



SKIN & LASER CLINIC

Lifestyle & Nutrition Assessment

Client Name: _____

Has your appetite changed recently? Yes _____ No _____

How many times a day do you eat? _____

How long does it take you to complete a meal? _____

Describe a typical:

Breakfast:

Lunch:

Dinner:

Snacks:

How many caffeinated drinks do you have a day? _____

Alcohol _____/day-week-month

Pop- regular or diet _____/day-week/month

How many times per week do you eat away from home? _____

List the type of restaurant(s):

List any food cravings? _____

List your favorite foods: _____

List foods you do not like: _____

Have you ever tried to lose weight before? Yes _____ No _____

Past diets you have attempted? _____

Number of attempts? _____



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Have you ever been advised by your physician to follow any type of diet? Yes _____ No _____

If "Yes" what type? What results did you have?

How would you rate your energy level on a scale of 1-10? (10 being high energy) _____

How would you rate your stress levels on a scale of 1-10? (10 being highly stressed) _____

Which of the following primarily describes your work or daily activity (please circle):

Sitting / Standing / Walking

How often each week do you engage in structured exercise? _____ Minutes _____ /Times a Week

What type of exercise do you do? _____

List any other activity and how many minutes you spend in each: _____

What are your main concerns regarding your exercise routine? _____

What are your main concerns with your eating habits/relationship with food? _____

What is/are the most important goal(s) for us to work on in our sessions? _____

What is your ideal/ goal weight? _____



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Body Composition Testing

Height _____ Presence _____ Activity Level (1-2-3-) _____
 Weight _____ %Body Fat _____
 %Water Hydration _____ Lbs Lean Mass _____ Lbs Fat Mass _____
 Estimated Daily Calorie Intake _____

Medical & Physical History

Check all that apply

Constipation/Bowel Problems	_____	Aching Joints	_____
Arthritis/Rheumatism	_____	Muscle cramps/aches	_____
Family Overweight	_____	Strong menstrual cramps	_____
Pain Killer/ Sleeping Pills	_____	PMS/ difficult cycle	_____
Cellulite	_____	Pre or Menopause	_____
Blood Pressure High/Low	_____	Yeast Infections	_____
Gastric Pains/Ulcers	_____	Frequent colds/infections	_____
Heart Disease	_____	Difficulty handling stress	_____
Cancer	_____	Poor concentration/lack of alertness	_____
Asthma	_____	Strong desire for sweets/chocolate	_____
Food Allergies	_____	Strong desire for breads/ beer	_____
Depression	_____	Take aspirin/ibuprofen often	_____
Anxiety	_____	Heartburn/Indigestion	_____
Fatigue/Lack of energy	_____	Abdominal Bloating/Gas	_____
Difficulty getting up in the morning	_____	Chronic Fatigue/Fibromyalgia	_____
Mid afternoon fatigue	_____	High Cholesterol	_____
Difficulty falling asleep	_____	Easily Irritated/Short Temper	_____
Overweight	_____	Lack of motivation/drive	_____
Headaches	_____	Birth Control	_____
Migraines	_____		

Other: _____

I hereby acknowledge that the products and wellness programs are not meant to replace the services of my physician, but rather as an adjunct to the other therapies, if desired. I understand that I should contact my physician before beginning any exercise, wellness or weight loss program. I am assuming full responsibility and hereby release Rejuv Skin & Laser Clinic and Charmaine Schmidt forever and fully of any responsibility. I have read and fully understand and comply with these statements.

Signature _____ Date: _____