Name: _____ Birthday: _____

Do you have heart disease? _____
Do you have high blood pressure? _____
Do you have high cholesterol? _____
Do you have high triglycerides? _____
Is there a family history of heart disease? _____
Do you have any metabolic diseases? _____
Do you have any pulmonary diseases? _____
Do you smoke? _____
Have you ever had cancer? _____
Do you have a sedentary lifestyle? _____
Have you ever lost consciousness? _____
Are you pregnant (Baby within 6months)? _____
Do you have osteoporosis? _____
Do you have arthritis or joint pain? _____
Do you have back pain or spinal disorders? _____
Do you have musculoskeletal pain/injuries? _____
Have you ever had a hernia? _____
Have you had surgery in the past year? _____
Are you anemic? _____
How would you rate your stress level? Low Med High
How would you rate your energy level? Low Med High

How many hours of sleep do you get/Night? _____
Do you travel often? _____
How much water does you consume/Day? _____
How much caffeine do you consume/Day? _____
How much alcohol do you consume/Week? _____
Are you on any medications? _____
Do you have any food allergies? _____
Do you have a strong disliking for any foods? _____
Do you tend to like basic or gourmet meals more? _____
Do you like to cook? _____

Notes:

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