

## Client Health and Fitness Evaluation

### General Client Information

**All information received on this form will be treated as strictly confidential. Please fill out the forms completely and accurately. This information is essential for your counselor to develop a program that addresses your needs, goals and is safe and effective.**

First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_ Maiden Name: \_\_\_\_\_

Address: \_\_\_\_\_ City, State: \_\_\_\_\_ Zip code: \_\_\_\_\_

Telephone (Best contact) : \_\_\_\_\_ E-mail address: \_\_\_\_\_

Age: \_\_\_\_\_ Gender: \_\_\_\_\_ Marital Status: \_\_\_\_\_ No. of Children: \_\_\_\_ Age of oldest child: \_\_\_\_ Age of youngest

child: \_\_\_\_ Occupation: \_\_\_\_\_ Current Position: \_\_\_\_\_

Days and times you work? (Example: M-F from 6am-3pm) \_\_\_\_\_

Do you consider your work/lifestyle physically - Strenuous  Active  Light  Sedentary

Emergency Contact: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone Number: \_\_\_\_\_

### Purpose and Goals

What is your primary goal in seeking nutrition or fitness counseling? \_\_\_\_\_

Do you have any limitations that would require special dietary or fitness needs? \_\_\_\_\_

Please list any major surgeries \_\_\_\_\_

What have you ever been diagnosed as having? \_\_\_\_\_

Do you have recent blood work? Yes  No  (Please bring recent lab work with you to your appointment, if it is recent.)

Have you ever been diagnosed with food allergies? If so, please list \_\_\_\_\_

Please list any other allergies (environmental) \_\_\_\_\_

Do you suffer from seasonal allergies, asthma or other respiratory problems? \_\_\_\_\_

### Structural and Metabolic Information

Current Height \_\_\_\_\_ Current Weight \_\_\_\_\_ Desired Weight \_\_\_\_\_ Weight at Age 18? \_\_\_\_ Weight 1 year ago \_\_\_\_\_

Weight 5 years ago \_\_\_\_\_ Highest weight (and age) \_\_\_\_/\_\_\_\_ Leanest weight (and age) \_\_\_\_/\_\_\_\_

At which age did you feel you were in the best physical shape? \_\_\_\_\_ Were you athletic in school? Yes / No

Are any members of your family overweight? \_\_\_\_\_ Were you considered overweight as a child? \_\_\_\_\_

**Mothers Only:** Weight prior to first pregnancy? \_\_\_\_\_ Weight 3 months after first delivery? \_\_\_\_\_

Weight 1 year after first pregnancy \_\_\_\_\_ Weight 3 mos .after last pregnancy \_\_\_\_\_ One year after last child \_\_\_\_\_

Did you exercise during pregnancy? \_\_\_\_ Did you nurse? Yes  No  Were there any complications with births?

If yes, please briefly explain \_\_\_\_\_

\_\_\_\_\_

**Prescription Medications, Non-Prescription Medications, Nutritional Supplements**

Please list your current daily regimen for medications, hormones, protein powder and nutritional supplements. Attach an extra sheet of paper if necessary to complete. It is important that you list everything taken.

Medication or Supplement	What time of day do you take this?	How long have you taken this?

**Family and Personal Medical History**

Have you or any family members developed blood pressure problems? \_\_\_\_ High cholesterol? \_\_\_\_ Hypothyroidism? \_\_\_\_  
 Diabetes or other blood sugar disorders? \_\_\_\_ Alzheimer’s Disease? \_\_\_\_ Arthritis or other mobility issues? \_\_\_\_  
 Depression or other emotional disorders? \_\_\_\_ Autoimmune disorders? \_\_\_\_ Are you or have you ever been treated for side effects or adverse events created by medications or surgical procedures? \_\_\_\_ yes \_\_\_\_ no. If yes, please explain and provide name medication or procedure.

**Family Ancestry:**

(I am interested in the study of nutritional archeology and would like to know (if you know) where your family’s ancestry evolved, when they might have immigrated, what illnesses they may have had and their longevity.

Family Member	Ancestry	Yr. Immigration	Cause of Death	Age of Death
<b>Dad’s Dad</b>				
<b>Dad’s Mom</b>				
<b>Mom’s Dad</b>				
<b>Mom’s Mom</b>				
<b>Mom</b>				
<b>Dad</b>				
<b>Brothers/Sisters</b>				
<b>Children</b>				

**Health Symptoms Questionnaire**

Please **circle symptoms** and check box indicating the occurrence and strength of a symptom. Use the 3rd box to indicate the strength of each symptom. 1= minor problem, tolerable, work with it; live with it; 2 = major problem when it occurs, requiring medication or bedrest; 3 = chronic problem, forces you to stop your activities, may require visit to doctor, continual medications, resulted in hospital visit or repeated treatments(could be lifelong).

**Head, Ears, Nose, Eyes**

	Last 48 hours	Last 30 days	Strength
Insomnia, sleep apnea, nocturnal fatigue, trouble getting out of bed	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Headaches, dizziness, fainting, vertigo, lightheadedness, migraines	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Itchy ears, earaches, ear infections, ringing in ears, drainage in ear	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Watery, itchy eyes, bags or dark circles under eye, tunnel vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sinus infection, hay fever, sneezing attacks, excessive mucus	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Please make comments here \_\_\_\_\_

**Mouth, Throat, Lungs**

	Last 48 hours	Last 30 days	Strength
Chronic coughing, gagging, need to clear throat, hoarseness, sore throat	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Swollen or discolored tongue, swollen gums or lips, dental infections	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Swollen glands, strep throat, bleeding gums, abnormal bad breath	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Chest congestion, difficulty breathing, shortness of breath	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Asthma, allergies, bronchitis, undetermined chest pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Please make comments here \_\_\_\_\_

**Digestion, Skin, Elimination**

	Last 48 hours	Last 30 days	Strength
Nausea, vomiting, diarrhea, constipation, water retention	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bloating, belching, passing gas, heartburn, stomach/intestinal pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Genital Itch or discharge, yeast infections, herpes infections	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Acne, rashes, hives, shingles, dry or broken skin, excessive sweating	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Kidney infections, prostate Inflammation, frequent urge to urinate	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Please make notes here \_\_\_\_\_

**Joints, Muscles, Energy, Pain and Inflammation**

	Last 48 hours	Last 30 days	Strength
Pain or aches in joints, arthritis, limitation of movement, lower back pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Pain or aches in muscles, fibromyalgia, feeling of weakness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Fatigue, feeling of tiredness daily, daily need to nap, headaches, migraine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Please make notes here \_\_\_\_\_

**Immunity**

	Last 48 hours	Last 30 days	Strength
Frequent colds or flu, seasonal allergies, yeast issues, lupus	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Toenail infections, skin fungus, hepatitis, HIV or other viruses	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cancer (current or remission), lymphatic issues, transplant	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Please make notes here \_\_\_\_\_

**Heart, Circulation**

Last 48 hours Last 30 days Strength

Irregular or skipped heartbeat, rapid or pounding heartbeat	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Blood pressure, high cholesterol, heart muscle concern, clotting issues	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cold hands or feet, easy bruising, varicose veins, erectile dysfunction	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Please make notes here \_\_\_\_\_

**Weight, Metabolic Activity, Brain Function**

Last 48 hours Last 30 days Strength

Binge eating or drinking, craving certain foods, compulsive eating	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Underweight, eating disorder, loss of appetite, yo-yo dieting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hyperactivity, apathy, lethargy, restlessness, sluggishness, confusion	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Memory loss, poor concentration, difficulty making decisions, fear, anxiety	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mood swings, nervousness, anger, irritability, aggressiveness, depression	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Please make notes here \_\_\_\_\_

**Female Transitions and Hormone Replacement Therapy**

Last 48 hours Last 30 days Strength

Breakout bleeding, excessive hair, bloating, irregular period, loss of menses	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lack of libido, night sweats, hot flashes, hormone replacement therapy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Vaginal discharge, dryness, breast tenderness, underarm pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cosmetic surgery, breast enhancement or reduction, botox or collagen injections	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**WOMEN ONLY: (Mark y or n):** Do you experience PMS prior to menstruation? \_\_\_\_\_

If yes, do you experience: Mood swings? \_\_\_\_\_ Tender breasts? \_\_\_\_\_ Severe cramping? \_\_\_\_\_ Back ache? \_\_\_\_\_ Do you take an oral contraceptive? \_\_\_\_\_ Have you used fertilization techniques in order to reproduce? \_\_\_\_\_ Have you had total hysterectomy? If yes, when \_\_\_\_\_? Have you ever ovarian cysts removed? \_\_\_\_\_ Have you been told you have cysts or fibroids? \_\_\_\_\_ Do you or any relatives have or have had hormonal-based cancer? (Ovarian, cervical, uterine or breast cancer? \_\_\_\_\_ If yes, which family member? \_\_\_\_\_). Have you had your hormones checked by blood work within the past year? \_\_\_\_\_ If so, have there been any findings outside the range, as indicated by your physician? \_\_\_\_\_ Do you maintain copies of your laboratory work? \_\_\_\_\_ Do you now, or have you in the past taken an oral contraceptive or hormone replacement therapy? \_\_\_\_\_ If so, please make sure the hormones and dosages are listed in "Prescription Medications and Nutritional Supplements". Please include any natural remedies, creams, etc.

**Lifestyle and Quality of Life Information**

**Sleep Cycle:** I go to sleep at \_\_\_\_\_ p.m. / a.m. I wake up at \_\_\_\_\_ a.m. / p.m.

Do you easily fall asleep easily (within 10 minutes) and sleep through the night? \_\_\_\_\_ Do you go to sleep, but wake up during the night? \_\_\_\_\_ How many hours sleep do you average nightly? \_\_\_\_\_ hrs.

**Morning Ritual:**

I eliminate in the morning easily \_\_\_\_\_ y/n. I have issues with this \_\_\_\_\_ y/n. I typically eliminate my bowels \_\_\_\_\_ times daily. I have gone \_\_\_\_\_ days without eliminating my bowels. I have used laxatives and detox programs. \_\_\_\_\_ y/n I have a need to eliminate during or just after I have eaten a meal \_\_\_\_\_ I require coffee/water/other helpers to eliminate \_\_\_\_\_ y/n I have had colonic irrigation \_\_\_\_\_ and it worked well for me \_\_\_\_\_ didn't work \_\_\_\_\_?

### Energy Evaluation

On a scale of 1-10, how would you rate your **stress** level (1=peace, love, harmony TO 10=your head about to explode)? \_\_\_\_\_  
 How do you overcome or combat this stress? \_\_\_\_\_  
 Do you use food to help you calm down? \_\_\_\_\_ If so, what time of the day? \_\_\_\_\_  
 Do you ever "sneak" eat things you know are not healthy? \_\_\_\_ If so, what time of the day? \_\_\_\_\_  
 Do they work to lower your stress? \_\_\_\_\_

On a scale of 1(in a coma) to 10 (Olympic miler), how would you rate your **energy**: upon arising? \_\_\_\_\_ 2 hours before lunch? \_\_\_\_\_  
 2 hours after lunch? \_\_\_\_ 1 hour prior to dinner? \_\_\_\_\_ 1 hour after dinner? \_\_\_\_\_ at bedtime? \_\_\_\_ Does your energy "dip" several times during the day? \_\_\_\_ If so, what times of the day? \_\_\_\_ Do you currently smoke? \_\_\_\_ If yes, how many daily? \_\_\_\_\_ If you quit, how long ago? \_\_\_\_\_ How many years of smoking? \_\_\_\_\_ Do you drink alcohol? - \_\_\_\_\_  
 Do you drink daily? \_\_\_\_ How many drinks? \_\_\_\_\_ Your favorite beverage (or one most consumed) is \_\_\_\_\_ Do you currently use recreational drugs? \_\_\_\_\_

### Exercise

I exercise \_\_\_\_ days a week. I exercise from \_\_\_\_\_ a.m./p.m. until \_\_\_\_\_ a.m./p.m., which is \_\_\_\_ total minutes daily. My routine is: (List minutes of each type of activity and # times weekly.) 1) \_\_\_\_\_ 2) \_\_\_\_\_  
 3) \_\_\_\_\_ 4) \_\_\_\_\_ I have other activities that will help with my exercise during the week, including (sports, golf, hiking, etc List your favorite activities, rest days, time spent etc. \_\_\_\_\_

### Nutritional Assessment

Do you find yourself not eating even as you are reminded that it is time to eat? \_\_\_\_\_ Have you ever had what was then described as a "low blood sugar" issue that was solved when you had something to eat? \_\_\_\_\_ Do you often have headaches from hunger? \_\_\_\_\_ Do they diminish once you have had something to eat? \_\_\_\_\_ Do you eat anything within 30 minutes of going to bed? \_\_\_\_\_ What? \_\_\_\_\_ Do you drink coffee more than once during the day? \_\_\_\_\_ How many? \_\_\_\_

Did you grow up eating cultural foods that are not considered mainstream American dining? \_\_\_\_\_ Do you have eating restrictions for religious reasons? \_\_\_\_\_ Do you restrict foods in your daily choices based on political reasons? \_\_\_\_\_  
 Unnatural distaste for certain foods(will not eat for any reason)? \_\_\_\_\_ Were you ever on a restricted food plan for athletics? \_\_\_\_\_  
 Were you ever on a "no-fat" diet \_\_\_\_\_? How long? \_\_\_\_\_ List all the various diets or restricted foods you may have tried over the years? \_\_\_\_\_ Would you say you have eaten at a "fast food" restaurant more than twice a week within the past year? \_\_\_\_\_

I typically eat \_\_\_\_ meals and \_\_\_\_ snacks during the day. I drink \_\_\_\_ oz. of water daily. I drink \_\_\_\_ cups of coffee or tea daily. I drink \_\_\_\_ glasses of soda or alcohol daily. What type usually? \_\_\_\_\_. Do you drink beverages with each meal? \_\_\_\_\_ Do you tend to get TOO full from your meals? \_\_\_\_\_ Are your eyes bigger than your stomach when you make your plate or order foods? \_\_\_\_\_ Do you suffer from indigestion shortly after you eat? \_\_\_\_ Two hours later? \_\_\_\_\_.

I tend to eat all day \_\_\_\_ y/n/ I eat every \_\_\_\_ hours. I eat all day long (less than an hour between snacks or noshing). \_\_\_\_ y/n. I eat breakfast \_\_\_\_ times a week. I find myself hungry at the end of each day \_\_\_\_ y/n. My last meal or snack is \_\_\_\_\_ minutes before bedtime. I often feel like I go to bed full \_\_\_\_\_ y/n. I often go to bed hungry or catch myself wanting to cheat eat" at night: \_\_\_\_ y/n It is typical for me to get up and have a snack after I have retired to bed at night. \_\_\_\_ y/n

Do you count calories? \_\_\_\_\_ Do you typically eat at your dining table? \_\_\_\_\_ Do you often have food (snacks, fruit, candy) in plain view on your counter or table? \_\_\_\_\_ Do you most often eat "take-out" food at home? \_\_\_\_\_ If you work outside the home, how many days weekly do you bring food from home? \_\_\_\_\_. Does your place of work allow desk displays of food (candy bowls, food in the open, etc.) \_\_\_\_\_ How many times weekly do you have home-prepared dinners? \_\_\_\_\_ When you eat, do you tend to stick to the same foods (even when bored with them?) \_\_\_\_\_ When you go out to eat, do you vary your choices for dining? \_\_\_\_\_ Do you personally do your grocery shopping? \_\_\_\_ y/n How many times weekly do you shop? \_\_\_\_\_

**Nutritional Assessment - (cont.)**

Do your food choices usually revolve around taste? \_\_\_\_\_ If so, what is that taste? \_\_\_\_\_ Do you tend to eat grains, cereals or bread at every meal? \_\_\_\_\_ Do you eat onions, peppers or hot sauce at most meals? \_\_\_\_\_ How many salads do you eat weekly? \_\_\_\_\_ Is your salad ever the main course of your meal? \_\_\_\_\_ Do you tend to eat foods by themselves or as part of a balanced meal? \_\_\_\_\_ Can you recognize the healthy attributes of the foods you eat? - \_\_\_\_\_ Do you ever choose foods for this reason rather than for the taste, comfort or familiarity? \_\_\_\_\_ Do you believe you have to sacrifice taste for health with foods? \_\_\_\_\_ If you could choose ANY FOOD to eat GUILT-FREE, which food or meal would you choose? \_\_\_\_\_

**Meal Schedule**

**My first meal is at** \_\_\_\_\_ a.m./p.m.

**My first snack is at** \_\_\_\_\_ a.m./p.m.

**My second meal is at** \_\_\_\_\_ a.m./p.m.

**My second snack is at** \_\_\_\_\_ a.m./p.m.

**My third meal is at** \_\_\_\_\_ a.m./p.m.

**My third snack is at** \_\_\_\_\_ a.m./p.m.

**Please read each section carefully and sign before appointment:**

Jem Welsh Nutrition provides services in nutritional counseling and body mechanics only and does not practice medicine. The intent of our services is to educate clients on proper nutrition and lifestyle adjustments for quality of life, as well as provide education in practical methods of obtaining optimal health. Jem Welsh Nutrition does not provide medical services, including but not limited to diagnosis, treatment, cure or management of any illness or disease.

**Please initial here that you have read and understand the above notice.** \_\_\_\_\_

**IMPORTANT! PLEASE BRING A SWIMSUIT AND PHOTO OF YOURSELF THAT YOU PARTICULARLY LIKE. The photos are for your baseline chart. THE PHOTO YOU BRING IS ABOUT YOUR BODY IMAGE.** If you don't have one you like, bring another family member whose image resembles your ideal or find an image from another source, such as a magazine picture) that reminds you of yourself when you were at your best physically, appearance-wise or what you hope to attain. It might help us!

**Please initial that you have read and understand the above notice.** \_\_\_\_\_

**IMPORTANT:** Please consult with your physician prior to starting any nutritional or exercise program. Client also understands that body fat analysis, lymphatic analysis and any bodywork (massage, drainage, Reiki massage) may be employed or recommended as part of the program and may require additional expense. All clients should inform counselor of any communicable disease or limitation of strength.

**Please initial that you have read and understand the above notice.** \_\_\_\_\_

Payment of services is expected at the time of each consultation or workshop, This cost does not include nutritional products, which may be recommended at the time of the visit. Package programs are available. All appointment fees are applied to appointments that are skipped or cancelled without providing 24-hour notice. Please provide your signature here indicating that you have read and understand the above notices regarding our services.

**Signature** \_\_\_\_\_ **Date** \_\_\_\_\_