



**Name:** \_\_\_\_\_

**D.O.B** \_\_\_\_\_

**Date:** \_\_\_\_\_

### **Personal Medical information:**

Please indicate if you have or have had any of the following conditions, if so, please provide details

- High/low blood pressure
- Shortness of breath on exertion
- Heart palpitation
- Chest pain
- Diabetes
- Arthritis, rheumatism or gout
- Back condition
- Joint pain
- Asthma
- Abdominal pain
- Thyroid problems
- Surgical operations
- History of miscarriage
- Re-occurring injuries
- Depression or anxiety including post- natal
- Other symptoms or conditions that concern you

## Energy Levels

**Y / N** On a typical workday, my energy is high, I am vigorous, and I can perform at my best.

### Energy Boosters – I experience the following energy boosters in my life

- Y / N** Healthy sleep
- Y / N** Regular exercise
- Y / N** Healthy eating habits
- Y / N** Stress management, relaxation, or fun activities
- Y / N** Maintain healthy weight
- Y / N** Maintain good physical health
- Y / N** Healthy mindset
- Y / N** Healthy family and personal relationships
- Y / N** Healthy finances & Job satisfaction
- Y / N** Other – describe \_\_\_\_\_

### Energy Drains – I experience the following energy drains in my life:

- Y / N** Poor or insufficient sleep
- Y / N** Minimal exercise
- Y / N** Unhealthy eating habits
- Y / N** Stress
- Y / N** Weight management issues
- Y / N** Physical health issues
- Y / N** Pessimism or emotional issues
- Y / N** Family or relationship issues
- Y / N** Job & Financial issues
- Y / N** Other – describe \_\_\_\_\_

### Readiness for Change

*On a scale of 1 -10, how ready are you to make changes to improve your energy level at this time?*

**Not ready 0 1 2 3 4 5 6 7 8 9 10 Very ready**

## Exercise

Do you currently exercise on a regular basis?

Y / N

If you answered yes;

How frequently?

\_\_\_\_\_

On average, how long is each session?

\_\_\_\_\_

What type of exercise do you do?

\_\_\_\_\_

## Readiness for Change

*On a scale of 1 -10, how ready are you to make changes to improve your exercise level at this time?*

**Not ready 0 1 2 3 4 5 6 7 8 9 10 Very ready**

## Sleep

I get 7-8 hours of sleep at night.

**Often / Sometimes / Rarely / Never**

I find it difficult to get to sleep at nights

**Often / Sometimes / Rarely / Never**

I wake feeling tired

**Often / Sometimes / Rarely / Never**

## Stress

I feel overwhelmed?

**Often / Sometimes / Rarely / Never**

I find it difficult to get along with people

**Often / Sometimes / Rarely / Never**

I feel frustrated, impatient, angry much of the time

**Often / Sometimes / Rarely / Never**

I experience feelings of tension and anxiety

**Often / Sometimes / Rarely / Never**

I have suffered a personal loss or misfortune in the past year (e.g. a job loss, disability, divorce, separation, or the death of someone close to you).

Y / N

I feel emotionally supported

Y / N

## Readiness for Change

*On a scale of 1 -10, how ready are you to make changes to improve your stress level at this time?*

**Not ready 0 1 2 3 4 5 6 7 8 9 10 Very ready**

## Nutrition

Have you ever followed a specific diet? If so, which one? **Y / N**

Do you eat breakfast? **Y / N**

If yes what do you generally eat for breakfast? \_\_\_\_\_

What do you generally eat for lunch? \_\_\_\_\_

What do you generally eat for dinner? \_\_\_\_\_

Do you cook most of your meals? **Y / N**

What do you snack on? \_\_\_\_\_

What foods do you crave? \_\_\_\_\_

Do you skip meals? \_\_\_\_\_

Does stress affect your eating habits? \_\_\_\_\_

Do you read food labels? \_\_\_\_\_

Do you add sugar to your food? \_\_\_\_\_

How many glasses of water would you drink per day? \_\_\_\_\_

How many cups of tea/coffee would you drink per day? \_\_\_\_\_

## **Readiness for Change**

*On a scale of 1 -10, how ready are you to make changes to improve your nutrition at this time?*

**Not ready 0 1 2 3 4 5 6 7 8 9 10 Very ready**