MEDICAL PROVIDER ASSESSMENT FORM

Name_____

D.O.B. _____

Date_____

Phone Number _____

SMART GOALS

(**S**pecific, **M**easureable, **A**chievable, **R**elevant, **T**ime-Framed)

_____

_____

_____

_____

_____

Confidence Level: _____

Please have your provider's office indicate the value and date of service below.

Date of measurement: _____

Weight_____

Height_____

Blood Pressure_____/_____

Waist (inches)_____

Pulse _____

Date of labs: _____

Fasting or Non Fasting _____

Total Cholesterol_____

HDL Cholesterol_____

TC/HDL Ratio_____

Glucose_____

** All personal health information provided will remain confidential and secure.*

Provider Name_____ Provider Signature_____

Completed forms may be returned by mail to Holtyn & Associates at:
P.O. Box 19335, Kalamazoo, MI 49019

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