AWC
ARMY Wellness Center
Europe

Metabolic Testing Data Sheet

Today's Date: _______________

ID (Last 4 SSN): __________ **Last Name:** ______________________ **First Name:** _____________________

Test conducted by: _______ **DOB: dd:** ________ **mm:** _______ **yyyy:** ________ **Sex:** □ **M** □ **F**

Height: ________ **(in)** **Weight:** __________ **(lb)** **Goal Weight:** __________ **(lb)**

Daily activity level (at work or home) is mostly: □ sedentary □ somewhat active □ very active

Current aerobic activity: □ walking □ running □ cycling □ stepping □ other: _______________

Days per week: _________ **Duration:** _________ (min)

Please Fill Out

Dear Metabolic Client:

Do you currently have or have you been diagnosed in the last 2 years with any of the following medical conditions?

Yes	No	Heart Disease			
Yes	No	Liver Disease			
Yes	No	Pancreatic Disease			
Yes	No	Anemia	Are you on medication?	Yes	No
Yes	No	Kidney Disease			
Yes	No	Breastfeeding			
Yes	No	Hypoglycemia			
Yes	No	Diabetes			
Yes	No	Thyroid problems			
Yes	No	Hypertension (High Blood Pressure)	Are you on BP meds?	Yes	No
Yes	Not	High cholesterol	Are you on medication?	Yes	No

Signature: ____

Test Administrator Use Only

Metabolic Results

RMR: ___________ Lifestyle Activity: __________ Exercise: ___________ Total: __________

Weight Loss/Gain: ____________ Maintenance Zone: __________ Metabolic Rate: Slow/Normal/Fast