

Firstname	Lastname	HAS ID _____
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Date	<input type="radio"/> Male <input type="radio"/> Female	DoB	Age (years) <input type="radio"/> Not sure
Event	Location	<input type="radio"/> Athlete <input type="radio"/> Unified partner	Sport
Delegation	SO Program		

Nutrition Assessment

Height ____ • ____ cm
Measure up to .01 cm

Height ____ inches
Measure up to 1/8 inch

Weight ____ • ____ kg
Measure up to .01 kg

Weight ____ lbs. ____ oz.
Measure up to 1/2 oz

Blood Pressure
____/____ ____/____
Left Arm Right Arm

Waist Circumference ____ • ____ cm
Measure up to .01 cm

Bone Mineral Density Test

T-score ____ • ____ - 9.9 to + 9.9

BMI

_____ BMI (individuals 18 years of age and over)

Referral Made for Follow Up
 Yes No

_____ BMI Percentile (individuals under 18 years of age)

Smoking cessation

Do you use tobacco products?
 Yes No

If yes, ask which products
 Cigarettes Cigars Pipe
 Chewing Tobacco

Is it OK to smoke in your home? Yes No

Have you smoked more than 5 packs of cigarettes (100) or more in your life? Yes No
(1 pack of cigarettes = 20 cigarettes)

How many times do you use tobacco products?
Per day ____ Per week ____ Per month ____ Per year ____

Does someone in your family smoke a tobacco product? (cigarettes, cigars, pipes)
 Yes No

In the past year, have you stopped smoking for one day or longer because you were trying to quit smoking?
 Yes No

Nutrition - Beverages

What do you drink when you are feeling thirsty?

- Water
- Fruit juice
- Soft drink
- Sport drink
- Milk product (include soy milk)



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Nutrition – Other Food

Do you eat other foods or take special nutrition pills (i.e., sport bar, sport drink, food supplement product like ensure, vitamin supplement, protein supplement)?

- sports bar, or sports drink
- nutrition supplement product
- vitamin, mineral or protein supplement Other _____

Regional Food Questions (Insert 5 key food and nutrition questions that represent the needs and food habits of the region)

Sources of Calcium <input type="checkbox"/> daily <input type="checkbox"/> more than once a week <input type="checkbox"/> never
Fruits and Vegetables <input type="checkbox"/> daily <input type="checkbox"/> more than once a week <input type="checkbox"/> never
Snack Foods <input type="checkbox"/> daily <input type="checkbox"/> more than once a week <input type="checkbox"/> never
Sweetened Beverages <input type="checkbox"/> daily <input type="checkbox"/> more than once a week <input type="checkbox"/> never
Fortified Foods (grains, breads, cereals) <input type="checkbox"/> daily <input type="checkbox"/> more than once a week <input type="checkbox"/> never

Sun Safety

Your hair color is

- blond/red
- brown
- black

Your eye color is

- blue/green
- hazel
- brown

When exposed to the sun in the summer do you

- burn
- burn and sometimes blister
- burn then tan
- tan

Do you know how to protect your skin in the sun?

- Yes No

Please check all that apply

- use of sunscreen
- wear a hat
- seek shade
- wear sunglasses

Do you use sunscreen in the winter months?

- Yes No