Anue
A Holistic Approach to a Healthier Lifestyle

Initial Client Questionnaire

First Name: _____ Middle Initial: _____ Last Name: _____

Medical History

Pregnant: Yes _____ No _____ Nursing: Yes _____ No _____

When was your last physical exam? _____

What are your current medical problems?

_____

_____

_____

What are your current medications (please include name, dosage, and purpose)?

_____

_____

_____

_____

_____

Do you have any medication or food allergies? Yes _____ No _____

If yes, please specify:

_____

_____

_____

Please list any operations or hospitalizations and indicate your age at the time.

Operation / Hospitalization	Age
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Please list any past or present individual or marital counseling.

_____

_____

Please indicate if you or any family member has had any of the following:

Condition	You	Relative (Specify)	Condition	You	Relative (Specify)
ADD / ADHD			Hernia		
Alcoholism			High Blood Pressure		
Allergies			High Cholesterol		
Anemia			Hyperthyroidism		
Anorexia			Hypothyroidism		
Anxiety			Irritable Bowel Syndrome		
Arthritis			Irregular Heartbeat		
Asthma			Kidney Disease		
Bulimia			Liver Disease		
Cancer			Low Back Pain		
Chest Pain			Low Blood Pressure		
Constipation			Migraines / Headaches		
Depression			Painful Joints		
Edema			Peripheral Vascular Disease		
Dizziness			Phlebitis		
Frequent Diarrhea			Polycystic Ovary Syndrome		
Frequent Nausea			Seizures / Epilepsy		
Gallbladder Disease			Shortness of Breath		
Gas / Bloating			Sleep Difficulties (i.e. Sleep Apnea)		
Gastric Bypass Surgery			Stroke		
Gout			Type 1 Diabetes		
Heart Attack			Type 2 Diabetes		
Heartburn			Ulcers		

If yes, please explain: _____

_____

_____

_____

Personal Habits

Do you smoke cigarettes? Yes _____ No _____

If yes, please specify: # per day _____ # of years _____

Do you drink alcohol? Yes _____ No _____

If yes, please specify: Type: _____ Amount: _____ Frequency: _____

Do you use recreational drugs? Yes _____ No _____

If yes, please specify: Type: _____ Frequency: _____

Social / Work Habits

What is the highest grade level you have completed? _____

What is your present occupation? _____

What is your work schedule (i.e. days, nights, shift work, etc.)? _____

Has your weight ever caused a problem at work? Yes _____ No _____

What is your sleep schedule? Work days: ____hours/night Non-work days: ____hours/night

What is your current relationship status? _____

If applicable, please describe your partner's weight (circle one):

Very Overweight	Slightly Overweight	About Average	Slightly Underweight	Very Underweight

Do you have any children? Yes _____ No _____

Who lives in your household? _____

How do you spend your free time? _____

_____

Weight History

Current Height: _____ Current Weight: _____ Weight 1 Year Ago: _____

What is you body build? Small _____ Medium _____ Large _____

(Place your thumb and middle finger around your wrist. Small = fingers overlap, Medium = fingers touch, Large = fingers don't touch)

What are your feelings regarding your weight (circle one)?

Completely Satisfied	Satisfied	Neutral	Dissatisfied	Completely Dissatified

At what weight have you felt your best? _____

How much weight would you like to lose? _____

Do you feel your weight affects your daily activities (circle one)?

No Effect	Some Effect	Much Effect	Extreme Effect

Why do you want to lose weight at this time? _____

_____

What do you attribute to your weight problem? _____

_____

Please describe the attitudes of the following people regarding your attempts at weight loss:

	Negative (Insensitive / Disapproving)	Indifferent (Don't care / Don't help)	Positive (Supportive / Understanding)
Husband			
Wife			
Children			
Parents			
Friends			
Employer			

Do these attitudes affect you? Yes _____ No _____

If yes, please describe: _____

_____

_____

Please identify the periods in your life when you have been overweight. Briefly describe your maximum weight, any events related to your weight gain (i.e. pregnancy, college, marriage, divorce, illness, etc.), and any methods you used to lose weight (i.e. diet pills, surgery, etc.).

Age	Maximum weight	Events related to weight gain	Method(s) used to lose weight
11-15			
16-20			
21-25			
26-30			
31-35			
36-40			
41-45			
46-50			
51-55			
56-60			
61+			

Please indicate which of the following weight loss methods you have used in the past.

Method	# of times used	Maximum weight lost	Comments about the program
Atkins (High Protein)			
Weight Watchers			
Jenny Craig			
LA Weight Loss			
Medication / Supplement			
Supervised Diet			
Unsupervised Diet			
Behavior Modification			
Psychotherapy			
Starvation			
Surgery			
Other (please specify):			

Please indicate any psychological changes you have experienced during or after a significant weight loss.

	Not At All	A Little	Moderately	Quite A Bit	Extremely
Depressed / Sad					
Anxious / Restless					
Happy / Elated					
Irritated / Angry					
Fatigued / Tired					
Lack of Self-Confidence					

Why do you feel your past weight management experiences were successful or unsuccessful?

_____

_____

_____

Eating Habits

Do you have any dietary preferences or restrictions? Yes _____ No _____

If yes, please describe:

_____ Vegan (consume no animal product, milk, or eggs)

_____ Lacto-Ovo Vegetarian (consume no animal products except milk and eggs)

_____ Other Vegetarian (consume some animal products)

_____ Food Allergy (please specify): _____

_____ Medical Restriction (please specify): _____

_____ Other (please specify): _____

Who plans your meals? _____

Who shops? _____

Who cooks? _____

What food(s) do you crave the most? _____

What do you consider to be your best food habit(s)? _____

What do you consider to be your worst food habit(s)? _____

Do you eat while watching TV? Yes _____ No _____

How many meals per day do you usually eat? _____

How many of those meals do you or someone in your household prepare? _____

How many meals per week do you usually eat out? _____

How often do you eat breakfast (circle one)?

Everyday Most Days Some Days Rarely or Never

How often do you skip meals (circle one)?

Everyday Most Days Some Days Rarely or Never

How often do you eat a meal or snack less than 2 hours before bedtime (circle one)?

Everyday Most Days Some Days Rarely or Never

Please indicate how often you eat at the following:

	Never	Monthly	Several times per month	Weekly	Several times per week	Daily	Several times per day
Full-Service Restaurants							
Fast Food Restaurants							
Cafeterias							
Hot Dog / Food Stands							
Vending Machines							
Other (please specify):							

What do you see getting in your way of establishing good eating habits? _____

_____

Exercise Habits

Are you currently physically active? Yes _____ No _____

If yes, please describe:

Type: _____ Frequency: _____ Duration: _____

How long have you been physically active on a regular basis? _____

Please rate your level of enjoyment regarding physical activity (circle one):

How many days per week are you willing to devote to exercise? _____

What time of day do you prefer to exercise? _____

Would you rather exercise solo, with a partner, with a group, or with a trainer? _____

Would you rather exercise at home, at work, at a pool, or at a health club? _____

Is your neighborhood safe enough for outdoor activities? Yes _____ No _____

Do you own any exercise equipment? Yes _____ No _____

If yes, please specify: _____

Are you a member of a health club? Yes _____ No _____

If yes, please specify: _____

Have you ever worked with a personal trainer? Yes _____ No _____

Do you experience any muscle or joint pain during exercise? Yes _____ No _____

If yes, please explain: _____

Are you physically limited in any way? Yes _____ No _____

If yes, please explain: _____

Please circle all that interest you:

Aerobics	Hiking	Stationary Bike
Competitive Sports	Karate	Swimming
Dance	Outdoor Cycling	Treadmill
Elliptical Machine	Personal Training	Walking
Exercise Videos	Resistance Bands	Weight Machines
Free Weights	Seated Exercises	Yoga

Other (please specify): _____

What do you see getting in your way of establishing good exercise habits? _____

_____

Timing

Please indicate if you are currently experiencing stress related to the following events:

_____ Work

_____ Relationships

_____ Children

_____ Moving

_____ Death of Relative or Friend

_____ Other (please specify): _____

Are you planning any major life changes in the next year? Yes _____ No _____

If yes, please describe: _____

Readiness to Change

Circle the response that best describes your current intentions regarding good dietary and lifestyle habits:

a. I am not planning to adopt any new dietary or lifestyle habits this year.
b. I'm planning to start making improvements in my dietary and lifestyle habits in the next 6 months.
c. I'm planning to start making improvements in my dietary and lifestyle habits in the next 30 days.
d. I'm currently trying to make dietary and lifestyle improvements.
e. I have adopted good dietary and lifestyle habits and maintained them for less than 6 months.
f. I have adopted good dietary and lifestyle habits and maintained then for more than 6 months.

Please include any additional information you feel may be relevant to your weight management program:

_____

_____

_____

_____