HUNTER ALLEN
PEAKS COACHING GROUP

LIFESTYLE ASSESSMENT FORM

Please answer each of the following questions. If you require additional space please enter comments at the bottom of the page in the comments section or attach with your email.

TO BEGIN…

What is your main purpose in working with PCG? _____

_____

_____

_____

_____

THE BASICS:

1. Date of Birth: _____
2. Age: _____
3. Current Weight: _____
4. Height: _____

WEIGHT:

5. Do you wish to: Gain weight ☐ Lose weight ☐
   If you're goal is to lose weight, how much: _____
6. Have you ever weighed your goal weight? If so when was the last time?
7. Weight change in the past year:
   High: _____ Low: _____
8. Usual weight in season:
   High: _____ Low: _____
9. Usual weight out of season:
   High: High: _____ Low: _____

STRESS:

10. On a scale from 1-10 (10 being excellent, 1 being very low) where do you rate your energy levels? Circle one: 1 2 3 4 5 6 7 8 9 10
11. On a scale from 1-10 (10 being excellent, 1 being very low) where do you rate your recovery from training sessions? Circle one: 1 2 3 4 5 6 7 8 9 10
12. What level of stress do you feel you are experiencing at this time?
    Minimal ☐ Average ☐ Considerable ☐ Unbearable ☐
13. What are the major causes or factors of your stress? (Check all that apply):
    Financial ☐ Career ☐ Personal ☐ Marriage ☐
    Health ☐ Family ☐ Spiritual ☐ Unfulfilled Expectations ☐
    Other (please explain) ☐ _____

14. How does your stress manifest itself?
    (examples: when I am stressed I cry, smoke, eat junk food, lose my temper, sulk, bite my nails etc.)

    _____

    _____

EXERCISE:

15. What do you do for exercise?
    Type:_____
    Frequency:_____
    Duration:_____
    Intensity:_____

16. Do you do double/stack workouts? Yes ☐ No ☐
    How often? _____

17. Do you do any lifestyle workouts (i.e. bike to work)? If yes, what?

    _____

    _____

18. What time of day do you typically exercise? _____

    Finish? _____

SLEEP

19. How many hours on average do you sleep daily (naps included)?

20. What time do you go to sleep? _____

    Wake-Up? _____

    Do you take naps? _____

21. Do you awaken feeling rested? Yes ☐ No ☐

22. What does "rested" feel like to you?

    _____

    _____

    What does "not rested" feel like to you?

    _____

23. Do you use an alarm to wake up each day? Yes ☐ No ☐

24. Do you feel you have to sleep-in on weekends due to fatigue? Yes ☐ No ☐

WORK

25. What is your occupation? _____

26. Do you enjoy your work? Yes ☐ No ☐

27. How many hours do you work a day? _____

28. At what times do you start and end work? _____

RECREATIONAL HABITS

29. Do you smoke? Yes ☐ No ☐
    If yes, how long have you been smoking? _____
    If yes, how often throughout the day? _____
    If no, does anyone in your household or workplace smoke? Yes ☐ No ☐

30. Do you drink recreationally? _____
    If yes, how often? _____
    If yes, how many drinks do you consume, on average? _____

31. Have you ever been treated for drug and/or alcohol dependency? Yes ☐ No ☐
    If yes, when? _____

32. Do you use recreational drugs? Yes ☐ No ☐
    If yes, how often and what type? _____

LEISURE

33. How many hours do you spend on average per day?
    Driving:_____
    Watching TV:_____
    Reading:_____
    Sitting at a computer:_____

34. What are your interests and hobbies?
    _____
    _____

35. Do you vacation regularly? Yes ☐ No ☐

36. When was your last vacation? _____

37. Was your last vacation relaxing? Rejuvenating? _____

38. What makes you feel rejuvenated? _____

39. Do you actively participate in any spiritual discipline? (Church, religious group, meditation? Include yoga if you feel it is meditative for you)
    Yes ☐ No ☐

    If yes, what kind and how often? _____

MEDICAL HISTORY:

40. Are you currently taking any medication? Yes ☐ No ☐

41. List/ Reason(s): _____

42. Please list any vitamins, minerals, herbal or homeopathic remedies, Sport nutrition supplements you are currently taking and the amounts/dosage:

_____
_____
_____
_____

43. Do you have any allergies or sensitivities? If so please list:

_____
_____
_____
_____

If yes, when were you last tested? What kinds of tests were administered?

_____
_____
_____
_____

44. Have you ever been?
Diagnosed with an illness? Explain: _____

_____
_____
_____
_____

Hospitalized? Reason?

_____
_____

45. Do you?
Have a history of overuse injuries? _____
Type(s): _____
Date(s): _____

FAMILY HISTORY:

46. Hereditary Diseases: (continued to next page)
Use F for father, M for mother, S for sibling, G for grandparent, O for others.

_____Heart Disease	_____Diabetes	_____Allergies
_____Hypertension	_____Arthritis	_____Mental Illness
_____Intestinal Disease	_____Osteoporosis	_____Alcoholism
_____Asthma	_____Ulcers	_____Gall Bladder
_____Kidney Dysfunction	_____Cancer: Type _____	

Other please list: _____

FEMALES:

1. Are you or could you be pregnant? Yes ☐ No ☐ N/A ☐

2. Are you pre-menopausal or menopausal? Yes ☐ No ☐ N/A ☐

3. Are you experiencing any menopausal symptoms? Yes ☐ No☐ N/A ☐
If yes, please specify: _____

4. Have you had a bone density test? Yes □ No □
   If yes, what was the result and date of the test? _____

DIETARY HABITS:

5. How many times a day do you eat: _____

6. Do you eat meals (Indicate how often per week):
   With Family: _____
   On the run: _____
   Fast Food: _____
   Home alone: _____
   Restaurants: _____

7. If you are eating out often, what type of restaurants, fast food, etc. are you eating at most often?

8. Do you feel there are restrictions on your diet due to preferences of others such as family, roommates or other reasons? Yes □ No □
   If so explain: _____

9. Does your training schedule change your usual dietary habits?
   If so explain: _____

10. Do you change your eating/food choices based on your weight trend? Yes □ No □

DIETARY BREAKDOWN

11. Are you a:
    Meat eater: □ Vegetarian: □ Vegan: □

12. How often do you eat meat?
    Daily: □ 2-3x a week: □ Once/week or less: □

13. How often do you consume dairy products?
    Daily: □ 2-3x a week: □ Once/week or less: □
    What are they? (i.e. milk, yogurt, cheese, ice cream?): _____

60. How many ½ cup servings of each do you typically eat in a day?
    _____Fruit: Fresh □ Dried □ Canned □
    _____Whole Grains
    _____Dairy Products: Type: _____
    _____Protein: Type: _____
    _____Vegetables: Cooked □ Raw □
    _____Other: Please specify other food types you eat daily: _____

61. Do you eat or use (indicate "1" for rarely, "2" for regularly, "3" for often):
    _____Aluminum pans _____Margarine _____Candy
    _____Microwave _____Fried foods _____Refined foods
    _____Luncheon meats _____Cigarettes _____Fast foods
    _____NutraSweet/Aspartame

62. Please indicate how many CUPS of the following you drink per day:
(A cup is 250ml. (1C = half of a regular sized plastic bottle of water, which is 500m

_____Beer	_____Red wine	_____White wine
_____Other alcohol beverages	_____Coffee	_____Tap water
_____Bottled or spring water	_____Soft drinks	_____Diet soft drinks
_____Tea- regular	_____Herbal tea	_____Milk (1% or 2%)
_____Milk (1% or 2%)	_____Fruit juices prepared	
_____Fresh vegetable juice	_____Fruit juices fresh squeezed at home	

_____Other: _____

PREFERENCES, CRAVINGS, ETC.

63. What are your favorite foods to eat? _____
_____
_____

64. How often do you eat your favorite foods? _____

65. Are their foods that you eat on a daily basis? What are they? _____
_____
_____

66. When you have a craving what do you usually want to eat? _____

67. How often do you fulfill your cravings? _____

68. Do you consider yourself as someone with a sweet tooth or someone who craves salty foods? Yes ☐ No ☐
How often?: _____

68. Do you avoid certain foods? If so please say why: _____

69. Do you experience any feelings or symptoms if meals are skipped? (i.e. dizzy, irritated, light headed, headaches)?
If so please explain: _____

70. Do you experience any symptoms after meals? (i.e. bloating, gas, fatigue)? If so are they related to particular foods? Explain.
_____
_____

71. Are there *foods that you cannot or wish to not live without in your diet?* If so list them here:
_____
_____
_____
_____

GOALS AND TRAINING

72. If you are an athlete: What are your *main* goals for the season?

    _____
    _____
    _____

73. As an athlete is having a shake/smoothie as a meal something you would consider on a daily basis for simplicity while on the road? Or do you prefer eating the meal?

    _____
    _____
    _____

74. What products are you currently eating on the bike (powder/gels/blocks?)

    _____
    _____
    _____

75. Will you be required to eat and drink a sponsored product this season? Yes ☐ No ☐
    Or can you choose? _____

BOWELS

76. How often do you have a bowel movement? (i.e. once a day, once every other day, twice a day): _____

77. Do you strain to have a bowel movement? Yes ☐ No ☐ Occasionally ☐

78. Is the strain related to any particular food or circumstance?

79. When you go to have a bowel movement how long do you have to wait in the bathroom before you actually have one? (i.e. immediate, 5 minutes, longer?)

80. Do you have loose bowel movements? Yes ☐ No ☐ Occasionally ☐
    Related to particular food or circumstances?

81. Does your bowel movement look like hard pellets? Yes ☐ No ☐ Occasionally ☐

82. Do your bowel movements look like and have the texture of a banana? Yes ☐ No ☐

83. Do you alternate between pellet and banana like bowel movement shapes? Yes ☐ No ☐

84. How/do bowel movements or need to urinate interfere with your training or competitions?

85. Please add any additional comments or information you feel may be helpful:

    _____
    _____
    _____
    _____
    _____
    _____

CLIENT STATEMENT:

I understand and acknowledge that the services provided are at all times restricted to consultation on the subject of health matters intended for general well-being and are not meant for the purposes of medical diagnosis, treatment or prescribing of medicine for any disease, or any licensed or controlled act which may constitute the practice of medicine.

I acknowledge that from the date I email or fax the questionnaire back to my nutritionist, my nutritionist has five (5) to seven (7) business days to create the custom plan and present it me.

This statement is being signed voluntarily.

Date: _____

Signature: _____

Name (please print): _____

Address: _____

City: _____

Province: _____

Postal Code: _____

Telephone: (H) _____

(C) _____

Thank you for your cooperation.

* All information contained on this form will be kept strictly confidential.