**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? |