



SELF-ASSESSMENT FORM

Name: \_\_\_\_\_

Date: \_\_\_\_\_

Age: \_\_\_\_\_ yrs Height: \_\_\_\_\_ My Current Weight: \_\_\_\_\_ lbs My Usual Wt: \_\_\_\_\_ lbs My Ideal Wt: \_\_\_\_\_

I ( ) do not weigh myself or ( ) I do weigh myself. If you do weigh yourself, how often? \_\_\_\_\_

I have been diagnosed with: \_\_\_\_\_ I ( ) do or I ( ) don't believe I have this diagnosis.

I consider my health to be: ( ) good, ( ) fair, ( ) poor.

I live ( ) alone or ( ) with \_\_\_\_\_

**PLEASE TRY TO DESCRIBE TO THE BEST OF YOUR ABILITY:**

Your Exercise History: \_\_\_\_\_

---



---

Your Dieting History: \_\_\_\_\_

---



---



---



---



---

I consider it a "GOOD DAY" is when I eat: ( ) more or ( ) less. I have "good days" about \_\_\_\_\_ days per week.

I consider it a "BAD DAY" is when I eat: ( ) more or ( ) less. I have "bad days" about \_\_\_\_\_ days per week.

*Please list the foods and drinks you have on a "Typical" day. Include amounts. Write "none" if you don't eat anything.*

BREAKFAST	SNACK	LUNCH	SNACK	DINNER	SNACK
Time: At: home / out Food:	Time: At: home / out Food:	Time: At: home / out Food:	Time: At: home / out Food:	Time: At: home / out Food:	Time: At: home / out Food:
Drink	Drink	Drink	Drink	Drink	Drink

Signature: \_\_\_\_\_