**Client Profile**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| DEMOGRAPHICS | | | | | |
| First Name |  | Middle Name |  | Last Name |  |
| Date of Birth |  | Age |  | Gender | \_\_ Male \_\_ Female |
| Occupation |  | | | | |
| Mailing Address |  | | | | |
| City, State, Zip Code |  | | | | |
| Phone |  | Email |  | Referred by |  |
| Emergency Contact |  | Relationship |  | Phone |  |
| **CONCERNS** | | | | | |
| What health and/ or nutritional concerns would you like to focus on? | | | | | |
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| --- | --- | --- | --- | --- | --- |
| MEDICAL HISTORY | | | | | |
| Please check “yes” for the health conditions that your doctor has diagnosed, and then record approximate date of onset. | | | | | |
| Height |  | | Weight and Ideal weight (if applicable) |  | |
| CONDITION | Yes | Date of Onset | CONDITION | Yes | Date of Onset |
| GASTROINTESTINAL |  |  | INFLAMMATORY/AUTOIMMUNE |  |  |
| Irritable Bowel Syndrome |  |  | Chronic Fatigue Syndrome |  |  |
| Inflammatory Bowel Disease |  |  | Rheumatoid Arthritis |  |  |
| Crohn’s Disease |  |  | Lupus SLE |  |  |
| Ulcerative Colitis |  |  | Frequent Infections |  |  |
| Celiac Disease |  |  | Severe Infectious Disease |  |  |
| Gastric or Peptic Ulcer Disease |  |  | Herpes |  |  |
| GERD, reflux/ heartburn |  |  | Gout |  |  |
| Hepatitis C or Liver Disease |  |  | Other: |  |  |
| Food Intolerance |  |  |  |  |  |
| Other: |  |  |  |  |  |
| RESPIRATORY |  |  | MUSCULOSKELETAL/ PAIN |  |  |
| Asthma |  |  | Osteoarthritis |  |  |
| Chronic Sinusitis |  |  | Chronic pain |  |  |
| Sleep Apnea |  |  | Fibromyalgia |  |  |
| Bronchitis or Emphysema |  |  | Migraines |  |  |
| Tuberculosis |  |  | Other: |  |  |
| Other: |  |  |  |  |  |
| CARDIOVASCULAR |  |  | URINARY/ REPRODUCTIVE |  |  |
| Heart Disease/ Heart Attack |  |  | Kidney Stones |  |  |
| Stroke |  |  | Urinary Tract Infections |  |  |
| Elevated Cholesterol |  |  | Yeast Infection |  |  |
| Irregular Heart Rate |  |  | Prostate Problem |  |  |
| High Blood Pressure |  |  | Other: |  |  |
| Other: |  |  |  |  |  |
| NEUROLOGICAL/ BRAIN |  |  | METABOLIC/ ENDOCRINE |  |  |
| Depression |  |  | Type 1 Diabetes |  |  |
| Anxiety |  |  | Type 2 Diabetes |  |  |
| Bipolar disorder |  |  | Metabolic Syndrome |  |  |
| ADD/ ADHD |  |  | Hypoglycemia |  |  |
| Multiple Sclerosis |  |  | Hypothyroidism |  |  |
| Seizures |  |  | Hyperthyroidism |  |  |
| Anorexia Nervosa |  |  | Polycystic Ovarian Syndrome |  |  |
| Bulimia |  |  | Infertility |  |  |
| Unspecified Eating Disorder |  |  | Other: |  |  |
| Parkinson’s Disease |  |  |  |  |  |
| DERMATOLOGICAL |  |  | CANCER: Please list type(s) and treatments. |  |  |
| Eczema |  |  |  |  |  |
| Psoriasis |  |  |  |  |  |
| Acne |  |  |  |  |  |
| Other: |  |  |  |  |  |
| Additional health conditions your doctor has diagnosed: | | | | | |
|  | | | | | |
| Please list any previous injuries, surgeries, and hospitalizations. Provide your age and date if known. | | | | | |
|  | | | | | |

Current list of medications:

Current list of vitamins/supplements/herbs/tonics:

**Goals**

What are your primary goals that you would like to achieve in the next 30 days?

What goals do you wish to accomplish in 6 months?

What goals do you wish to accomplish in 1 year?

What are your obstacles or challenges with achieving your goals?

Identify your ***Stage of Change*** (highlight or circle one)

**Precontemplation**- no intention to change; no knowledge of need for change

**Contemplation**- aware problem exists; seriously thinking about making change

**Preparation**- intending to take action within next month; where behavior and intention meet

**Action**- modify behaviors, environment, or experiences to overcome problem; most effort

**Maintenance**- work to prevent relapse and consolidate gains made

**Fitness History**

Type 1:

Frequency:

Duration:

Intensity:

Type 2:

Frequency:

Duration:

Intensity:

Type 3:

Frequency:

Duration:

Intensity:

How long on regular exercise program?

Ever worked with a trainer before?

If not currently exercising, when was the last time on a regular program?

**Nutrition Profile**

Explain briefly overall nutrition:

Give a sample diet you eat in a typical day below:

Breakfast:

Snack:

Lunch:

Snack:

Dinner:

Snack:

Daily caffeine consumption:

Daily water consumption:

Weekly alcohol consumption:

Hours of sleep per night on average:

Explain your energy level:

Explain your stress level: