**CLIENT ASSESSMENT**

Name:

Age:

Male/ Female:

Current Weight:

Date of Birth:

Date of commencement:

\*Home Physical Address (meal delivery clients):

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  |  | MEDICAL HISTORY QUESTIONNAIRE | | |
|  |  | Section A | |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  | 1 | When last did you have a physical examination? |  |
|  |  |  |  |  |
|  |  | 2 | If you are allergic to any foods, medications, or other substances, please name below: | | |
|  |  |  |  |  |  | |
|  |  | 3 | If you have been told that you have any chronic or serious illnesses, please list below: | | |
|  |  |  |  |  |  | |
|  |  | 4 | Give the following information pertaining to the last 3 times you have  been hospitalised (if applicable) |  |  | |
|  |  |  |  |  |  | |
|  |  |  | Reason for hospitalisation: |  |  | |
|  |  |  | Month and year of hospitalisation: |  |  | |
|  |  |  | Hospital: |  |  | |
|  |  |  | City/ Province: |  |  | |
|  |  |  |  |  |  | |
|  |  |  |  |  |  | |
|  |  | Section B | |  |  | |
|  |  |  |  |  |  | |
|  |  |  | **During the last 12 months:** |  |  | |
|  |  |  |  |  |  | |
|  |  |  |  |  |  | |
| Yes | No | 1 | Has a physician prescribed any form of medication for you? |  |  | |
|  |  |  |  |  |  | |
|  |  |  |  |  |  | |
| Yes | No | 2 | Has your weight fluctuated more than a few kilograms? |  |  | |
|  |  |  |  |  |  | |
|  |  |  |  |  |  | |
| Yes | No | 3 | Did you attempt to bring about this weight change through diet or exercise? |  |  | |
|  |  |  |  |  |  | |
|  |  |  |  |  |  | |
| Yes | No | 4 | Have you experienced any faintness, light-headedness, or blackouts? |  |  | |
|  |  |  |  |  |  | |
|  |  |  |  |  |  | |
| Yes | No | 5 | Have you occasionally had trouble sleeping? |  |  | |
|  |  |  |  |  |  | |
|  |  |  |  |  |  | |
| Yes | No | 6 | Have you experienced blurred vision? |  |  | |
|  |  |  |  |  |  | |
|  |  |  |  |  |  | |
| Yes | No | 7 | Have you had any severe headaches? |  |  | |
|  |  |  |  |  |  | |
|  |  |  |  |  |  | |
| Yes | No | 8 | Have you experienced chronic morning cough? |  |  | |
|  |  |  |  |  |  | |
|  |  |  |  |  |  | |
| Yes | No | 9 | Have you experienced any temporary change in your speech  pattern, such as slurring or loss of speech? |  |  | |
|  |  |  |  |  |  | |
|  |  |  |  |  |  | |
| Yes | No | 10 | Have you felt unusually nervous or anxious for no apparent reason? |  |  | |
|  |  |  |  |  |  | |
|  |  |  |  |  |  | |
| Yes | No | 11 | Have you experienced unusual heartbeats such as skipped  beats or palpitations? |  |  | |
|  |  |  |  |  |  | |
|  |  |  |  |  |  | |
| Yes | No | 12 | Have you experienced periods in which your heart felt as though it were racing for no apparent reason? |  |  | |
|  |  |  |  |  |  | |
|  |  |  | **At present:** |  |  | |
|  |  |  |  |  |  | |
|  |  |  |  |  |  | |
| Yes | No | 1 | Do you experience shortness or loss of breath while walking with others your own age? |  |  | |
|  |  |  |  |  |  | |
|  |  |  |  |  |  | |
| Yes | No | 2 | Do you experience sudden tingling, or numbness, or loss of feeling in your arms, hands, legs, feet or face? |  |  | |
|  |  |  |  |  |  | |
|  |  |  |  |  |  | |
| Yes | No | 3 | Have you ever noticed that your hands or feet sometimes feel cooler than other parts of your body? |  |  | |
|  |  |  |  |  |  | |
|  |  |  |  |  |  | |
| Yes | No | 4 | Do you experience swelling of your feet or ankles? |  |  | |
|  |  |  |  |  |  | |
|  |  |  |  |  |  | |
| Yes | No | 5 | Do you experience any discomfort in your chest? |  |  | |
|  |  |  |  |  |  | |
|  |  |  |  |  |  | |
| Yes | No | 6 | Do you get pains or cramps in your legs? |  |  | |
|  |  |  |  |  |  | |
|  |  |  |  |  |  | |
| Yes | No | 7 | Do you experience any pressure or heaviness in your chest? |  |  | |
|  |  |  |  |  |  | |
|  |  |  |  |  |  | |
| Yes | No | 8 | Have you ever been told that your blood pressure was abnormal? |  |  | |
|  |  |  |  |  |  | |
|  |  |  |  |  |  | |
| Yes | No | 9 | Have you ever been told that your serum cholesterol or triglycerides level was high? |  |  | |
|  |  |  |  |  |  | |
|  |  |  |  |  |  | |
| Yes | No | 10 | Do you have diabetes? |  |  | |
|  |  |  |  |  |  | |
|  |  |  |  |  |  | |
| Yes | No | 11 | If yes, how is it controlled? |  |  | |
|  |  |  |  |  |  | |
|  |  |  |  |  |  | |
|  |  |  |  |  |  | |
| Yes | No | 12 | Have you ever been told that you have any of the following diseases? |  |  | |

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| 12 | Have you ever been told that you have the following illnesses? | | | | | |
|  |  |  |  |  |  |  |
|  |  | Myocardinal infarcation |  |  | Arteriosclerosis |  |
|  |  |  |  |  |  |  |
|  |  | Heart  disease |  |  | Thyroid disease |  |
|  |  |  |  |  |  |  |
|  |  | Coronary thrombosis |  |  | Rheumatic heart |  |
|  |  |  |  |  |  |  |
|  |  | Heart attack |  |  | Heart valve disease |  |
|  |  |  |  |  |  |  |
|  |  | Coronary  occlusion |  |  | Heart Failure |  |
|  |  |  |  |  |  |  |
|  |  | Heart murmur |  |  | Heart block |  |
|  |  |  |  |  |  |  |
|  |  | Aneurysm |  |  | Angina |  |
|  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |
| 13 | Have you ever had any of the following medical procedures? | | | | |  |
|  |  |  |  |  |  |  |
|  |  | Heart  surgery |  |  | Pacemaker implant |  |
|  |  |  |  |  |  |  |
|  |  | Cardiac catheterization |  |  | Defibrilator |  |
|  |  |  |  |  |  |  |
|  |  | Coronary angioplasty |  |  | Heart transplantation |  |
|  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |

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|  |  |  | Section C |  |  |  |
|  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |
|  |  |  | Has any member of your immediate family been treated for or suspected to have any of these conditions? Please identify relationship to you (mother, sister, brother, etc): |  |  |  |
|  |  |  |  |  |  |  |
|  |  |  | i) Diabetes |  |  |  |
|  |  |  |  |  |  |  |
|  |  |  | ii) Stroke |  |  |  |
|  |  |  |  |  |  |  |
|  |  |  | iii) Heart disease |  |  |  |
|  |  |  |  |  |  |  |
|  |  |  | iv) High blood pressure |  |  |  |

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| --- |
| Goals and objectives during this evaluation period |
|  |
| List of food preferences (wHAT FOOD DO YOU LIKE) |
|  |
| How often do you eat out? |
|  |
| WHEN YOU EAT OUT WHAT DO YOU USUALLY EAT? |
|  |
| HOW OFTEN DO YOU EXERCISE? |
|  |
| WHAT DO YOU NORMALLY EAT ON A TYPICAL DAY FROM BREAKFAST TO DINNER? INCLUDING SNACKS? |
| Breakfast:  Lunch:  Dinner:  Snacks: |

Acknowledgement

You acknowledge that the information that you have provided to Body Evolution is both true and correct.

Members Name:

Signature:

Date:

Place signed