



PHYSICAL STATISTIC FORM

Name _____ Page _____

For Re-Evaluation, I attached Dietary Guidelines Checklist & Dietary Avoid Checklist **Y N**

MEASUREMENT OR READING	Date	Date	Date	Date	Date	Date	Date	Date	Date	Date	Date	Date	Date
1-Weight													
2-Blood Pressure - Sitting													
3-Blood Pressure – Lying													
4- Blood Pressure - Standing													
5-Pulse													
6-pH Oral A.M.													
7-pH Oral P.M.													
8-pH Urine A.M.													
9-pH Urine P.M.													
10-Cuff Pressure – Before													
11-Cuff Pressure – After													
12-Exercise #Days Per Week													
13- Supplements As Directed													
14-Re-Evaluation Scheduled													

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