Fit 4 Life™
Lifestyle & Movement Experts

HPN™
HOLISTIC PERFORMANCE NUTRITION

New Client Information

Name____ **Date**__________________

Address____

City______________________ **State / Country**__________ **Post Code**______________

Home #_________________ **Cell #**___________ **Work #**__________________

E-Mail________________________________ **Occupation**______________

Referred By__________________________ **D.O.B**__________________

Age:	**Wt:**	**Ht:**	**BP:**	**BF%:**
Measurements:	**Chest:**	**Waist:**	**Hips:**	

What is your main reason for seeking nutritional guidance?

____

____

____

What are your expected outcomes from this process?

____

____

____

____

Family History (tick all that apply):

Stroke	☐	Diabetes	☐
High BP	☐	Weight Problems	☐
Depression	☐	Ulcer	☐
Heart Disease	☐	Psoriasis	☐

Notes:__________________________________

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Arthritis (RA or OA) ☐ Glaucoma ☐ ____

Cancer ☐ Type?________________ Family Side: ♀____♂____

Personal History (circle all that apply):

Arthritis RA OA Stroke High Cholesterol How High?_______ High Blood Pressure How High?_______ Diabetes Metabolic Syndrome Insulin Resistance Low Blood Sugar Chronic Fatigue Fibromyalgia Multiple Chemical Sensitivities Infectious Mononucleosis Frequent Colds/Flu Herpes/ HPV Cold Sores Cancer What type?_________ Chemo?____________ Rads? Steroids? Surgeries What type?____________________ ______________________________ ______________________________	Thyroid Problems Hypothyroidism Hyperthyroidism Headaches Chronic Tension Migraines Cluster Hormonal Food Allergies To What?____________ Seasonal Allergies To What?____________ Medication Allergies To What?____________ Sleep Problems Forgetfulness Hot Flashes PMS Birth Control Pills/ Hormones Weight Problems Constipation Diarrhea Abdominal Cramping/ Bloating Yeast Infections Low Libido Ulcers

On a scale of 1-10, how would you rate your energy levels? (circle) (1=poor; 10=excellent)

1 2 3 4 5 6 8 9 10

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How would you describe your general health? (circle):

Excellent *Very Good* *Good* *Ok* *Poor*

What Medications and Dosages are you taking? List all please:

____

____

____

What Vitamins and herbal supplements are you taking? List all please:

____

____

____

Circle all that applies to you

Antacids	*Daily Often Sometimes Never*	**Protein Drinks**	*Daily Often Sometimes Never*
Appetite Suppressants	*Daily Often Sometimes Never*	**Aspirin**	*Daily Often Sometimes Never*
Coffee	*Daily Often Sometimes Never*	**Alcohol**	*Daily Often Sometimes Never*
Tylenol	*Daily Often Sometimes Never*	**Tap water**	*Daily Often Sometimes Never*
Decaf Coffee	*Daily Often Sometimes Never*	**Ibuprofen**	*Daily Often Sometimes Never*
Bottled water	*Daily Often Sometimes Never*	**Diet Soda**	*Daily Often Sometimes Never*
Laxatives	*Daily Often Sometimes Never*	**Refined sugars**	*Daily Often Sometimes Never*
Candy	*Daily Often Sometimes Never*	**White bread**	*Daily Often Sometimes Never*
Margarine	*Daily Often Sometimes Never*	**Butter**	*Daily Often Sometimes Never*
Fast foods	*Daily Often Sometimes Never*	**Chewing gum**	*Daily Often Sometimes Never*
Fried foods	*Daily Often Sometimes Never*	**Chips**	*Daily Often Sometimes Never*

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Salt w/out tasting	*Daily* *Often* *Sometimes* *Never*	**Tobacco**	*Daily* *Often* *Sometimes* *Never*
Cigarettes	*Daily* *Often* *Sometimes* *Never*	**Artificial Sweeteners**	*Daily* *Often* *Sometimes* *Never*
Coffee Creamers	*Daily* *Often* *Sometimes* *Never*		

List any food aversions and/or foods you dislike:

____

____

Do you get noticeably irritated, weak, or lightheaded if you haven't eaten in a while?

____

Do you crave certain foods? _________ What foods? Sweets? Chocolate? Bread/Pasta? Fried Foods? Alcoholic drinks? Sodas/Diet Sodas? Meat? Other?

____

Are you:

Under excessive amounts of stress______ at home__________ at work___________
Physical Stress____________________ Mental Stress________________________________
Exposed to chemicals regularly________ Type_________________________________
Exposed to smoke regularly__________

How often do you have bowel movements? ______________per day/ week/ month
Urinate? _________ per day

How is your dental health? Prone to Cavities? Gum Disease? Bleeding Gums?
____

Are your nails week or brittle?____

Average Sleep per night? ____

Any sleeping problems? ____

To what extent will you commit to achieving better health?

Little_______ Moderate _______ Major________ Extreme_______

Is there anything else about either your history or your current condition that you feel is important to mention?

____

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