Athlete Assessment

Name Your Name

Address Your Address

Phone Number Your Phone Number

Age Your age

Occupation Your occupation

DOB Your date of birth

Next of Kin Contact

Name Name

Relationship Your relationship

Number Phone number

GP and Medical Consultant Details

Name Name

Number Phone number

Practice or Hospital Practice or hospital

Coach or Other Healthcare Professional Contact (if applicable)

Name Name

Number Number

View Document

Introduction Questions

Are you an athlete, coach, healthcare professional, media or business?

Your answer here

In what ways are you aiming to optimise life and/or sport?

Your answer here

What do you see as your top 3 challenges currently?

Your answer here

What are the top 3 things that we can help support you with?

Your answer here

What is your ultimate outcome from working together?

Your answer here

Where did you hear about us?

Your answer here

Nutrition Questions

Current Weight (kg) Current weight

Highest Weight (kg) Highest weight

Lowest Weight (kg) Lowest weight

Height (m) Height

Weight Aim (if applicable) (kg) Weight

Outline your weekly training type/duration/time of day

Your answer here

Past medical history and medical conditions

Your answer here

Prescribed medications

Your answer here

View Document

Current investigations (if applicable)

Your answer

Nutritional Supplements and Race Nutrition. Please include brand names/dose/regularity of dose.

Your answer

Reason or aim for nutritional intervention?

Your answer

Have you had contact with a performance nutritionist or dietitian in the past? If so, please detail why.

Your answer

Have you trialled any diets for weight loss, performance gains, symptom management, and/or clinical medical management of a condition?

Your answer

Were they a success?

Your answer

Do you suffer any symptoms in relation to food intolerance/ exercise or from a medical condition? Please detail what, if applicable.

Your answer

Do you exclude any foods from your diet? If so, what and why?

Your answer

Do you have any barriers to making changes to your diet and nutrition?

Your answer

Explain your sleeping patterns

Your answer

What is your current fluid intake per day?

Your answer

Do you smoke?

Your answer

Do you drink alcohol? If so how much, what, when?

Your answer

State any vitamins, minerals, protein and energy supplements you use on a day to day basis or in racing and training. State regularity, dose and brand

Your answer

View Document

Do you have a history of injury? If so, what?

Your answer

Females: Do you have a regular period cycle? Do you use an oral contraceptive pill?

Your answer

Males: Do you suffer with a loss of libido?

Your answer

What are your barrier to making changes to your nutrition?

Your answer

Have you had any recent blood tests? If so, please include the results

Your answer

View Document