847.825.2278 (CAST)

Nutrition and Fitness Assessment

Name: ______________________________________ Age: _________ Gender: ☐ M ☐ F

Address: ____________________________________ Telephone: _____________________________

____________________________________ E-mail: _________________________________

Past/Present Medical History (please check all that apply)

☐ Diabetes Type I	☐ Food allergies	☐ Cancer
☐ Diabetes Type II	☐ Food intolerances	☐ Osteoporosis
☐ High Blood Pressure	☐ Orthopedic problems	☐ Kidney disease
☐ High Cholesterol	☐ Hyperthyroid	☐ Asthma
☐ High Triglycerides	☐ Hypothyroid	☐ Other
☐ Heart Attack	☐ G.I. problems	☐ Other
☐ Heart Disease	☐ Stroke	

Current Medications

Medication/Dose/Frequency	Reason
☐	
☐	
☐	
☐	
☐	
☐	

Current Supplements (please include all vitamins, herbs, nutritional supplements [greens, protein powder, etc])

☐	☐	☐
☐	☐	☐
☐	☐	☐

Surgical History (please list any surgeries you have had and the year each was performed)

☐
___
☐
___
☐
___

Lab Results

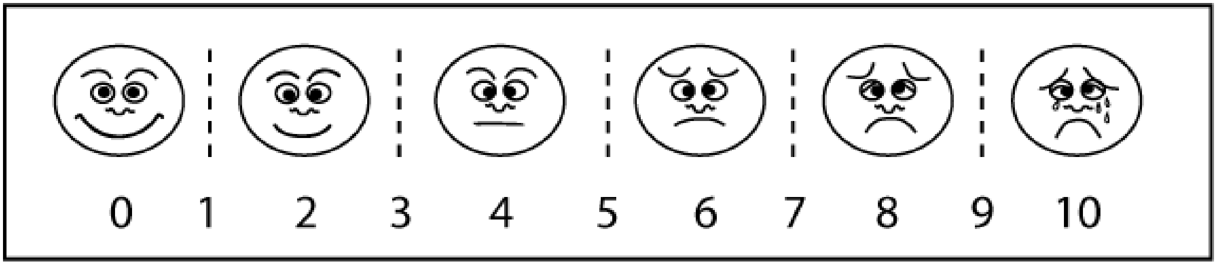
☐ Hgb/Hct	☐ Total Cholesterol	☐ Triglycerides	☐ Total Protein
☐ Na+	☐ HDL	☐ BUN	☐ HgA1c
☐ K++	☐ LDL	☐ Cr	☐
☐ Mg++	☐ Cholesterol Ratio	☐ Albumin	☐

Fitness Test Results (Staff Only)

☐ Height	☐ BP	☐ Sit-ups
☐ Weight	☐ RHR	☐ Push-ups
☐ BMI	☐ Step-test HR	☐ Sit and Reach
☐ % Body Fat	☐ Wall Sit	Circumferential Arm:
Skin fold R arm:	Sum of skin folds:	Circumferential Abdomen:
Skin fold R Abdomen:		Circumferential Waist:
Skin fold R Thigh:		Circumferential Hips:
Skin fold R Chest:		Circumferential Thigh:

Stress Exposure

On a scale from 0 to 10, circle where you would put yourself on a typical day



Wellness Goals (please pick top 3-4 most important goals)

- ☐ Weight loss
- ☐ Weight management
- ☐ Weight gain
- ☐ Advice on healthy nutrition choices
- ☐ Improve overall health
- ☐ Feel better
- ☐ Reduce stress
- ☐ Increased strength
- ☐ Increased muscle endurance
- ☐ Increased cardio endurance
- ☐ Increased flexibility
- ☐ Improved functional movements
- ☐ Tone muscles
- ☐ Other ______________________________

Dietary Information

How many, on average, do you eat/drink of the following each week:

Fast food	0	1-2	3-5	6-8	9-10	>10
Juices	0	1-2	3-5	6-8	9-10	>10
Regular soft drinks	0	1-2	3-5	6-8	9-10	>10
Diet soft drinks	0	1-2	3-5	6-8	9-10	>10
Alcoholic beverages	0	1-2	3-5	6-8	9-10	>10
Processed foods	0	1-2	3-5	6-8	9-10	>10
Sugary foods	0	1-2	3-5	6-8	9-10	>10
Fruits	0	1-2	3-5	6-8	9-10	>10
Vegetables	0	1-2	3-5	6-8	9-10	>10
Red meats	0	1-2	3-5	6-8	9-10	>10
Non-red meats	0	1-2	3-5	6-8	9-10	>10
Fish	0	1-2	3-5	6-8	9-10	>10
Nuts/legumes	0	1-2	3-5	6-8	9-10	>10

How often per week, on average, do you:

Skip meals	0	1-2	3-5	6-8	9-10	>10
Eat a meal at your desk	0	1-2	3-5	6-8	9-10	>10
Go out to a restaurant for a meal	0	1-2	3-5	6-8	9-10	>10
Eat carry-out	0	1-2	3-5	6-8	9-10	>10
Eat a frozen meal	0	1-2	3-5	6-8	9-10	>10

How often, on average, do you eat each day?

- ☐ > 6 times a day
- ☐ 3-4 times a day
- ☐ Whenever hungry
- ☐ 5-6 times a day
- ☐ Breakfast, lunch and dinner
- ☐ 2 or fewer times a day

Current Activity Level

On a scale of 1 (primarily sedentary) to 10 (vigorous exercise), how would you score your typical daily activity level?

1 2 3 4 5 6 7 8 9 10

Describe your current exercise regime, if any:

____

____

____

Achieving Your Goals

On a scale of 1 to 10, how ready are you to commit to achieving your goals?

1 2 3 4 5 6 7 8 9 10

What keeps you from achieving your nutrition and fitness goals? (please check all that apply)

- ☐ Lack of "how to" knowledge
- ☐ Cost
- ☐ Lack of equipment
- ☐ Hitting a plateau
- ☐ Time
- ☐ Getting started
- ☐ Lack of results
- ☐ Self-consciousness
- ☐ Staying motivated
- ☐ Other: ____

What motivates you? (please check all that apply)

- ☐ Seeing results
- ☐ Accountability to self
- ☐ Accountability to group
- ☐ Having fun
- ☐ Praise/Rewards
- ☐ Feeling better
- ☐ Competition with self
- ☐ Competition with others
- ☐ Tracking results
- ☐ Other: ____

Describe any physical limitations that might impact the design of your fitness program.

____

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What do you expect from your personal nutrition and fitness trainer?

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What else would you like us to know?

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____

****FOR STAFF:***

Treatment Plan Recommendations:

Rehabilitation Care:

Primary Medical Care:

Nutritional Counseling:

Personal Training:

Individual:

Small Group:

Session Availability:

Monday:	**Tuesday**	**Wednesday**	**Thursday**	**Friday**	**Saturday**
Morning	Morning	Morning	Morning	Morning	Morning
Afternoon	Afternoon	Afternoon	Afternoon	Afternoon	Afternoon
Evening	Evening	Evening	Evening	Evening	Evening