WELLNESS CENTER of Plymouth

PERSONAL HEALTH PROFILE

Date: _____ Name: _____

Age: _____ Male/Female: _____ Height: _____ Weight: _____

Health Goals

Are you interested in…	Improving your health?	YES/NO
	Improving your immune system?	YES/NO
	Improving your appearance?	YES/NO
	Decreasing body fat?	YES/NO
	Losing weight?	YES/NO
	Gaining weight?	YES/NO
	Anti-Aging?	YES/NO
	Disease prevention?	YES/NO
	Increasing your energy level?	YES/NO
	Improving athletic performance?	YES/NO
	Improving hormone balance?	YES/NO
	Cardiovascular issues?	YES/NO
	Blood Sugar issues?	YES/NO

Social History

Do you use cigars/cigarettes/chew tobacco? (Please circle which product) YES/NO

If YES, How much _____ History of use? _____

DO you drink alcohol? YES/NO How much _____ History of use? _____

Do you use illicit drugs? YES/NO How much _____ History of use? _____

Are you allergic to substances other than medications? YES/NO

If YES, please list: _____

_____

Nutrition Profile

Do you consistently eat a well-balanced nutritious diet? YES/NO Are you Knowledgeable about the food pyramid? YES/NO

Do you eat accordingly on a consistent basis? YES/NO

How many servings of the following do you eat PER DAY?

Fruits/Vegetables: _____ None _____ 1 _____ 2 _____ 3 _____ 4 or more

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Dairy Products: _____ None _____ 1 _____ 2 _____ 3 _____ 4 or more

Breads/Grains _____ None _____ 1 _____ 2 _____ 3 _____ 4 or more

Meat: _____ None _____ 1 _____ 2 _____ 3 _____ 4 or more

Fish: _____ None _____ 1 _____ 2 _____ 3 _____ 4 or more

Beans/Nuts: _____ None _____ 1 _____ 2 _____ 3 _____ 4 or more

Do you drink coffee? YES/NO Regular/Decaf How many 8oz cups a day? _____

Do you drink pop? YES/NO Regular/Diet How many ounces a day? _____

Do you use sugar substitute? YES/NO Which one? _____

Do you eat sweets, candy, etc.? YES/NO Daily? __ Weekly? __ What type? _____

Do you drink at least 8 full (8oz) glasses of water per day? YES/NO

Do you have cravings? YES/NO What do you crave? _____

_____

Any specific time that you have these cravings? YES/NO When? _____

Do you have any food sensitivities/allergies? YES/NO

If YES, please list: _____

_____

Do you currently take any vitamins, minerals or other Nutritional Supplements? YES/NO

If YES, please list: _____

Are you familiar with antioxidant supplements and their role in prevention of chronic disease, cancer and slowing the aging process? YES/NO

Do you currently take antioxidants? YES/NO

If YES, please list: _____

_____

Do you have children? YES/NO What are their ages? _____

Are they consistently eating a well-balanced nutritional diet? YES/NO

Fruits/Vegetables _____ 3 Meals Daily _____

Are they currently utilizing any vitamins, minerals or nutritional supplements? YES/NO

If YES, please specify: _____

Health History

What illnesses/conditions/syndromes do you suffer from presently? _____

_____

In the past? _____

What medication are you currently on? _____

Are there any other health concerns that we need to be aware of? YES/NO

If YES, please list: _____

_____

Appearance Profile (please circle one)

Do you want to: lose weight gain weight maintain weight lose body fat and inches

Have you been on any weight reduction diets in the past 3-5 years?

If YES, which one(s) _____

How much weight did you lose? _____ pounds Any problems with the program? _____

Did you regain weight? YES/NO If YES, how many pounds _____

What is your goal weight? _____

Do you exercise? YES/NO

If YES, what type: _____

How often: _____ Daily _____ Weekly _____ Monthly

How long have you been exercising? _____

Risk Profile

Is there a personal of family history of heart disease or circulatory problems? YES/NO

If YES, please specify: _____

Have you ever had your cholesterol level checked?

If YES, date tested: _____ Cholesterol Level _____

Is there a personal or family history of osteoporosis (loss of bone density)? YES/NO

If YES, please specify: _____

Menopause status: _____Pre _____ Post _____ Estrogen use

Are you concerned about your risk of osteoporosis? YES/NO

Are you currently taking calcium and vitamin "D" supplements?

Stress Profile

How would you rate your daily stress level? ___None ___ Mild ___ Moderate ___High

Type of stress: ___ Home ___ Occupational ___Psychological Please describe: _____

_____

What is your overall energy/stamina level throughout the day?

NONE POOR FAIR GOOD EXCELLENT

Does your energy fluctuate throughout the day? YES/NO

What time of day do you have the variations in energy? _____