Khronology Functional Fitness and Nutrition
Initial Fitness and Nutritional Assessment

Name: _____
Email: _____
DOB: _____ Age:_____ Gender:_____
Height: _____ Weight:_____ Usual Weight: _____ Desired Weight: _____
Have you gained or lost weight recently ?(y/n)____ If so, why? _____
What are your main personal health concerns, in order of importance? Have you received any treatment for these concerns?
_____
_____
_____

Please indicate if you or a family member has had any of the following now or in the past, along with years affected if known:

Self	Specified Relative	Disease
		heart disease/heart attack
		stroke
		elevated cholesterol
		hypertension/high blood pressure
		diabetes
		metabolic syndrome / insulin resistance / hypoglycemia
		thyroid issues
		hormonal issues
		depression/anxiety/mental issues
		eating disorder
		crohn's disease / IBS
		celiac disease
		food allergies
		environmental allergies
		skin conditions (eczema, psoriasis, etc)
		autoimmune disorder / CFS
		gout/arthritis
		cancer
		respiratory issues (asthma, COPD, etc)

Do you use tobacco products?(y/n) _____ If yes, how much and what type? _____
Do you have any recent lab result(s) you would like to share? (cholesterol, blood sugar, blood pressure, etc)

Current Medications:	Name	Dosage	For what?
_____	_____	_____	
_____	_____	_____	

Current Supplements / Herbs / Vitamins:	Name	Dosage	For what?
_____	_____	_____	
_____	_____	_____	
_____	_____	_____	

Please list any alternative treatments you are undertaking_____

Number of bowel movements per day :_____
Do you have cravings?(y/n)_____ If so, what kind of food(s)? _____
Do you have any food allergies or sensitivities? (y/n)_____ If so, what kind of food(s)? _____
How many times per day do you eat (include a meals and snacks)? _____
Do you ever skip meals? (yn)_____ If so, which ones and why? _____
Have you ever been on a modified diet (vegan/vegetarian; Paleo; weight watchers; raw food; Atkins, etc)? Please list all_____
Do you generally cook your own meals? (yn)_____
Where do you usually grocery shop? _____
How would you describe most meals? Relaxed? Rushed? At table? In front of TV? In car? Alone? With family/friends? _____
What is your relationship with food? (example – do you "live to eat" or "eat to live"?)_____
Do you need caffeine / sweets in the afternoon?_____
How often do you exercise (times per week)?_____
How long are your exercise sessions?_____
What type of exercises do you do?_____
Do you have any reasons you should NOT do physical activity?_____
How often do you engage in stress relieving activities? (times per month)_____ What do you do?_____
How many hours of sleep do you get on average per night?_____
Do you feel your sleep is restful?_____
Do you have any difficulty falling asleep, staying asleep or waking up in the morning?_____
What is your usual bed time?_____ Waking time?_____
How would you rate your energy level on a scale of 1 (low) to 10 (high)_____

Please indicate by highlighting if you have any of the following symptoms:

dry, cracked or brittle nails	dry, itchy, scaling, flaky skin/rashes	dandruff
achy or stiff joints	thirsty most of the time	constipation
poor mood / irritable/ easily angered	difficulty focusing or concentrating	PMS
lack of motivation / depressed mood	trouble waking up in the morning	need substances to get going (i.e. caffeine)
low self esteem/confidence	trouble falling asleep	trouble staying asleep
crave sweets	crave starch like bread and pasta	crave salt
easily stressed/overwhelmed	weak and shaky at times	anxious or stressed if skip meals
sore/weak muscles	frequent infections	heart flutters/palpitations
frequent headaches or migraines	acid reflux / heartburn	muscle twitching
impaired taste or smell	frequent diarrhea	wounds heal poorly
hair loss	sexual difficulty	excessive sweating
body odor	bad breath	edema / retaining water
bloated / gassy	sensitive to cold	cold hands/feet
mood swings	dont feel well after eating	sinusitis/allergies
chronic yeast/fungal infections (jock itch, athlete's foot)	mouth sores	dark smelly urine
dizziness when standing	dark circles under eyes	panic attacks
PLEASE LIST ANY OTHER BOTHERSOME SYMPTOMS		

1. What are your major fitness goals? [circle all that apply]
Fat loss / Muscle gain
General fitness
Functional fitness
Aerobic conditioning
Muscular endurance
Muscular strength
Improved flexibility
Other:

2. What is your current level of fitness? [What is fitness level? Your fitness level means your body's ability to withstand a physical workload (how much) and to recover in a timely manner.]
0-Decoditioned-never worked out 1-novice 2-internediate 3-advanced 4-athlete

3. Are there any body parts that you would like to focus on?

Legs Arms Butt

Abs Chest Other?

4. What are your top three fitness goals?

1)

2)

3)

5. How long after beginning your training do you expect to see/feel changes in your body?

1 week / 2 weeks / 4 weeks / 6 weeks

6. Do you have a specific event / date you are focusing on for your fitness goals?

7. How would you describe your current knowledge of exercise and fitness training?

I am not familiar / I have a little experience /
I am quite experienced / I am an expert

8. If you currently exercise, would you say your routine is:

Ineffective / Effective / Very Effective

9. What will motivate you to achieve your fitness goals?

10. How motivated are you to achieving your goals?

Least 1 2 3 4 5 Most

11. What, if any, are your expected barriers towards your exercise program? (E.g. long work hours, lack of facilities or time)

I understand and acknowledge that recommendations and services provided are done so solely for the purpose of wellness and prevention, and is in no way intended to diagnose or treat serious medical conditions. All information will be kept strictly confidential.

Electronic Signature: _____ Date: _____