

Wellness Profile

Your responses within this questionnaire are strictly confidential and are used solely for wellness purposes.

Personal Information:

Name: _____ Cell Phone # (____) _____

Birth Date: ____/____/____ Height : _____ Weight: _____

Do you want to gain or lose weight? Gain Lose Desired Weight: _____

What was your weight?

One year ago: _____ Birth Weight: _____ At 20 years of age: _____

What is the main reason for your decision to gain or lose weight? _____

If losing weight, when did you begin gaining excess weight? (give reasons, if known): _____

What has been your maximum lifetime weight (non-pregnant) and when? _____

Previous diets you have followed: Give dates and results of your weight loss: _____

Is your spouse, fiancée or partner overweight? Yes No

Health & fitness goals:

1. _____

2. _____

3. _____

4. _____

Primary or referring doctor:	_____
Date of last physical exam:	_____
Initial weight:	_____
Initial height:	_____
Initial BMI:	_____
Initial waist/hip ratio:	_____
Initial blood pressure:	_____
Date of last lab work:	_____
Date of last EKG:	_____

Lifestyle:

Type of Work (for example: sitting at a desk or computer, driving, lifting) _____

Purposeful Exercise: Currently Yes No Since _____ Years Total _____

Cardiovascular _____ Frequency _____ Duration _____

Weight Training _____ Frequency _____ Duration _____

Flexibility _____ Frequency _____ Duration _____

Other _____ Frequency _____ Duration _____

Stress Level: Low Medium High

Energy Level: Low Medium High

When you are experiencing a stressful situation do you tend to eat more or less? Explain: _____

Nutritional Profile

Water: _____ Glasses /Day

Alcohol: Frequency _____ Amount _____ Type _____

Caffeinated beverages:

_____ Cups of coffee (regular)

_____ Cans of soda (regular, diet, energy beverage)

_____ Cups of tea

_____ Other - Specify

Food allergies or intolerances: Yes No List any: _____

Foods to Avoid:

1. _____

2. _____

3. _____

Food that is enjoyed:

1. _____

2. _____

3. _____

How often do you eat out? _____ Which Meals? _____

How would you generally describe your eating habits? Good Fair Poor

How many times a day do you eat? (Circle one) 1 2 3 4 5 6 7 or more

Description of your current eating pattern/sample of your meals:

Meal 1 Breakfast _____

Meal 2 Snack _____

Meal 3 Lunch _____

Meal 4 Snack _____

Meal 5 Dinner _____

How often do you eat "fast foods?" _____

Within your household, who plans the meals? Who cooks? Who shops? _____

Do you wake up hungry at night? Yes No

Have you ever been diagnosed with an eating disorder (e.g.: anorexia, bulimia)? Yes No

Please call us at 305-571-0662 to schedule your wellness evaluation.

