ALIGN WELLNESS STUDIO

Health and Lifestyle History

*Name*_____ *Age*____ *Date of Birth*__/__/__ *Date* _____

*Your Primary Care Physician*_____ *Last complete exam*___/___/___

Allergies to Medications: _____

Have you **ever** been diagnosed with or are you **currently** under care for**(please answer all):**

Disease/Symptom	Yes	No	Date(s)	Disease/Symptom	Yes	No	Date(s)
Alcohol Abuse	__	__	_____	Insomnia	__	__	_____
Angina/Chest Pain	__	__	_____	Irregular Pulse	__	__	_____
Anxiety	__	__	_____	Headaches	__	__	_____
Anemia	__	__	_____	High Blood Pressure	__	__	_____
Anorexia/Bulimia	__	__	_____	Joint Pain	__	__	_____
Arthritis	__	__	_____	Kidney Disease	__	__	_____
Asthma	__	__	_____	Liver Disease	__	__	_____
Back Pain	__	__	_____	Mental Illness	__	__	_____
Cancer	__	__	_____	Menstrual Irregularities	__	__	_____
Cholesterol Problem	__	__	_____	Migraine Headaches	__	__	_____
Constipation	__	__	_____	Palpitations	__	__	_____
Depression	__	__	_____	Seizure Disorder	__	__	_____
Diabetes	__	__	_____	Shortness of Breath	__	__	_____
Diarrhea	__	__	_____	Snoring/Sleep Apnea	__	__	_____
Drug Abuse	__	__	_____	Stroke	__	__	_____
Fatigue	__	__	_____	Swollen Ankles	__	__	_____
Frequent Urination	__	__	_____	Stroke	__	__	_____
Gallbladder Disease	__	__	_____	Thyroid Disease	__	__	_____
Gout	__	__	_____	Ulcers	__	__	_____
Heart Disease	__	__	_____	Other:			

Describe any YES answers and any other problems not listed above:

_____
_____
_____
_____

_____
_____
_____
_____
_____
_____

Surgeries:	Family History:	Medications:
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Name_____ ***Date***_____

Social History:

Who do you live with? _____

Describe your current support system: _____

Do you drink alcohol? _____ Drinks/week? _____ Do you use street drugs?_____

Do you smoke?____ Packs/day? ____ Number of years smoked?_____Date Quit!_____

Occupation_____ Employer_____

Typical Schedule_____

Hobbies/Other Interests: _____

Goals:

What are your preliminary goals for this program (health, energy, pounds, size, other)?

_____

What are your **three main** reasons for wanting to start this program? **Be specific**.

1. _____

2. _____

3. _____

Why **now?** _____

Do you have **support** to undertake this program? _____

Are there any **barriers** to your efforts at this time? _____

How **important** do you feel it is that you begin now? Very Somewhat Slightly Not

How **confident** are you that you will reach your goals? Very Somewhat Slightly Not

Current Activity:

Do you currently engage in any regular physical activity? _____

What Kinds? How often/how long?_____

_____

How do you feel about exercise?_____

Are there any known medical or other reasons you cannot exercise? _____

_____

Have you had any specific injuries or problems? _____

How much time can you reasonably devote to an exercise program during the week?_____

_____

Team Member's Notes:

Name:_____ ***Date***_____

Weight History:

When did you first become overweight/underweight? Age _____Year _____

How did your weight problem start? _____

How much did you gain/lose?_____ How long did it take? _____What did you weigh? _____

What was your highest weight (except for pregnancy)? _____ Your age then?_____

What was your lowest weight (since childhood?) _____ Your age then? _____

Have you ever stayed the same weight for five years or more?____ Weight ____ When____

What do you think is the cause of your weight problem? _____

_____

What means of weight loss have you tried before (programs, meds, hypnosis, fad diets etc.):

Method:	Weight loss:	Length:	When:	Successful?:
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Have you experienced any side effects or illnesses as a result of any diet?_____

Explain: _____

Have you or are you taking any weight loss medications (type, dose, dates, experience)? ____

_____

Have you ever taken laxatives or induced vomiting to try to lose weight? _____

Have you ever had an eating disorder?_____

Are there any foods that you consider "bad" or "forbidden"?_____

Are there some foods you find impossible to stop eating once you start?_____

If so, what foods? _____

Are you generally hungry when you eat?_____

Do you eat "by the clock"? _____

Are there any stressors or other issues that you feel affect your eating and your weight?____

_____

_____

_____

Any other information that might be helpful?_____

_____

Team Member's Notes:

Name:_____ ***Date***_____

Nutrition:

Are you currently following any special diet? ____ If yes, type _____

Has this or any other particular diet been recommended by a physician? _____

Have you been told you should watch your cholesterol/Fat?_____ Salt?_____

Do you take a multivitamin regularly?_____Calcium Supplement?(Dose?)_____

Have you ever been told you have (or may have) diabetes? _____

Are any other members of your household on a special diet? _____

Do you have any allergies (or other reasons to avoid) any foods? _____

Who does the grocery shopping? _____

Who does the food preparation? _____

Is income a factor in your selection of foods? _____

How many/which meals per week are eaten out of the home (i.e. in a restaurant)? _____

_____

What types of restaurants do you enjoy? _____

How many times a week do you eat in a fast food restaurant? _____

Do you have any strong food likes or dislikes? _____

Are your eating habits on weekends vastly different from during the week?_____

Describe: _____

What areas of your diet are you most concerned about?_____

_____

A typical day's intake right now might look like (include times typically eaten):

Breakfast **Snack** **Lunch** **Snack** **Dinner** **Snack**

Team Member's Notes:

If you have **any questions** about this form, or if there is other information that might be important, please discuss it with the doctor. **If any information changes, inform the doctor.**

Client Signature_____**Date**_____