



## 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.

<b>Illness/Disease/Symptom</b>	<b>Self: Age Diagnosed</b>	<b>Relative: Age Diagnosed</b>	<b>Describe/Specify</b>
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: Age Diagnosed	Relative: Age Diagnosed	Describe/Specify
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.

<b>Medication/Supplement/ Antibiotic</b>	<b>Dose</b>	<b>Units</b>	<b>Frequency</b>	<b>Start Date</b>	<b>Stop Date</b>
<b>Example:</b> 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

<b>Activity</b>	<b>Type/Intensity (low/moderate/high)</b>	<b># of Days per Week</b>	<b>Duration (minutes)</b>
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 \_\_\_\_\_)

## **12-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 12 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 Cancellation Policy below and understand it completely.

Please sign: \_\_\_\_\_

Date: \_\_\_\_\_

I \_\_\_\_\_ have seen and read the Booty Lab Guidelines from and understand it completely. (This will be shown when you come in.)

Please sign: \_\_\_\_\_

Date: \_\_\_\_\_