Welcome!

Helpful tools to keep up to date and informed with us:

1. Like our Facebook Page: www.facebook.com/thefitbodyrx
2. Facebook PRIVATE group.- Please request to join after beginning here:
3. https://facebook.com/groups/262009118556522?ref=bookmark
4. Follow us on Instagram: @Thefitbodyrx @brittanywalkers
5. As a new client- Please fill out our online contact form ASAP:

New Client Assessment

Name:______________________________ Date of Birth:_____________Age:________

Home Address:_____________________City:_________State:_______Zip:________

Phone Numbers:

Home:_________________Cell:_______________Work:_________________________

Email Address:____

How did you hear about us:_____________________ Referral of:_______________

FITBODYrx NOTES: (leave blank)

____

Lifestyle / wellness / nutrition information

(Please leave the questions with your answers)

Current weight: ______ Height: ________

Ideal weight: ______ Weight 1 month ago: ______ Weight 1 year ago: ______

Are you currently working: Y/N: _______________

How many hours per week: ________________

Work Schedule:____

What physical demands does your job require?_____________________________

Sleeping Habits:

What time do you go to sleep? ________________

What time do you wake up?__________________

Do you sleep well?____

Do you feel rested when you wake up in the morning?_______________________

Women:

Are your periods regular?________________________

How many days of flow?________________________

How frequent? ________________________

Are you pregnant (or possibly?) ___________

What kind of birth control do you use or did you use?__________

Do you have children? YES NO (circle) IF SO:

Boy or Girl/AGE:_____Natural Birth or Cecarian:_____Total Weight Gain:_____

Boy or Girl/AGE:_____Natural Birth or Cecarian:_____Total Weight Gain:_____

Boy or Girl/AGE:_____Natural Birth or Cecarian:_____Total Weight Gain:_____

Boy or Girl/AGE:_____Natural Birth or Cecarian:_____Total Weight Gain:_____

Boy or Girl/AGE:_____Natural Birth or Cecarian:_____Total Weight Gain:_____

Activity:

How is your energy level?____

What role does exercise and activity play in your life?______________________

What type of exercise do you engage in?_________________________________

How often?____

Duration and Intensity per session?_____________________________________

If you could do any type of exercise, what would you do?__________________

Do you feel pain in your chest when doing physical activity?________________

In the past month, have you experienced pain in your chest when you are not doing physical activity:____

In home exercise/Gym Time:

How much time do you have per week to dedicate to working out, in home # of days, in the gym # of days. (Be realistic to start):

Home:______days/wk. Gym:______days/wk.

Do you currently exercise mostly at a gym, home, or rarely:________________

Is your focus more on weights, cardio, classes, etc?_______________________

What time of day do you currently workout or could work out?_____________

What time of day do you do cardio or could do cardio?____________________

Overall Health/Habits:

Do you smoke?________If yes, how much?________________________________

Do you drink alcohol?_______If yes, how much?__________________________

Do you use caffeine?________If yes, how much?__________________________

Current physical/mental health challenges:

(For each condition that applies, please give the approximate date it developed, was diagnosed, and current status
if it doesn't apply- leave it blank)

Arthritis:_________________________

Asthma:_________________________

Bone or joint problems:_________________________

Bowel disorder (chron's, colitis, IBS, etc) :_________________________

Cancer:___________________________
Candida Albicans (yeast infection):___________________________
Cardiovascular disease, heart attack, other heart condition or surgery:__________________________
Diabetes:___________________________
Dizziness:___________________________
Epilepsy or seizure disorder:___________________________
Hypertension/high blood pressure:___________________________
Hypoglycemia (low blood sugar):___________________________
Immune system imbalance (lupus, Epstein-barr, HIV):________________________
Liver Disease (Hepatitis, Hepatitis C) :___________________________
Nervous System Disease (MS, Parkinson's):___________________________
Ulcers:________________
Urinary tract disorders (kidney, bladder):_________________________
Weight loss or gain:____
List any other health challenges:
____
____

Medications:
List ANY/ALL Medications you are taking and what for, or may take periodically INCLUDING over the counter medications:

Medication:_________________ How Often:_______________ For:_______________

Medication:_________________ How Often:_______________ For:_______________

Medication:_________________ How Often:_______________ For:_______________

Medication:_________________ How Often:_______________ For:_______________

Medication:_________________ How Often:_______________ For:_______________

Medication:_________________ How Often:_______________ For:_______________

Medication:_________________ How Often:_______________ For:_______________

Medication:_________________ How Often:_______________ For:_______________

Do you use any alternative medicine/natural options?_______________________

Supplements/Vitamins/Allergies

Do you have any food allergies or food sensitivities? What foods? __________

____

What supplements do you take? __________________________

Supplements you have taken in the past? __________________________________

____

Foods/Cravings

What percentage of your food is prepared at home?________________________

Where do you get your other food? ________________________

What are you foods of choice? ____

What do you crave? ____

What kind of diet have you eaten in the last 6 months?

____

Do you currently experience food binges? If so, what are you trigger foods?

Do you have a history of an eating disorder (anorexia, bulimia, or compulsive over-eating)?____________________________

Do you have a current eating disorder? ____________________________________

Top 4-5 Drinks of choice (non-alcohol):____________________________________

What sweeteners do you use? (For coffee oatmeal, etc. such as splenda, sugar, truvia, stevia)____

What foods can you NOT stand:

-Please see complete "FOOD LIST" below and list, these foods may be used on your meal plan if not listed here. Please put these foods you will not eat here.

____________	____________	____________	SENSITIVITY:__________
____________	____________	____________	ALLERGY:____________
____________	____________	____________	ALLERGY:____________
____________	____________	____________	ALLERGY:____________
____________	____________	____________	____________

What else would you like to share?

____

____

COOKING CAPABILITIES/SCHEDULE:

On a scale of 1-10, 1 being bad, 10 being comfortable, How comfortable are you with cooking:______________

What does your schedule permit for as far as food prep?

____

Please share with us a typical day for you (Schedule)

____
____
____
____
____
____
____
____
____
____
____

LEVEL TO START AT:

Now to the next phase! YOUR NEW BEGINNING! Your almost done!

Below is to understand where you are mentally as far as motivation but as well as what is obtainable for you right now as well. Keep in mind if it is too hard, the progress will be just as slow. So if you start where you belong, it should get you there appropriately.

Option 1: I need an easy adjustment/start to things
- More varieties as similar as possible to my habits/ways throughout the day
- A little easier to prepare, More on the go foods/easier to accommodate out to eat
- Lose weight (or gain muscle in) smaller amounts to begin.
- 6 small meals a day (included snacks)
- Things to help substitute your current cravings to slowly mold yourself into a new lifestyle.

Option 2: Almost there! Fairly Familiar with what Clean Eating is...
- Less similar than my current eating style/habits than option 1 would give me.
- A little more prep time needed sometimes (stricter grocery list/brand)
- Geared for a medium grade clean eating style with obedience needed.
- Get to your goal a little quicker
- Detox naturally a little quicker, feel even more energized.
- 6 small meals a day (included snacks)

Option 3: I AM READY to focus!
- Stricter meals, detailed brands, etc. (This does make shopping easy though)
- 6 small meals a day (included snacks)
- Get to your goal the fastest. Maybe not immediately, but faster by cutting to the chase.
- Detox naturally, healing your body at the cellular level the quickest.
- Harder to adjust at first for some. Great for those that need a challenge as well.
- You might need additional prep time, but not always the case. This is with any option.

The great thing is, we can always adjust and take a step forward or back on your next plan. REMEMBER: Option 3 WILL NOT be the fastest way if it isn't obtainable. Please understand that the appropriate starting point will in fact be the best/quickest way to your goal. Please try to be completely honest with yourself when choosing above. Please note, we do still push you to new levels so be prepared mentally for this as well.

YOUR OPTION CHOICE:______________________________________

Once Completed- please attached the following in an email (or type it out)

1.) Completed Assessment (Including the FOOD LOGS BELOW)

2.) Current photo (Front, side, back) all 3 would be great. Best option of attire would be in a bikini, shorts and sports bra (best for us to see true body composition etc), or tight fitting clothing is ok too (last option). Men please wear shorts.

3.) Picture of a goal you have in mind if you desire.

4.) By completing the assessment you understand that our nutritional plans are copyrighted and belong to TheFITBODYrx and are not to be shared, copied, manipulated and distributed, etc. Please initial:_______________

5.) Completed Food Logs. See below on the next page.

FOOD LOGS:

**Very important: Do not change your daily foods right now, give us what you really eat, portion size and so on as best to your knowledge. This way we determine where to take you in the beginning based on the level you will be starting at.

3 DAYS OF: ANY AND ALL INTAKE (WHAT, WHERE FROM (IF OUT TO EAT) APPROX SERVING SIZE), EVEN IF IT IS 2 CHIPS YOU TOSS IN YOUR MOUTH ON THE WAY OUT THE DOOR. You can also fill out the food log I sent in your assessment email as well and take a photo or scan and send via email/fax along with this.

DAY ONE:

TIME______________CONSUMED: ____

TIME______________CONSUMED: ____

TIME______________CONSUMED: ____

TIME______________CONSUMED: ____

TIME______________CONSUMED: ____

TIME______________CONSUMED: ____

LIQUIDS: : ____

DAY TWO:

TIME______________CONSUMED: ____

TIME______________CONSUMED: ____

TIME______________CONSUMED: ____

TIME______________CONSUMED: ____

TIME______________CONSUMED: ____

TIME______________CONSUMED: ____

LIQUIDS: : ____

DAY THREE:

TIME_______________CONSUMED: ____

TIME_______________CONSUMED: ____

TIME_______________CONSUMED: ____

TIME_______________CONSUMED: ____

TIME_______________CONSUMED: ____

TIME_______________CONSUMED: ____

LIQUIDS: : ____

COMPLETE FOOD LIST

(Below is a list of common foods we use/incorporate into our meal plans. It is important to know if you CAN NOT stand them and have tried them again in the last 12 months. If you are not sure, do not add them to your list above on PAGE 4)

Vegetables

- Asparagus
- Avocados
- Beets
- Bell peppers
  (Red, Green, Yellow, Orange)
- Broccoli
- Brussels sprouts
- Cabbage
- Carrots
- Cauliflower
- Celery
- Collard greens
- Cucumbers
- Eggplant
- Fennel
- Garlic
- Green beans
- Green peas
- Kale
- Leeks
- Mushrooms
- Mushrooms, shiitake
- Mustard greens
- Olives
- Onions
- Potatoes
- Peas
- Romaine lettuce
- Sea vegetables
- Spinach
- Squash, summer
- Squash, winter
- Sweet potatoes
- Swiss chard
- Tomatoes
- Turnip greens
- Yams
- Sour Kraut

Fruits

- Apples
- Apricots
- Bananas
- Blueberries
- Cantaloupe
- Cranberries
- Figs
- Grapefruit
- Grapes
- Kiwifruit
- Lemon/Limes
- Oranges
- Papaya
- Pears
- Pineapple
- Plums
- Prunes
- Raisins
- Raspberries
- Strawberries
- Watermelon

Nuts, Seeds & Oils

- Almonds
- Cashews
- Flaxseeds
- Olive oil, extra virgin
- Coconut Oil
- Peanuts
- Pumpkin seeds
- Sesame seeds
- Sunflower seeds
- Walnuts
- Pecans

Eggs & Dairy

- Cheese
- Cottage Cheese
- Eggs
- Milk, 2%, cow's
- Milk, goat
- Yogurt
- Greek Yogurt
- (Non Dairy) Almond Milk

Beans & Legumes

- Black beans
- Dried peas
- Edamame
- Garbanzo beans
  (chickpeas)
- Hummus
- Kidney beans
- Lentils
- Lima beans
- Miso
- Navy beans
- Pinto beans

Poultry, Lean Meats, Other Meats

- Beef, lean organic
- Chicken
- Lamb
- Turkey
- Bison
- Flank Steak/Filet Mignon

Grains

- Barley
- Brown rice
- Buckwheat
- Corn
- Millet
- Oats-Oatmeal
- Rice Cereal
- Quinoa
- Rye
- Spelt
- Whole wheat

Other

- Green tea