General Information

Last Name:
First Name:
Reason for appointment:

Personal Information

Date of Birth:	Occupation:
Height:	Current Weight:
Usual Body Weight:	Desired Weight:

Past Medical History Check-Off

	Client (√)	Family (√)
Acid Reflux		
Asthma		
Depression		
Diabetes		
Food Allergies		
Gastrointestinal Condition		
Heart Disease		
High Blood Pressure		
High Cholesterol		
Hypothyroidism		
Joint or Back Pain		
Kidney Disease		
Liver Disease		
Osteoarthritis		
Overweight/Obese		
Pulmonary Disease		
Stroke		
Urinary Stress Incontinence		
Other:		

Medications:
Vitamins/Minerals/Supplements and/or Herbals:
Do you smoke cigarettes? If so, how much?
Do you drink alcohol? If so, how much?