Today's Date (circle one):
1/17/18 1/18/18 1/19/18

Initial Health Assessment

Name: _____ **E-mail:** _____

DOB: _____ **Community:** _____

How would you rate your overall health? (1 = poor and 10 = great)

1 2 3 4 5 6 7 8 9 10

Why did you give yourself this number? _____

Do you exercise daily? (YES/NO) If yes, what type and how often? _____

How would you rate your stress level? (1= No stress; 10 = extremely stressed)

1 2 3 4 5 6 7 8 9 10

How many cups of water do you drink daily?

0 1 2 3 4 5 6 7 8 9 10

How many cups of pop/juice/tang/kool-aid do you drink weekly?

0 1 2 3 4 5 6 7 8 9 10 10 or more

Please circle the following items that you experience weekly:

Tobacco cravings	Alcohol cravings	Sweet cravings	Salt cravings
Emotional eating	Fatigue	Feeling overwhelmed	Sluggishness
Lack of motivation	Depression	Trouble sleeping	Anxiety

What are your Health Goals? _____

_____

What information would you like to learn in this class? _____

_____

Screening Results

Weight:	Height:	BP:
TC:	HDL:	TRG:
LDL:	GLU:	A1C:

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Weigh In (if applicable):

FEB 25: _____

FEB 1: _____

FEB 8: _____

FEB 15: _____

FEB 22: _____ _____

March 1: _____

March 8: _____

May 24: _____