Health Risk Assessment

General Information:

Client Name____ Date ____________________________

Address ____

City _______________________________________ State & Zip _________________________________

Phone# ___________________________________ Best Time to Reach ___________________________

D.O.B. ____________________________________ Email _______________________________________

Weight _______________________ Height _______________________ Age ______________________

Emergency Contact Information:

Name ____ Phone Number ____________________________

Exercise History:

1. About how many minutes per week do you spend doing light activity? *Examples: walking 2-3mph, bowling, gardening*

   _______ minutes/week

2. About how many minutes per week do you spend doing moderate activity? *Examples: walking 3.5-4mph, golfing, water aerobics*

   _______ minutes/week

3. About how many minutes per week do you spend doing vigorous activity? *Examples: jogging, aerobic exercise class, cycling, swimming*

   _______ minutes/week

Nutrition:

1. How many servings of fruit do typically eat per day?

   _______ servings/day *(1 serving = medium piece of fruit, 1 cup fruit, ¼ cup dried fruit)*

2. How many servings of vegetables do you typically eat per day?

   _______ servings/day *(1 serving = 1 cup raw vegetables, ½ cup cooked, 2 cups leafy greens)*

3. How many days of week do you usually eat breakfast?

   _______ days/week

4. How many 8oz glasses of water do you typically drink during a day?

   _______ glasses/day

5. How many **sugared** beverages do you usually drink **per day**?

   sweet tea _______ oz, regular soda _______ oz, lemonade _______ oz, fruit juice _______ oz,

   coffee drinks (i.e. frappuccino) _______ oz, energy drinks _______ oz, other ________ oz

6. How many times per week do you typically eat out?

   _______ times/week

Medical History:

	Received a diagnosis or experiencing problems	Currently taking prescription medication (please list name(s))
Allergies (please list)		
Anorexia/Bulimia within last 2 years		
Cancer		
Chronic Fatigue/Fainting		
Diabetes/Hypoglycemia		
Epilepsy/Seizures		
Gout		
Headaches/migraines		
Heart problems, chest pains, diagnosed arrhythmia, COPD		
High blood pressure		
High cholesterol		
Joint pain (such as arthritis)		
Major surgeries scheduled during program		
Osteoporosis		
Pregnant, lactating, or planning to be pregnant during program		
Spinal condition/back pain		
Thyroid condition		
Ulcers/stomach problems		

Social History:

	Yes	If yes, please quantify if applicable
Alcohol use		_____ drinks per day _____ drinks per week
Anger management issues		
Daily vitamins *(If yes, please list in 3rd column)*		
Financial stress		
High stress lifestyle		
Last physical	_______/_______/_______	
Low energy		
Smoke		_____ cigarettes per day _____ cigarettes per week
Stress eater		

Additional prescription medications, vitamins, over the counter drugs and/or supplements:

____

____

____

A doctor's conformation or notification will be decided by your answers on this form.

Client Signature ____ Date ________________

Long Term Goals:

1. ____
2. ____
3. ____

Plan of Action Goals:

1. ____
2. ____
3. ____

Breakfast

Time: __________

____

____

____

Beverage: _________________________________

Lunch

Time: __________

____

____

____

Beverage: _________________________________

Dinner

Time: __________

____

____

____

Beverage: _________________________________

Snacks

Time: _______ ____

Time: _______ ____

Time: _______ ____