Integrated Physical Therapy_Nutrition and Wellness Assessment

Lifestyle and Diet:

"It is more important to know the person who has a condition than it is to know the condition the person has" -Hippocrates

Name:_____

Exercise: How often do you engage in regular exercise for a minimum of 30- 45 minutes at a time, per week?
Explain**:**_____

_____

Do you smoke or use tobacco products, if so, how often?:_____

How many alcoholic beverages do you consume per week?_____

Are you around or have you been exposed to toxic chemicals, including medications, foreign travel or regularly use conventional cleaning products in the home? Explain:_____

_____

How many glasses (or ounces) of purified water do you drink per day**?**_____

How many hours of restful sleep do you get per night?

_____

_____

In the morning upon awakening, do you feel rested and energetic or tired,stiff?_____

Eating Habits

How many meals do you eat per week that are processed or "fast food"? _____versus Home cooked? (Consider Breakfast, Lunch, dinner and snacks)_____
_____

Do you use artificial sweeteners? (Equal, Splenda, Sweet-N- Low….)
YES NO

Briefly describe meals on a typical day, be honest and specific, include all snacks (may use separate nutritional diary:_____
_____
_____
_____

How much coffee or cola do you drink per week?_____

Are you actively trying to lose weight, gain weight? Please explain:_____
If the answer is NO , skip to Stress Management

Have you "struggled' with weight issues in the past?_____

What do you feel are some obstacles to achieving a healthy weight**?**_____
_____

What has worked for you in the past regarding weight loss?

_____
_____
_____

How do you suppose you can improve your success with regard to maintaining healthy eating habits?

_____

_____

_____

_____

Are you vegan or vegetarian?:_____

Do you have any dietary restrictions (religious, personal or medical)?_____

Stress management

How "stressed" do you feel on most days? 0=not at all to 10= extreme stress? 1 2 3 4 5 6 7 8 9 10

List those areas in your life that you currently find stressful (example: job, home, health…)

_____

_____

Do you have food cravings for such things as sweets, chocolate, salty foods….?

_____

***Circle all that apply*: Which statements describe you most accurately**: A. Happy, optimistic and easygoing, B. moody, stressed anxious or uptight 3. People pleaser C. Easily frustrated, easily distracted or bored D. Focused, Self directed, goal oriented

After a stressful day or event, how do you typically cope with stressful feelings?

_____

_____

What do you do to relax?

_____

How well is this working for you?

_____

What one or two things would you like to focus on changing in your health/diet/nutrition/ or lifestyle? Be specific regarding your intentions:_____

_____

_____

_____

Are you ready to make changes now, and if not, what is preventing you from making the changes you desire? Explain in detail:_____

_____

_____

_____

How will making these desired changes impact your life and describe what that would feel like? _____

_____

Rate the level of support you feel from friends, family etc .to make changes to your diet or lifestyle. (0 1 2 3 4 5 6 7 8 9 10 greatest)

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I, _____ Understand that a successful coaching relationship will require honesty, trust and commitment. I attest that the information I have provided in this questionnaire is an honest and accurate representation of myself and my health, and I am willing to participate in this wellness program.

Signature:_____Date:_____