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Race Day Nutritional Analysis package version

Date: _____ Blood Type: _____

Name: _____
Address: _____
_____
Phone: (home) _____ (work) _____(cell) _____
Email address: _____
Health concerns/ issues: _____
Birthday: _____
Age: _____ weight: _____ height: _____ M/F: _____

Date of race? _____ What distance/type of race? Tri/ Du (circle 1): sprint ___ Oly ___ ½ IM___ IM ___; cycling ____: metric 100___ 100 miles ___ multiple days? Y __ N __ How many if yes: ____ ; Running____ : 5K ___ , 10K ___, ½ mar ___, marathon ___, ultra ___
Reasons for race day nutrition review: _____
_____
How did you hear about me? __ friend (_____) __ magazine ad (_LSM _PhillyFit) __ website __ other (_____)

Do you smoke or use tobacco products? _____ Does anyone smoke in your home? _____
If yes, how many packs per day? You _____ someone else _____
Do you use over the counter drugs? Yes _____ No _____
If yes, what do you take? _____ for what symptom? _____
how much, how often? _____
Do you take prescription drugs? Yes _____ No _____
If yes, what do you take? _____ for what symptom? _____
How much, how often? _____
How much water do you drink per day? _____ glasses
Is it filtered or purified? Please specify: _____
How many cups of coffee _____, soda _____, or black tea _____ do you drink daily?
How many cups of diet soda _____, diet tea _____ or diet drinks _____ do you drink daily?
Which artificial sweeteners are you most familiar with? (check those you know; mark with an "X" if you use that one)

__ Aspartame __ Saccharin __ Sucralose __ Equal
__ Acesulfame-K __ NutraSweet __ Splenda __ other _____

Do you take nutritional supplements (vitamins)? Yes ___ No ____
If yes, please list what you take. Please include brand, type, quantity taken per day:
_____
_____
_____

How would you rate your knowledge of nutrition and nutritional supplements?
__ excellent __ fairly good __ poor __ know nothing

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What is your typical training schedule? Please list day of week, time of day, distance and/or time of session and what sport.
Sunday: _____
Monday: _____
Tuesday: _____
Wednesday: _____
Thursday: _____
Friday: _____
Saturday: _____

Do you drink alcohol? Yes ____ No ____
If yes, how much and how often? _____
_____ beer _____ wine _____ spirits _____ mixed drinks
Do you have food allergies? Yes ___ No ___ Not sure ____
If yes, to what? _____
_____
Do you have food cravings? Yes ____ No _____
If yes, what do you crave? (chocolate, salty snacks, sweets, cookies, etc)
_____
_____
Do you avoid certain foods? Yes ____ No ____
If yes, what do you avoid and why? _____
_____

Do you experience the following on while exercising or in racing? (mark with R if racing)

__ acid reflux	__ nausea	__ difficulty breathing	__ diarrhea	__fatigue
__ constipation	__ headaches	__ heavy legs	__ back pain	__cramps
__ chills	__ fatigue/ tired	__ cannot sleep	__ cannot stay asleep	__heartburn
__ sinus congestion	__ other (please list: _____)		__ other _____	__mood swings

Please list what your current pre-race meal consists of:
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

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For the following section, please write down as accurately as possible, everything that you have eaten and drank for the past 2-4 days. Please be as specific as possible. Also include coffee (specify if caf/decaf), alcoholic beverages, soda (what kind or if diet), candy bars, etc and estimate the serving sizes (1 cup, 8 oz liquid, etc). If you drink milk, please indicate if whole, 2% or skim, etc. Please explain as well as possible how the food was prepared, eg. 1 chicken breast – fried, baked or broiled? With skin? Breaded? Marinated? In what? What type of oil was used, etc.

Every day meals – day of week: _____

When did you go to sleep? _____ When did you wake up? _____
How did you sleep? ___ soundly ___ tossed and turned ___ out like a light
Did you have trouble falling asleep? _____ Did you have trouble staying asleep? _____
Did you exercise? Yes___ No ___ What? _____
How long? _____ What time? _____
Did you have a bowel movement? Yes ___ No ___ how many times today? _____
Do you take fiber supplements? Yes ___ No ___ if yes, which one _____
Symptoms: _____

Breakfast: (what time? _____)
_____
_____
_____

Snacks: (what time? _____)
_____
_____

Lunch: (what time? _____)
_____
_____
_____
_____

Snacks: (what time? _____)
_____
_____
_____

Dinner: (what time? _____)
_____
_____
_____
_____
_____

Is this your usual way of eating? Yes ____ No ____
If no, what made it different? _____
_____

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Every day meals – day of week: _____

When did you go to sleep? _____ When did you wake up? _____
How did you sleep? ___ soundly ___ tossed and turned ___ out like a light
Did you have trouble falling asleep? _____ Did you have trouble staying asleep? _____
Did you exercise? Yes___ No ___ What? _____
How long? _____ What time? _____
Did you have a bowel movement? Yes ___ No ___ how many times today? _____
Do you take fiber supplements? Yes ___ No ___ if yes, which one _____
Symptoms: _____

Breakfast: (what time? _____)
_____
_____
_____

Snacks: (what time? _____)
_____
_____

Lunch: (what time? _____)
_____
_____
_____
_____

Snacks: (what time? _____)
_____
_____
_____

Dinner: (what time? _____)
_____
_____
_____
_____
_____

Is this your usual way of eating? Yes ____ No ____
If no, what made it different? _____
_____

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Every day meals – day of week: _____

When did you go to sleep? _____ When did you wake up? _____
How did you sleep? ___ soundly ___ tossed and turned ___ out like a light
Did you have trouble falling asleep? _____ Did you have trouble staying asleep? _____
Did you exercise? Yes___ No ___ What? _____
How long? _____ What time? _____
Did you have a bowel movement? Yes ___ No ___ how many times today? _____
Do you take fiber supplements? Yes ___ No ___ if yes, which one _____
Symptoms: _____

Breakfast: (what time? _____)
_____
_____
_____

Snacks: (what time? _____)
_____
_____

Lunch: (what time? _____)
_____
_____
_____
_____

Snacks: (what time? _____)
_____
_____
_____

Dinner: (what time? _____)
_____
_____
_____
_____
_____

Is this your usual way of eating? Yes ____ No ____
If no, what made it different? _____
_____

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Pre-Race Day Meal – what you do day before:

When did you go to sleep? _____ When did you wake up? _____
How did you sleep? ___ soundly ___ tossed and turned ___ out like a light
Did you have trouble falling asleep? _____ Did you have trouble staying asleep? _____
Distance of race: _____ Time of race start: _____

Any symptoms day before race?: Please list them, if any:
_____

Breakfast: (what time? _____)
_____
_____

Snack/ Lunch?: (what time_____)
_____
_____
_____
_____
_____
_____

Pre Race Meal: (what time typically? _____)
_____
_____
_____

Other meals?: (what time? _____)
_____
_____
_____
_____

Additional comments/ concerns:
_____
_____

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Race Day meals – on race day: _____

When did you go to sleep? _____ When did you wake up? _____
How did you sleep? ___ soundly ___ tossed and turned ___ out like a light
Did you have trouble falling asleep? _____ Did you have trouble staying asleep? _____
What distance race? _____ How long ago was last race? _____

Do you have a bowel movement before race ? Yes ___ No ___ how many times usually? _____
Do you take fiber supplements? Yes ___ No ___ if yes, which one _____ when? _____
Symptoms usually experienced during/after event: _____
_____
_____

Breakfast: (what time? _____)
_____
_____
_____

What used before race/swim :: (what time? _____)
_____
_____

What planning to use on bike: (which product? How much per bottle? How many per hour? etc)
_____
_____
_____
_____

What planning to use on run: (which product? How much? etc)
_____
_____
_____

Post Race meal: (how soon after race? _____)
_____
_____
_____
_____
_____

Thank you for your participation. *Joanna K Chodorowska, BA, NC*

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~ healthy nutrition for everyday living ~
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Nutritional Client Statement

I hereby understand to the following:

I fully understand that *Joanna K Chodorowska* is not a medical doctor or practitioner and that *Nutrition in Motion*, at *106 Pimlico Way*, *North Wales*, *PA 19454* is not a medical practice or medical place of practice. I am not here for medical diagnostic or treatment procedures.

The services performed by *Joanna K Chodorowska/ Nutrition in Motion* are restricted to consultation on the subject of nutritional matters intended for the maintenance of the best possible state of nutritional health and do not involve diagnosing, prognosticating, treatment of prescribing of remedies for the treatment of disease or any act which will constitute the practice of medicine in this state in which a license is required for such practices. Please consult your physician before starting a new program.

Date: _____

Signed: _____

Print Name: _____

Name of client if not over 18: _____

Birthday: _____

Address: _____

City: _____ State: _____ Zip: _____

Tel: _____ Work: _____

Email: _____

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CANCELLATION POLICY

Effective May 6, 2013

Appointments that are cancelled and rescheduled by phone 24 hours prior to the appointment will incur no additional charges. Cancellations made the same day will incur a full charge as I am not able to replace the appointment. Cancellations the night before for an early morning appointment or same day cancellations will incur a half price charge for the scheduled length of the appointment, even if the appointment is rescheduled. If you reschedule right away, I will be less likely to charge for missing an appointment time. I am not an ogre!!

You are paying for the time slot. If you are late for your appointment, you will be charged for that session from the time it was supposed to start. Please call 215-272-6774 at any time with any changes to the schedule. Sending an email is not adequate as I may not receive the email until after the appointment time. Please realize that I am not in front of my computer all day. You must call to cancel or reschedule the appointment in order to avoid being charged for the session.

Missing your appointment (aka. no show) will incur full charge for the appointment plus an additional 10% fee for my driving time, if applicable. Forgetting to 'write the appointment in your calendar' is not a valid excuse for missing an appointment. I will try my best to confirm appointments, but since most are scheduled within 1 weeks time, a reminder seems unnecessary. Emergency situations will not be included in this policy.

Sessions that are pre-purchased as in packages, will be forfeited after 1 year if not used. It is not my responsibility to remind you that you have sessions left. I will keep track of sessions used most of the time, but unused sessions will be lost after a year of purchase.

Thank you for your understanding and cooperation. I look forward to working with all of you to help you reach your goals nutritionally. To YOUR health!

Founder, President
Nutrition in Motion, LLC

I have read and agree to this policy. I agree to pay any charges resulting if I do cancel within the parameters of this agreement. If you do not feel comfortable with providing PayPal info, please check here __ and sign the document agreeing that you will pay for the missed appointment by either cash or check.

Name **Date** PayPal account (email address used for PP)

Signature email to use for communication if diff than PP

MC/VS exp date/ 3-digit code on back

Billing Address