

Allison Walker – Personalized Wellness

* Fitness Specialist

* Dietitian

* Motivational Speaker

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General Information

Date _____ Age _____ DOB _____ Ht. _____ Wt. _____ Desired Wt. _____ M _____ F _____

Please wrap your middle finger and thumb around your wrist. Select one:

Fingers Overlap _____ Fingers Meet _____ Fingers Barely Touch _____

Name _____

Address _____

Phone Local _____ Work _____ Other _____

E-mail address _____

Married _____ Single _____ Children _____ If so how many? _____

Pregnant _____ Lactating _____ Trying to Have Children _____

Occupation _____

What are your specific goals for this meeting? What particular questions do you have before we begin? _____

Personal Health Information

Please list any medical problems/complications that may affect your diet (i.e. appetite, wt. gain/loss, food intolerance/allergies, etc.) _____

Please check all that apply.

- Diabetes/Gestational Diabetes
- Heart Disease/Related Problems
- High Cholesterol
- High Blood Pressure
- Low Blood Pressure
- Gastric Bypass Surgery
- Diverticulitis
- Significant Weight Loss
- Osteoporosis
- Pace Maker

- Kidney Problems
- Constipation
- Diarrhea
- Cancer
- Chewing/Swallowing Problems
- Anemic
- Significant Weight Gain
- Thyroid Problems
- Have tried multiple diets
- Elevated Liver Enzymes

Please list any medications that you take daily _____

Personal Lifestyle Information

Do you smoke cigarettes? _____ If so, how many per week? _____

Do you drink alcoholic beverages? _____ If so how many per week? _____

Do you take any supplements on a daily basis? _____ If so, please list them and how many. _____

Would you say that you eat out more often or prepare food at home more often? i.e. pack a lunch, eat dinner at home, and etc. _____ Who prepares meals at home? _____

How many ounces of the following beverages do you drink in a day?

(Diet /Regular Cola) _____ oz. Tea _____ oz. Coffee _____ oz. Juice _____ oz.

Water _____ oz. Gatorade/PowerAde _____ oz. Sugar-free drinks _____ oz.

How many times a day would you say you eat meals? Please include snacks. _____

Activity and Exercise History

Please indicate which of the following best describes your workout and daily activities.

____ Sedentary

____ Very active

____ Mildly active

____ Heavy physical activity

____ Active

____ Athlete

Do you exercise? _____ If so, how many days per week? _____

Name of Activity (Cardio, Weights, Etc)	Duration (Minutes)	Frequency (Per Week)	Intensity (Perceived Exertion)
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_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

PLEASE ADD ANY ADDITIONAL COMMENTS THAT WOULD HELP ME BETTER SERVE YOU! _____

OFFICE USE

Body Fat % _____

RMR _____

Current Weight _____