ASSESSMENT FORM
Joda P. Derrickson, PhD, RDN dba Lightshine Wellness

Name_____Today's Date_____

Birthday _____Age_____Gender _____Height _____ Weight _____

Physical Address _____

Email_____Cell Phone_____

Preferred contact method Email Call Text Best times to contact me _____

Emergency Contact Name _____Phone_____

How would you like Dr. D to work with you? Check all that apply then rank the Top 3.

My place Her place Online Via Phone Other: _____

My strengths Check all that apply then rank the Top 3.

Bold Caring Cook Well Confident Detail-oriented Financially Secure
Fast Learner Fit Flexible Hard worker Honest Open-minded
Organized Perseverant (Don't give up) Strong Wise _____

List medical conditions or injuries that Dr. Derrickson MUST know about with any lab value, etc.

My biggest challenges (that Dr. D must know to help me accomplish my goals)

1.
2.
3.

Describe your diet preferences and items you can't eat or drink

- ❑ I eat three or more times a day with breakfast

Describe your current weekly fitness routine

If you are worried about excess body fat, what could have caused this?

___All ___Abnormal metabolism ___ Genetics __Not exercising enough __Insufficient sleep __ Excessive portions __Eating out__ Skipping meals ___ Uncontrolled eating __ Excess sugar/carbs ____Excess alcohol ___ Excess fat/fried __ Medications: _____

How would you like Dr. D to assist you? Check all that apply then rank the Top 3.

All Balance Build Muscle Confidence Diet/Eating well Energy healing Finances Fitness Flexibility Food sensitivities Food shopping/preparation Goal accomplishment Happiness Life Purpose Lifestyle habits Lose body fat Health/disease management Nutrition Overcoming obstacles Pain reduction Portion control RESET Self-Care Self-Love Spiritual well-being Willpower

Other: _____

Top three goals or issues I would like Dr. D to assist me with

1.

2.

3.

Do you have doctor's clearance to exercise or otherwise accept full responsibility for your actions regarding diet, exercise, financial and other lifestyle changes? Yes or NO

If NO, please stop here. You are NOT eligible to work with Dr. Derrickson

How soon would you like to start?

How long would you like to work with Dr. Derrickson?

One visit 3-6 visits Weekly Monthly Annually Other_____

Verification statement.
I hereby verify that the information in accurate and that I want to work with Dr. Derrickson to accomplish my goals and I fully intended to release Dr. Derrickson/Lightshine Wellness of all liability other than overt negligence as indicated with my signature on her liability waiver agreement. Checking off this box is the equivalence of my signature.

Signature _____

Date:_____

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