

CLIENT INITIAL HEALTH ASSESSMENT

Please fill out this assessment form prior to our first session. It will be reviewed at the first session.

NAME:

DATE:

ADDRESS:

CITY:

STATE:

ZIP:

PHONE:

EMAIL:

AGE:

HEIGHT:

WEIGHT:

OCCUPATION:

HOURS WORKED/WEEK:

RELATIONSHIP STATUS:

CHILDREN - HOW MANY:

HOW DID YOU HEAR ABOUT US?

The information provided will be utilized to help you achieve your health goals. Please be as thorough and accurate as possible.

The information provided by Origin is for educational purposes only and is not a substitute for professional medical care. We are not doctors and do not provide medical advise, diagnosis, treatment or other services to prevent or cure disease. If you believe you have a health problem, or if you have any questions regarding your health or a medical condition, you should consult your physician or other qualified healthcare provider.

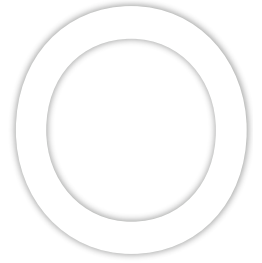
1. What are your health goals for these consultations?

2. What do you typically eat for breakfast?

Lunch?

Dinner?

Snacks?



3. At what general time do you eat breakfast?

Lunch?

Dinner?

Snacks?

4. Do you use caffeine? If so, from what source(s) (coffee, tea, soda)?

5. How many hours do you usually sleep at night? Do you feel that you have any sleep issues?

6. Do you have regular bowel movements? Any problems with constipation or diarrhea?

7. Do you have or have you had any major illnesses?

8. How is/was the general health of your mother, father and any siblings?

9. Do you take any vitamins or supplements?

10. How much water do you drink in a day? Is your water from the tap, bottled or filtered?

11. Do you consume alcohol?

12. Do you smoke?

13. Do you cook your own meals? If so, how often?

14. How often do you eat out? When you eat out, do you typically eat at a deli, a restaurant or fast food?
15. What types of diets have you tried? Have you felt that any of them were successful?
16. Do you struggle with cravings? If so, for what? Is there a time of day that your cravings are the strongest?
17. Describe your physical activity, what kind and how often?
18. On a scale from 1-5, with 5 being the highest, how would you rate your overall stress level?
19. Using the same scale, how would you rate your overall energy level?
20. How would you describe your general mood? Generally happy? Varying mood swings?
Extreme mood swings? Depression?
21. How often would you say that you get sick? How severe are your illnesses?
22. Do you have any food allergies that you know of?
23. Do you know your cholesterol level?
24. Do you focus on a low-fat or fat controlled diet?
25. Are you happy with your current weight? What is your history of weight loss/gain?
26. Is there anything else you want to share about your eating or lifestyle habits?