WELLNESS
intake form

Name:

Address:

Email:

Preferred contact phone #:

How did you hear about me?

Age:

Date of birth:

Height:

Current weight:

Weight one year ago:

Ideal weight:

History of family health problems:

Occupation:

Please rate your stress levels on a scale of 1-10 (10 being high):

How would you rate the pace of your life:
Very fast paced (busy), little free time (moderate slow), or relaxed:

Do you experience any troubles with digestion? (constipation, diarrhea, IBS, colitis, acid reflux, etc.)

How do you sleep at night?

How much water do you drink per day?

Do you eat when you are bored? stressed?

Do you have challenges with portion control?

Are you addicted to any of the following: caffeine, sugar, alcohol, or cigarettes?

How often do you exercise?

What type of exercise do you like best?

Have you tried health/weight loss/nutrition/wellness programs in the past?
If so, which, and were they successful?

Do you take any medications/supplements, if so please list:

Therapies: (i.e. mental health, massage, or other)

Please detail the foods you typically eat for:
Breakfast:

Lunch:

Dinner:

Snacks:

Beverages:

What are your major health concerns?

What would you like to be different 6 months from now?

What is holding you back from being healthier?

Would support with your health and wellness goals be of interest to you?

Do you prefer group or individualized support?

Is there anything else that is important to know regarding your health that you have not mentioned?