Assessment Form

This is an expandable form. Simply type your information into the boxes next to the labels and it will automatically drop down to allow for more comments. Do not print off, as this will reduce the efficiency and make very small, inconvenient boxes—this form is meant to be digital. Be sure to include as much information as possible to allow for accuracy. Scanned medical papers are acceptable to add as an attachment.

**Personal information**

|  |  |  |
| --- | --- | --- |
| Full name |  | |
| Date of birth |  | |
| Height |  | |
| Weight |  | |
| Ethnic background |  | |
| Marital status |  | |
| Children |  | |
| Full address |  | |
| Email address |  | |
| Phone number |  | |
| Income type |  | |
| Occupation |  | |
| Emergency contact info  (name, phone, email) |  | Relationship: |

**Medical history**

|  |  |  |
| --- | --- | --- |
| Primary Care Physician  (name, clinic address) |  | Phone: |
| Insurance type |  | |
| Blood Pressure |  | |
| Blood Panels  (vitamins and minerals) |  | |
| Cholesterol  (HDL, triglycerides, other—full panel) |  | |
| Food allergies |  | |
| Drug allergies |  | |
| Medical procedures  (surgery, physical therapy, etc) |  | |
| Disability status (Y/N) |  | |
| Health conditions |  | |
| Current medications |  | |
| Previous medications no longer in use |  | |
| Herbs |  | |
| Vitamin/mineral supplements |  | |
| Symptoms of concern |  | |