Health Assessment Form
For Individual Nutrition & Fitness Consultation Request

*Please complete the information below. This form must be completed and received prior to meeting with me. Your responses will be kept **confidential**. If information is not available, please write n/a. If the response is none, then please write none.*

Name:_____

Date of Birth:_____ Sex (circle): M F Age:_____

Address:_____

Phone number:_____ E-mail:_____

Best Times to Meet/Call You:_____

Occupation:_____

Physician/Health Care Provider:_____

Physician Address:_____

Insurance Company:_____

Subscriber Name and Date of Birth:_____

If you have any of the following information, please include it:

% Body Fat:_____% (Date measured_____)

Blood Pressure:_____ (Date measured_____)

Labs:

Fasting Lipoprotein profile results and date measured:

Total Cholesterol:_____ LDL: _____HDL:_____ Triglycerides:_____

To be filled out by client *Dietitian use only*

Personal Medical History: (Check all that apply):

__ Heart disease or stroke **___Food allergies** **___Anemia**
___High blood pressure **___Diabetes** **___Depression**
___Hyperlipidemia **___Obesity** **___Major surgery**
___Thyroid/other hormone **___Arthritis** **___Hypoglycemia**
___Hormone conditions **___Dentures** **___Indigestion**
___Cancer **___Chewing problems** **___Physical handicaps**
___Lung problems **___Constipation** **___Surgeries (list type & approx. date below)**
___Food sensitivities **___Diarrhea**
___Ulcers **___Other allergies**
___Gastrointestinal disorders
___Pregnant or breastfeeding **_____Other (please list)**

Family Medical History:(Check all that apply):

___Heart disease **___Food allergies**
___High blood pressure **___Diabetes**
___Hyperlipidemia **___Obesity**
___Thyroid/other hormone **___Arthritis**
___Cancer **___Gallbladder**
___Lung problems **___Gastrointestinal**
___Food sensitivities
___Other

Medications:

Name of Medication	Purpose

Are you taking any vitamins/minerals? Y N
If so, what kind, how often and amount?_____
_____
_____

Herbal Therapies/Supplements? Y N
If so, please explain/list_____
_____

Dietary Supplements(e.g. Metamucil, ergogenic aids)? Y N
If so, please list _____
_____

To be filled out by client	*Dietitian use only*
Do you drink alcohol?_____ # drinks per day_____ per week_____ **Type of alcohol:_____** **Do you smoke tobacco?_____** **Do you chew tobacco?_____**	
Height:_____ **Present Weight(please weigh in morning w/o shoes/clothes)_____** **Usual Weight:_____** **Desired Weight_____** **If Pregnant, when is your due date?_____ Pre-pregnancy wt_____**	
Have you ever taken diet pills? (please circle) Y N **Have you ever been on a special diet: Y N** **If yes, what type and when:** **How successful were you?**	
Who prepares the meals in your house?_____ **Is anyone in your house on a special diet?_____** **How often do you eat out?_____** **Which restaurants do you frequent?_____**	
Exercise: ☐ No exercise ☐ Very light activity (sitting at desk, standing activities) ☐ Light activity (walking on a level surface, house cleaning) ☐ Moderate activity (walking fast, dancing, weeding) ☐ Vigorous activity (soccer, running) **Exercise Frequency Per Week:** ☐ Inactive on a regular basis ☐ Moderate activity < 30 minutes 1-3 days ☐ Moderate activity < 30 minutes 4-7 days ☐ Moderate activity at least 30 minutes 1-3 days ☐ Moderate activity at least 30 minutes 4-7 days ☐ Vigorous activity for at least 30 minutes at least 3 days per week **Please list any physical limitations, obstacles, preferences**: _____ _____ **What exercise equipment (if any) do you have available to you at home?** _____	

If you belong to a gym, please name it:_____	
On average, how much sleep do you get per night?_____ **Please rate you stress level: High Moderate Low**	

How would you generally describe your eating habits? Good Fair Poor **Has your appetite changed recently? Y N** **If so, how?_____** **Any unintentional weight lost? Y N** **Have you ever gone on an eating binge? Y N** **Have you ever induced vomiting after you eat? Y N** **Are there any foods that you avoid? Y N** **If yes, please list_____** **Do you eat if front of the TV? Y N** **How often do you skip a meal?** **Everyday ☐ most days ☐ some days ☐ rarely or never ☐** **How often do you eat late at night?** **Everyday ☐ most days ☐ some days ☐ rarely or never ☐**	

Personal Goals

Please read all of the questions in this section first, then answer them to the best of your ability:

What are you trying to achieve for your overall health?

What would you like to learn from working with a registered dietitian?

What specific lifestyle changes would you like to make?

Describe any recent or ongoing efforts to promote your health (e.g. following a specific eating pattern, walking three times a week, reading food labels). Please be as specific as you can.

If there is anything else you'd like to add that will help me help you, e.g. describe your family situation (children, spouse, partner, cooking abilities/limitations, time restraints etc….):

Based on the information above and an initial meeting, I will do a:

- **Nutritional assessment (body weight recommendations, calorie and nutrient needs to promote your health)**
- **Determine your Body Mass Index**
- **Make recommendations to help you achieve mutually agreed upon goals for your health promotion.**
- **I will give you ways to measure your progress**
- **We can set up a plan for follow-up sessions**
- **You may email me with questions as you progress**

Our goal is to empower you with the tools needed to make healthful and permanent lifestyle changes that will last your lifetime. If for whatever reason I am unable to assist you in this process, I will suggest other avenues for you to take.

Please E-mail

E-mail: energizeyoursize@cox.net Phone: 858-212-7239