New Client Assessment Form

First Name_________________ Last Name_____________________

Address__________________________ City_____________________ State_____ Zip _________

Please indicate your preferred method of contact (Please circle): home work cell email

Home Phone (____) _____-_______ Birth Date _____/ _____/ _____ Age _____

Work Phone (____) _____-_______ Email Address: ________________________

Cell Phone (____) _____-_______ Height ___'_____" Weight_____ Sex_____

Occupation ____________________ Marital Status _________________________

Do you have children? Yes No Age of children ________________________

Are you pregnant? Yes No Due date __________

Primary Care Provider __________________ Date of last physical exam __________________

Would you like to receive email notifications regarding how to live healthy? __________

If yes, please sign ________________________________

How did you hear about us?(circle)friend, online search, social media, other

Know someone that could benefit from joining us?(please write at least one name)

____

Past Medical and Surgical History

Please indicate whether you or your relatives* have been diagnosed with any of the following diseases or symptoms (specify which relative and date of diagnosis) *Relatives include: parents, grandparents, siblings.

Illness/Disease/Symptom	Self: Age Diagnosed	Relative: Age Diagnosed	Describe/Specify
Allergies (specify type of allergy)			
Anemia			
Anxiety or Panic Attacks			
Arthritis (osteoarthritis or rheumatoid)			
Asthma			
Autoimmune conditions (specific type)			
Bronchitis			
Cancer			
Chronic Fatigue Syndrome			
Crohn's Disease or Ulcerative Colitis			
Depression			
Diabetes (specify: Type I, II, Prediabetes, Gestational)			
Dry / Itchy skin, Rashes, Dermatitis			
Eczema			
Emphysema			
Epilepsy, Convulsions, or Seizures			
Eye Disease (specify)			
Fibromyalgia			
Food Allergies or Sensitivities			
Fungal Infection (athlete's foot, ringworm, other)			
Gallbladder Disease/Gallstones (specify)			
Grout			
Heart Attack/Angina			
Heartburn			
Heart Disease (specify)			
Hepatitis			
High blood fats (cholesterol, triglycerides)			
High blood pressure (hypertension)			
Hypoglycemia (low blood sugar)			
Intestinal Disease (specify)			
Inflammatory Bowel Disease (Crohn's or Ulcerative Colitis)			
Irritable Bowel Syndrome			
Kidney Disease/failure or Kidney stone			
Lung Disease (specify)			
Liver Disease			
Mononucleosis			
Illness/Disease/Symptom	**Self:**	**Relative:**	**Describe/Specify**

	Age Diagnosed	Age Diagnosed	
Osteoporosis			
PMS			
Polycystic Ovarian Syndrome			
Pneumonia			
Prostate Problems			
Psychiatric Conditions			
Seizures or Epilepsy			
Sinusitis			
Sleep apnea			
Stroke			
Thyroid Disease (hypo- or hyperthyroid)			
Urinary Tract Infection			
Other (describe)			
Injuries	**Age**	**Describe/Specify**	
Back injury			
Broken (specify)			
Head injury			
Neck injury			
Other (describe)			
Diagnostic Studies	**Age at study**	**Describe/Specify**	
Barium Enema			
Bone Scan			
CAT Scan: abdomen, brain, spine (specify)			
Chest X-ray			
Colonoscopy or Sigmoidoscopy (specify)			
EKG			
Liver Scan			
NMR/MRI			
Upper GI Series			
Other (describe)			
Operations	**Age at operation**	**Describe/Specify**	
Dental surgery			
Gall Bladder			
Hernia			
Hysterectomy			
Tonsillectomy			
Other (describe)			

List any hospitalizations in the last 5 years: ____

____

Do you smoke (please circle)? **Never** **In the past** **Currently** **How long?** _________

Alcohol use: **Never** **In the past** **Currently** **Type/amount/frequency** _________________________

Medication, Supplement, and Antibiotic Intake

Please provide the names of any medications, supplements and/or antibiotics and the dosage you are currently taking.

Medication/Supplement / Antibiotic	Dose	Units	Frequency	Start Date	Stop Date
Example: One-a-Day (brand) Men's Multivitamin	1200	Mg	Daily	08/12/2007	Current

Are you allergic to any medications? Yes No Please list: ____

Lifestyle: Social support and readiness for change

Physical activity: Using the table, please describe your physical activity

Activity	Type/Intensity (low/moderate/high)	# of Days per Week	Duration (minutes)
Stretching/Yoga			
Cardio/Aerobics (walking, jogging, biking, etc.)			
Strength-training (weight lifting, pilates, some yoga)			
Sports or Leisure			
Other (specify/describe)			

Does anything limit you from being physically active?

____

Indicate daily stressors and rate the level of stress from 1 (extremely low) to 10 (extremely high)

Work ________ Family ________ Social ________ Financial ________ Health ________ Other ________

What helps you unwind? ____

On average, how many hours of sleep do you get? Weekdays ________ Weekends ________

Weight History

Would you like to weigh today (please circle)? Yes No

Height ____'____" Weight _______ Desired body weight _______

Have you had any recent changes in your weight that you are concerned about (please circle)? Yes No
If yes, please explain: ____

Diet History:

What barriers are preventing you from achieving your nutrition goals?

____

____

In the past, I have tried the following techniques, diets, behaviors, etc. to reach my nutrition goals...

____

____

____

On a scale of 1 (not willing) to 5 (very willing), please indicate your readiness/willingness to do the following:

To improve your health, how ready/willing are you to:	1	2	3	4	5
Significantly modify your diet					
Keep a record of everything you eat each day					
Modify your lifestyle (ex: work demands, sleep habits, physical activity)					
Practice relaxation techniques					
Engage in regular exercise/physical activity					

Do you follow any special diet or have diet restrictions or limitations for any reason (health, cultural, religious or other)? Yes No If so, please describe ____

Please list any food allergies, sensitivities or intolerances ____

____

Do you find cooking difficult? Yes No Please describe ______________________________________

Which meals do you eat regularly, circle all of the following that apply:
Breakfast Lunch Dinner/Supper Snacks (time__________)

24-Hour Appointment Cancellation Required

BootyLab has a 24-hour cancellation/rescheduling policy. If you miss your appointment, cancel, or change your appointment with less than 24 hours' notice, you will be charged for the visit in full. This policy includes personal training and nutritional counseling sessions.

Thank you for understanding and your cooperation.

I ________________________ have seen and read the Cancelation Policy below and understand it completely.
Please sign: _____________________________ **Date: _____________________________**

I ________________________ have seen and read the HIPPA from and understand it completely.
(This will be shown when you come in.)
Please sign: _____________________________ **Date: _____________________________**

I ________________________ have seen and read the BootyLab Guidelines from and understand it completely. (This will be shown when you come in.)
Please sign: _____________________________ **Date: _____________________________**