CUSTOMIZED NUTRITION PLAN APPLICATION AND WAIVER

ekin nutrition

BASIC INFORMATION

Name: _____ DOB: ___/___/___

Email: _____ Cell Phone: _____

Address: _____ City: _____ Zip: _____

NUTRITION & HEALTH ASSESSMENT

Please fill out what you currently eat in an average day and the approximate time that you eat:

Meal 1 ____:____ _____

Meal 2 ____:____ _____

Meal 3 ____:____ _____

Meal 4 ____:____ _____

Meal 5 ____:____ _____

Meal 6 ____:____ _____

Post workout shake: Y or N **Goals:** Body Fat% _____ Weight _____

What time do you wake up on a typical day? ____:____ What time do you go to bed on a typical day? ____:____

What time do you work out on a typical day? ____:____

What TYPE of exercise and how many days per week do you exercise? _____

_____

What other activities? (Sports, bicycle riding etc)_____

Are you interested in learning about products to help you get the best results?

___ Protein Shakes ___ Vitamins/Greens ___ Post Workout/Recovery

___ Meal/Snack Replacements ___ Fiber Supplements ___ Food Scale

___ Other _____

Do you use any special diet products? Yes No If yes, please describe: _____

_____

Questions or Concerns: _____

_____

***You must scan on an Inbody 570 before turning these papers in to your coach. **Credit card info must be provided as well to get your account set up. Call Ekin 515-327-1629 if you prefer to give it over the phone.**

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BRIEF MEDICAL HISTORY

When was your last complete physical exam? ____/____/____

Please indicate (x) whether you have or had any of the following conditions:

____ High Blood Pressure	____ Chest Pain	____ Orthopedic Conditions	____ Stroke
____ Heart Disease or Attack	____ Dizziness	____ Osteoporosis	____ Hypoglycemia
____ Diabetes	____ Heart Murmur	____ Hernia	____ Anemia
____ High Cholesterol	____ Shortness/Breath	____ Arthritis	____ Cancer
____ Irregular Heart Rate	____ Respiratory	____ Thyroid Disorder	____ Blood Disorder
____ Epilepsy or Convulsions	____ GI Disorder	____ Lactose Intolerant	____ Wt loss surgery

Food allergies or nutrition concerns? (Dairy, Gluten, Protein etc.): _____

_____

These Customized Nutrition Plans ARE NOT DIETS; they require a commitment to a lifestyle change. Because we only choose to work with committed clients, there is no refund if you are unable or unwilling to follow our recommendations.

Please consult your nutrition coach for any questions. Thank you in advance for your commitment to your health.

WAIVER

I, the undersigned, have read, understand, and have answered the above health/medical survey questions fully and truthfully. I am aware of my responsibility to consult with me personal physician regarding my clearance to engage in strenuous exercise and/or a nutritional support program. I do hereby intend to be legally bound for myself and waive release of any and all rights and claims for damages I may have against the participating training facility, and the fitness trainer/certified fitness nutrition specialist administering this program as well as the program creators themselves or anyone in connection with them for any and all injuries suffered while following the training and/or nutrition program provided to me. I also understand and agree to the no refund policy stated above.

Client Signature_____ Date _____

Billing Information (**Required to activate LifeBase App**)

CC#_____ exp _____ 3 dig _____

(THIS INFO WILL BE BLACKED OUT AFTER ENTERED)

Parent Name: _____

Parent email address: _____

Parent Cell: _____