Inside Out Weight Loss Program

Initial Evaluation Form—Physical Wellness

Fill out & Bring to Physical Wellness Visit

General Medical History & Information

Are you under the care of a physician, chiropractor, or other health care professional for any reason?

If yes, list reason:____

Are you aware of any disease or disorder that would complicate your participation in a testing or exercise program?____

Has your doctor ever told you that you have a bone or joint problem that has been or could be made worse by exercise?____

Are you taking any medications? If yes please indicate the type of medication, dosage, frequency and reason(s) for taking it. ____

Please list any allergies____

Has your doctor ever said your blood pressure was too high? ______________________________

Are you over age 65? ____________ **Are you unaccustomed to vigorous exercise?** ____________

Is there any reason not mentioned here why you should not follow a regular exercise program?
If so, please explain ____

Please describe any past or current musculoskeletal conditions you have incurred such as muscle pulls, sprains, fractures, surgery, back pain, or general discomfort:

Head / Neck ____

Upper Back ____

Shoulder / Clavicle ____

Arm / Elbow ____

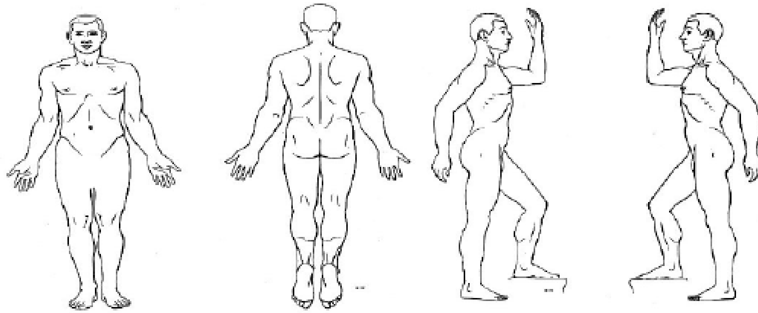
Wrist / Hand ____

Lower Back ____

Hip / Pelvis ____

Thigh / Knee ____

Lower Leg / Ankle / Foot



Please circle any areas of pain, injury, tension, or restriction of movement.

Have you recently experienced any chest pain associated with either exercise or stress?
If so, please explain ____

Do you have a family history of any of the following conditions?

Heart Disease _________ Heart Attack _________ Hypertension _________ Gout _________

Abnormal EKG _________ Asthma _________ High Cholesterol _________ Angina _________

Diabetes _________ Other heart conditions _________

Do you have a family history of cardiovascular disease? If so, how many occurrences and what approximate ages? ____

Are you a smoker? If so, what is your smoking frequency? ______________________

Are you on any specific food / nutritional plan at this time? ______________________

Do you take dietary supplements? If yes, please list ______________________

____

How many beverages do you consume per day that contains caffeine? ______________

Do you experience any frequent weight fluctuations? ______________________

Have you experienced a recent weight gain or loss? ______________________

If yes, list change ______________________ Over how long? ______________

Your answers to these questions will be discussed with you prior to your session. Thank You.

Body Type / Activity Level / Goal Information

What are your goals? (Circle those that apply)

Body Fat Loss   Muscle Gain   Strength Production   Increase Flexibility   General Health Maintenance

How active are you and/or what is your exercise lifestyle like? (Circle those that apply)

Sedentary   Moderate Exercise   Competitive Exercise   Bodybuilding

Does your job require you to be….. (Circle those that apply)

Sedentary   Somewhat Active   Active   Very Active

Please answer yes or no to the following questions:

Is it hard for you to gain weight?
Can you eat a lot and still not gain weight?
Do you gain or lose weight according to your fluctuations in activity and food consumption?
Is it hard for you to lose weight?
Do you gain weight if you're not careful about food intake?

Current Nutritional Consumption

Please list the foods, beverages, supplements etc that you take on the average day.

Time / Qty / Food-Beverage-Supplement