GREATER
LIFE
NUTRITION

1801 Red Bud Lane, Suite A
Round Rock, TX 78664

Today's Date: _____

Health Assessment

Office Use ONLY
1 2 3

First Name: _____ Last Name: _____
Address: _____
City: _____ State: _____ Zip Code: _____
Phone (Cell): _____ Phone (Home/Work): _____
Date of Birth: ___/___/_____ Age: _____ Sex: _____ Race: _____
Email Address (Please Print) _____
Current Height: _____ Weight: _____Weight 1 Year Ago: _____
Lowest Adult Weight: _____ At what Age? _____ How long maintained? _____
Lowest Adult Weight Maintained for > 1 year_____ At what age? _____
What is your personal goal weight this time? _____lbs

How many times have you intentionally lost 20lbs or more and gained it all back?
Never Once or twice _ 3-4 Times _ 5+ Times _ _

*Have you ever been Diagnosed with an Eating Disorder? Yes or NoIf Yes, what type? _____

Do you exercise? Yes or No Frequency per week? _____Hrs or mins per session_____
How long have you been exercising? _____ What type of exercise do you do? _____

Check all that Apply:

☐ I eat when I am not hungry.	☐ I can over eat almost any food.
☐ I sometime eat much faster and/or much more than others.	☐ I graze or snack frequently between meals
☐ I isolate from others so I can eat the way I want.	☐ I am obsessive about the way I think about food.
☐ I sometimes think I will Eat moderately and then eat much more than I expected to eat.	☐ I think weight causes me serious physical and social problems and I still overeat
☐ I use food to numb difficult feelings	☐ I have tried to stop bingeing and been unable to stay stopped

Medical Diagnosis: (Have you ever been Diagnosed with Anything?)

Year	Reason

List All Current Medications and Supplements Including Name, Frequency, and Dose (Include hormones and birth control pills.)

Name of Medication	Dose	Frequency		Name of Medication	Dose	Frequency

Do you Smoke Cigarettes? _____(Y/N) If Yes, # per day _____ For how long? _____
Do you Drink Alcohol? _____ (Y/N) If yes, How Much/Quantity per Week? _____
Have you ever participated in Counseling or Psychotherapy? (Y/N)_____
If yes, Whom_____
Type: Individual: Family _ Couples_ _ Substance abuse ____

Check if YOU have or had any of the following:

Condition	Check	Condition	Check	Condition	Check
Cancer (Active)		Asthma		Irregular Heartbeat	
Diabetes		Anemia		Phlebitis	
Kidney Disease (Dialysis) ESRD		Chest Pain		Low Back Pain	
Severe Depression		Chronic Diarrhea		Epilepsy	
Celiac		Chronic Constipation		Seizures	
Heart Disease		Fainting		Shortness of Breath	
Liver Disease		Frequent Headaches		Sleep Difficulties	
Kidney Disease (Non-Dialysis)		Frequent Nausea		Stroke	
		Gallbladder Disease		Swelling of Feet	
Cancer (Previously)		Gout		Thyroid Disease	
High Blood Pressure		Heartburn Allergies		Ulcers	
High Cholesterol		Dizziness		Yellowing	
Lap band		Arthritis		Hemorrhoids	
Gastric Bypass		Alcoholism/Drug Abuse		Neuropathy	
Anxiety/Panic Attacks		Mild Depression			

For Women Only:Please check ALL that Currently Apply

Do you have an IUD		**Do you take Birth Control**		**Hormone Replacement Therapy**	
E-sure		**Use any other form of Birth Control**		**Are you Pregnant or Planning to be Pregnant (next 6 months)**	
PCOS		**Full Hysterectomy**		**Partial Hysterectomy**	

Do you still menstruate regularly? Yes No
If No, When did you Stop Menstruating and Why?_____

Primary Care Physician:
Full Name: _____
Address: _____
Phone Number: _____

Additional Care Provider(s)
Full Name: _____
Address: _____
Phone Number: _____

Consent to Contact PCP or Other Health Care Providers:

_____ _____
Sign Date

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25% BF (F) _____

20% BF (M) _____

New Weight:_____

Current Weight:_____Desired Weight:_____Date:_____

***How did you hear about us?
TV:_____Internet:_____Newspaper:_____Radio:_____

***If someone referred you who may we Thank?_____

Weight loss can be complex. If you have failed in the past, it could be because you have some of the following (Check All that Apply)

- ☐ Fatigue
- ☐ Difficulty getting to sleep
- ☐ Difficulty staying asleep
- ☐ High amounts of stress
- ☐ Over heating
- ☐ Cold hands and feet
- ☐ Low sex drive
- ☐ Abdominal Pain
- ☐ Diarrhea
- ☐ Constipation
- ☐ Gas after a meal
- ☐ Frequent Urination
- ☐ Sugar Cravings
- ☐ Irritable if meals are missed
- ☐ Fatigue after meals
- ☐ Fibromyalgia
- ☐ Depression
- ☐ Mental fatigue
- ☐ Menopause
- ☐ Muscle pain
- ☐ Joint pain
- ☐ Back pain
- ☐ Knee pain
- ☐ Hip pain
- ☐ Take pain medication

Please list any of the major health concerns in order of importance

1._____
2._____
3._____
4._____

Please list any food allergies

1._____
2._____

Previous Weight Loss Plans and / or surgeries

_____
_____

Name_____

Date of birth: _____