LYNFIT

Experience & Philosophy

My philosophy is KEEP IT SIMPLE and make it metabolic, so you see and feel faster results which keeps you motivated to stay on plan. Only eat delicious food every day so you learn to CRAVE what's good for you.

We have more control over our health and weight issues than we realize, and it all starts with making the decision to change and follow through by replacing bad eating habits with healthier ones. We need to be stronger than our excuses if we desire change. I know that letting go of bad habits is hard. I've been where you are, and I know how you feel but the plan to do so doesn't have to be. I was once 40 lbs. overweight despite the fact I was over-exercising for more than three hours every day (I now know it is an addiction). I also have hypothyroidism, so I've struggled my whole life with my food and weight. My nickname growing up was "Roly Poly." 'Nuff said, right?

I believe in true, lasting change that starts on the inside first. I learned and believe that diet, not exercise, is responsible for 90 percent of weight loss results and success, whether your goal is to lose weight, get in shape, or relieve your aches and pains. We cannot exercise away a bad diet and I believe that everyone can lose weight, melt off fat, and live a healthier lifestyle, no matter their age or how slow their metabolism may be. To be truly "transformed" requires a holistic approach to health that includes more than just physical and mental well-being. To be truly fit, we need to be stronger than our excuses if we desire change. We need to become spiritually strong first. It's not about religion, but it's all about a relationship with God.

Today, the metabolic boosting, anti-aging, evolutionary health movement has gained tremendous mainstream acceptance. Every day, another little bit of science turns the corner to reveal and recalibrate what being healthy really requires. I believe in a strategic, yet super simple approach, and the smart use of safe, metabolic boosting supplements, and delicious metabolic boosting protein shakes and lean bars as meal replacements to make eating healthy easy, even in today's fast-paced, on-the-go world. This approach not only delivers the best results, but it also saves you a lot of precious time and money. Faster, easier, and a lot more delicious!

For the past 28 years I have devoted my life and I'm on a mission to help change as many lives as humanly possible. I'm passionate about helping others improve their health and happiness. I love research and studying global trends regarding anti-aging, anti-cancer, and of course, all things metabolism. I spend at least two hours every day doing just that. I continue to study and evolve, keeping my 17+ certifications with scientific associations. I'm honored to be awarded "Elite Trainer," which is the highest level a trainer can reach and requires me to keep up with current science and studies by earning 20 credits every year.

Specialist in Performance Nutrition
Metabolic Nutrition Expert
Behavior Modification Specialist
Metabolic Exercise
Elite Fitness trainer
AS Exercise Science
Specialist in Exercise-Fitness Therapy
Specialist in Senior Fitness
Youth Fitness Trainer
Specialist in Cancer Therapy
Corrective Exercise Specialist (pain management)
Specialist in Sports Conditioning
Feldenkrais Method (movement specialist)
Specialist in Holistic Recovery
Thai Massage Stretch
Associate Chaplain/Billy Graham Emergency Disaster Relief Chaplain
Myontonology (study of muscle tone of the face)

I believe in you, now it's time for YOU to start believing. My dream is to have anyone who struggles with health issues and can't seem to lose weight, try living the LynFit Leaner Lifestyle way for seven days. Once you experience how easy it really is to lose weight by drinking two protein shakes or eating Lean Bars a day, ditching grains, dairy, and sugars from your diet and emphasizing cleaner, leaner foods (yep, eating more delicious salads and lean protein), and get moving, you'll see how good you feel and be happier. There is no greater empowerment than your personal experience. You'll finally break through the frustration and plateaus that you might have experienced in the past from doing the same old thing but expecting different results.

Are you ready for change? BELIEVE, BEGIN, BECOME! It's all up to you!

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Health History Questionnaire

Qualifier Assessment

1. Do you currently have a health and fitness program? Yes No

   Please check the one that best describes your work & exercise habits:
   - Intense occupational and recreational exertion ___ ___
   - Moderate occupational and recreational exertion ___ ___
   - Sedentary occupational and intense recreational exertion ___ ___
   - Sedentary occupational and moderate recreational exertion ___ ___
   - Sedentary occupational and light recreational exertion ___ ___

2. Stress Scale: To what degree do you perceive your environment as stressful?
   WORK: Minimal ___ Moderate ___ Average ___ Extremely ___
   HOME: Minimal ___ Moderate ___ Average ___ Extremely ___
   DIET: Minimal ___ Moderate ___ Average ___ Extremely ___

3. Do you work more than 40 hours a week? Yes No
4. What are your specific health and fitness goals?

5. How quickly would you like to achieve your goals? Do you want to see results fast or slower and at a more moderate pace? _____
6. How well is your current health and fitness program working for you? Why or why not?

7. What hurdles do you need to overcome to achieve your goal?
   (eg; family support, self-sabotage, excuses, negative attitude, depression, lack of social support, lack of knowledge?)

8. If you could design the perfect plan, what would it be?

9. Does your family support your goal? Yes No
10. Are you ready and 100% committed to make changes? Yes No
11. What diets have you tried? What was the outcome and how did your body react?

12. On a scale of 1-10, how motivated are you to do whatever it takes to lose weight or get in shape?

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Health History Questionnaire

Please answer the questions to the best of your ability. Unless otherwise indicated, circle the single best choice for each question. As is customary, all your responses are completely confidential. PLEASE BE THOROUGH.

Name: _____ Height: _____Weight: _____

Gender: _____ Age: _____ Birth date: _____

Address: _____

Email: _____Best # to reach you _____

Emergency Contact: _____ Phone: _____

Personal Physician: _____ Phone: _____

When was your last Physical Exam? _____
Please attach a copy of the most recent blood work.

1.) Do you consume alcohol? If Yes, how much? How often? What type?	Yes	No
2.) Have you ever had a definite or suspected heart attack or stroke?	Yes	No
3.) Have you ever had coronary bypass surgery or any other type of heart surgery?	Yes	No
4.) Do you have any other cardiovascular or pulmonary (lung) disease (Other than asthma, allergies or mitral valve prolapse)	Yes	No
5.) Have you ever had a history of diabetes, thyroid, kidney, or liver disease? If Yes, please circle which one.	Yes	No
6.) Have you ever been told by a health professional that you have had an abnormal resting or exercise (treadmill) electrocardiogram (EKG)?	Yes	No

If you answered YES to any of questions 1 through 6, Please describe:

7.) Are you pregnant or is it likely that you could be pregnant at this time? If Yes, what is your expected due date?	Yes	No
8.) Have you had surgery or been diagnosed with any disease in the past three months? If Yes, please list date of surgery and/or name of disease:	Yes	No
9.) Do you currently have any of the following:		
a.) Pain or discomfort in the chest or surrounding areas that occurs when you engage in physical activity?	Yes	No
b.) Shortness of breath	Yes	No
c.) Unexplained dizziness or fainting	Yes	No
d.) Difficulty breathing at night except in upright position	Yes	No

	e.) Swelling of the ankles (recurrent and unrelated to injury)	Yes	No
	f.) Heart palpitations (irregularity or racing of the heart on more than one occasion)	Yes	No
	g.) Pain in the legs that causes you to stop walking (claudication)	Yes	No
	h.) Known heart murmur	Yes	No
	If Yes to any of the above, have you discussed with your personal physician?	Yes	No
10.) Within the past 12 months, has a health care professional told you that your blood cholesterol or lipids profile were abnormal?		Yes	No
11.) Do you currently smoke cigarettes or have you quit within the past 12 months?		Yes	No
12.) Have your father or brother(s) had heart disease prior to age 55 or mother or sister(s) had heart disease prior to age 65		Yes	No
13.) Within the past 12 months, has a health care professional told you that you have high blood pressure (systolic ≥140 OR diastolic ≥ 90)?		Yes	No
14.) Currently, do you have high blood pressure or within the past 12 months have you taken any medicines to control your blood pressure?		Yes	No
15.) Have you ever been told by a health care professional that you have a fasting blood glucose greater than or equal to 140 mg/dl?		Yes	No
16.) Have you ever taken digitalis, quinine, or any other drug for your heart?		Yes	No
17.) Have you ever taken nitroglycerin or any other tablets you take for chest pain—tablets you take by placing under your tongue?		Yes	No

If you have answered YES to any of questions 8 through 17 please describe.

Please attach bloodwork and/or lab results

Type:

Frequency: Days per week:

Duration: Minutes:

Intensity (circle one): *low* *moderate* *high*

20.) Are you currently under treatment for blood clots?	Yes	No
21.) Do you have any problems with bones, joints, or muscles that may be aggravated with exercise? **(Circle all that apply)**	Yes	No
22.) Do you have any back, neck, knee, hip or joint problems?	Yes	No
23.) Have you been told by a health care professional that you should not exercise?	Yes	No
24.) Are there any other conditions (mitral valve prolapse, epilepsy, history of rheumatic fever, asthma, cancer, anemia, hepatitis, etc.) that may *hinder* your ability to exercise?	Yes	No
25.) During the past six months have you experienced any *unexplained* weight loss or gain (greater than ten pounds for no known reason)?	Yes	No
26.) Are you currently being treated for any other medical condition by a physician?	Yes	No
27.) How many hours do you sleep?		
28.) What's your current bed/sleep schedule?		
29.) How much weight have you gained in the past 10 years?		

If you have answered YES to any of questions 20 through 26 please describe:

Please list below **ALL** prescription and over-the-counter medications you are currently taking. It is extremely important that you are honest and list all medications, herbal teas, or night time sleep aid, and the reason you are taking them as well as how much and when.

Medication	Reason for taking	Dosage	Amount/When

Are there any medicines that your physician has prescribed to you in the past 12 months, which you are currently **NOT** taking? **If Yes, please list below and reason for not taking**	Yes	No
Would you like to eliminate any of these medications?	Yes	No

Please list **EVERY** dietary supplement that you are currently taking. Be sure to include protein shakes, bars, all sports drinks, vegetable juices, and fiber. Send the nutritional info or a label via email prior to your visit.

Dietary Supplement	Reason for taking	Dosage	Amount/When

I have answered the Health History Questionnaire accurately and completely. I understand that my medical / health history is a very important factor in the development of my fitness / wellness program. I understand that certain medical or physical conditions which are known to me, but which I do not disclose to Lisa Lynn fitness, LLC (dba LynFit Nutrition) may result is serious injury to me. If any of the above conditions change, I will immediately inform Lisa Lynn Fitness, LLC (dba LynFit Nutrition) of those changes. I knowingly and willingly assume all risks of injury resulting from my failure to disclose accurate, complete, and updated information in accordance with the attached questionnaire.

Client Signature: _____ Date: _____

LynFit Nutrition LLC Staff Signature: _____ Date: _____

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Client Dietary Worksheet

List all foods and drinks consumed, as well as how much and what you put on them. This should include sauces, dressings, milk, sugar placed in coffee, etc. It is very important that you list EVERYTHING, and the bad days are the most important! List any food you think I should know about, even if it's only once per week. **BE HONEST**. This is only the way I can help you for cravings.

Day/Time	Food and Amount			

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Health Q & A
Confidentiality Agreement

PLEASE READ THE BELOW STATEMENT AND SIGN WHERE INDICATED

I, _____ understand that the information collected by **LISA LYNN FITNESS LLC (dba LYNFIT NUTRITION)** will be used for fitness evaluation purposes and for the design, implementation, progression, and maintenance of an individualized fitness weight loss program only. I further understand that all such information is confidential and will not be shared with anyone without my prior written authorization, except in the case of a medical emergency, or to the minimum extent necessary to achieve a safe and effective fitness program.

NAME: _____
(PLEASE PRINT LEGIBLY)

SIGNATURE: _____ DATE: _____