

CLIENT ASSESSMENT FORM

Date:
Program:

Name:	<input type="checkbox"/> M <input type="checkbox"/> F	DOB:
Address:		
Email Address:	Phone:	

ANTHROPOMETRICS:

Height: _____ Weight: _____ Goal Weight: _____ Body fat% _____ RMR: _____

Medical History:	<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Diabetes
	<input type="checkbox"/> High Chol/TG	<input type="checkbox"/> Cancer
	<input type="checkbox"/> HTN	<input type="checkbox"/> GI (IBS)/other

HEALTH & FITNESS GOALS:

- 1.
- 2.
- 3.

Previous weight loss experiences, successes, failures, programs, etc?

Year	Type	Why did it not work out?

How many times per week do you eat out?

Days	Restaurant	Breakfast/lunch/dinner?

What would you identify as your biggest obstacles to achieving your goals?
