Nutrition & Health Assessment

Name: _____ Date: _____/_____/_____

Address: _____ City_____State___Zip_____

Home Phone: _____ Work Phone: _____ E-mail _____

Reason for Consultation: _____

Birth date: ___/___/___ Age: ___ M/F: ___ Marital Status: ___ Children: ___ Height: ___

Referred By: _____

Brief Medical History

Please indicate (✓) whether you have or had any of the following conditions:

___ High Blood Pressure
___ Heart Disease or Heart Attack
___ Diabetes
___ High Cholesterol Level
___ Irregular Heart Rate
___ Chest Pain
___ Dizziness
___ Heart Murmur
___ Shortness of Breath
___ Respiratory Disease
___ Epilepsy or Convulsions
___ Orthopedic Conditions
___ Osteoporosis
___ Hernia
___ Arthritis
___ Thyroid Disorder
___ Gastrointestinal Disorder
___ Stroke
___ Hypoglycemia
___ Anemia
___ Cancer
___ Blood Disorder
___ Lactose Intolerant

Please explain above (✓) conditions: _____

_____

List all old or recent injuries: _____

_____

When was your last complete physical exam? _____

List any recent and or past operations and dates performed: _____

List all Food Allergies: _____

List all medication you are currently taking: _____

Do you smoke? Yes No Frequency: _____

Do you drink? Yes No Frequency: _____

How many times a week do you exercise? _____

What kind of exercise do you do? _____

Have you ever been on a diet before? Yes No If yes, describe: _____

_____

Do you use any special diet products? Yes No If yes, describe: _____

_____

Loss of Consciousness/Heart Attack/Stroke? YES NO If yes, how long ago? _____

FAMILY HISTORY

Do any of your blood relatives (brothers, sisters, parents, grand parents, aunts, uncles, etc.) have or have had:

__Heart Attacks __Heart Operation __High Blood Pressure __High Cholesterol
__Diabetes __Epilepsy __Congenital Heart Disease Other _____

Mark the appropriate blank by writing next to it which relative has or has had this condition.

Description of Daily Schedule – list TIMES ONLY.

MORNING	AFTERNOON	EVENING
Wake-up: Workouts: Breakfast: Snacks:	Workouts: Lunch: Snacks:	Workouts: Dinner: Snacks: Bedtime:
Notes:	Notes:	Notes:

These programs ARE NOT DIETS; they require a commitment to a lifestyle change. Because we only choose to work with committed clients, there is no refund if you are unable or unwilling to follow our recommendations. You may gift or sell your sessions to another client or use them at a later time as they have no expiration date. Thank you in advance for your commitment.

WAIVER

I, the undersigned, have read, understand, and have answered the above health/medical survey questions fully and truthfully. I am aware of my responsibility to consult with my personal physician regarding my clearance to engage in strenuous exercise and/or a nutritional support program. I do hereby intend to be legally bound for myself and waive release of any and all rights and claims for damages I may have against the participating training facility, and the fitness trainer/certified fitness nutrition specialist administering this program as well as the program creators themselves or anyone in connection with them for any and all injuries suffered while following the training and/or nutrition program provided to me. I also understand and agree to the no refund policy stated above.

Client Signature _____ Date _____

Print Client Name _____