

**Please circle Yes or No**

1. Do you feel stronger this week? Y or N
2. Are you excited about training this week? Y or N
3. If your goal is to put on weight; is it happening? Y or N
4. If your goal is to lose weight, is it happening? Y or N
5. If your goal is improved fitness, is it happening? Y or N
6. Are you sleeping well? Y or N
7. Do you wake up feeling refreshed every morning? Y or N
8. Are you hungry? Y or N
9. Are you happy? Y or N
10. Do you have a good libido? Y or N
11. Is it hard to get up in the morning? Y or N
12. Do you still feel fatigued, even when well slept? Y or N
13. Do you crave salty Foods? Y or N
14. Does everything feel like a chore? Y or N
15. Does it take extra effort for everyday tasks? Y or N
16. Do the little things seem to get to you? Y or N
17. Does it take you longer than normal to recover? Y or N
18. Do you get light headed when you stand up fast? Y or N
19. Do you feel mildly depressed? Y or N
20. Do you enjoy life? Y or N
21. Does it get worse if you skip a meal? Y or N
22. Does your focus slip, thoughts get fuzzy? Y or N
23. Is your memory getting less accurate? Y or N
24. Do people seem more irritating than before? Y or N
25. Do you not really feel awake until 10 am? Y or N
26. Do you get sleepy between 3 and 4 pm? Y or N
27. Do you feel better after 6pm with evening meal? Y or N
28. Has your productivity dropped? Y or N
29. Are you ready to feel better? Y or N
30. Do you suffer from intense PMS symptoms? Y or N

**Digestion:**

How many bowel movements/day do you have? 0 1 2 3 4 when \_\_\_\_\_?  
 Do you experience: Gas \_\_\_\_\_ Bloating \_\_\_\_\_ If so, when? \_\_\_\_\_ How often? \_\_\_\_\_  
 List food sensitivities: \_\_\_\_\_  
 Do you experience: Diarrhea \_\_\_\_\_ Constipation \_\_\_\_\_ If so, when? \_\_\_\_\_ How often? \_\_\_\_\_  
 Comments: \_\_\_\_\_

**Lifestyle:**

Rate your stress level at work: Low Medium High How many hours/week do you work? \_\_\_\_/wk  
 Rate your everyday life stress level: Low Medium High Have children? Y or N Age(s)? \_\_\_\_\_  
 Comments: \_\_\_\_\_

**Energy:**

Rate your energy at the following times:  
 Arising: Low Medium High Morning (arising - Noon) Low Medium High  
 Afternoon (Noon-5 pm): Low Medium High Evening (5:00 pm - bedtime): Low Medium High  
 Bedtime: Low Medium High What time do you wake up?: \_\_\_\_\_ Go to bed? \_\_\_\_\_  
 Comments: \_\_\_\_\_

**Physical:**

Total workouts/week: \_\_\_\_  
 # strength: \_\_\_\_\_ # cardio: \_\_\_\_\_ where: \_\_\_\_\_  
 # leisure: \_\_\_\_\_ what: \_\_\_\_\_  
 Comments: \_\_\_\_\_

**Supplements/Medications:**

List any medications you are presently taking: \_\_\_\_\_  
 List any supplements you are presently taking: \_\_\_\_\_  
 Comments: \_\_\_\_\_

**Females only:**

Are your menstrual cycles regular? Yes \_\_\_\_\_ No \_\_\_\_\_ Do you experience PMS? Yes \_\_\_\_\_ No \_\_\_\_\_  
 Are you taking the birth control pill? Yes \_\_\_\_\_ No \_\_\_\_\_ If yes, name: \_\_\_\_\_  
 Goals/Additional Comments: \_\_\_\_\_  
 Injuries: \_\_\_\_\_