Assessment Worksheet

Date:_____ **Dietitian:**_____

Client Name:_____

Address:_____

Phone:_____ **Email:**_____

DOB:_____ **Age:**_____

Personal Doctor:_____

M.D. location/Phone:_____

Medications:_____

_____

Multi-vitamins/Supplements:_____

Medical History:_____

_____

Family Health History (ex: diabetes, heart disease, etc.):

_____

_____

Physical Activity:_____