Designed for Health Client Profile

Name____Date____/____/____

Address____

City____ State________ Zip ___________________

Email____

Phone: (Mobile)____________________________ (Home)____________________________________

(Work)______________________________________ Birthday_____/______/________ Age ___________

What is the best way to contact you? Phone Email What time is best to call: ______________________

Occupation ___________________________________Average # work hours / week____ _______________

Referred by ____

Blood type ______ Height_____ft__ _____in Weight_______ lbs Gender___ _ Marital Status_______________

Motivation

What are your top 5 health concerns?

1.
2.
3.
4.
5.

Why is important for you to address these health concerns right now?

What strategies have you tried to address these concerns (if any)?

What are your personal health goals? What would your ideal life look like in a state of peak health/performance?

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Designed for Health

Would you want to read more about health issues that may be affecting you? yes / no

Describe the support (or lack) that you would have to make diet and lifestyle changes.

What would be your 3 greatest obstacles to making lasting changes?

1.
2.
3.

Do you have any things you won't give up or won't do in order to improve your health?

Personal Health History

How were you born? Vaginally / C-section How long were you breastfed?___________________months

What were your eating habits like growing up?

What diseases and disorders run in your family?

If you are under the care of any health care practitioners please list their name and reason you are seeing them.

Have you ever had a bone scan? yes / no Do you have Osteoporosis or Osteopenia? yes / no

Have you ever been told that you have any of the following conditions? (circle all that apply)

Scoliosis High / Low Blood Pressure Disc bulging or Herniation Arthritis Stenosis Diabetes

Spondylolisthesis Joint Replacement / Fusion Chronic Headaches Other: ______________________________

Are any of the following hard for you? (circle all that apply) Dizziness Balancing Manual cueing

Being up high Being upside down Auditory cues Other: ____________________________________

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Diet

How much pure water do you drink per day? ________fl. oz caffeinated drinks? _________fl. oz

What percent of your food is cooked from scratch? ________%

How many times per week do you eat out?_________ times / week

How much time per day on average do you spend in the kitchen? ________hours / day

Describe your feelings towards cooking.

What kind of cookware do you use typically?

What kinds of fats do you usually cook with?

In your opinion, what do you think are the three least healthy foods you eat each week and why?

1.
2.
3.

Conversely, what do you think are the three healthiest foods you eat each week and why?

1.
2.
3.

Do you have any of the following symptoms? (circle all that apply)

Tired after meals Bloated after meals Gassy after meals Constipation often

Diarrhea often Excessively hungry Little or no appetite Crave sugar Crave salt

Describe your feelings about eating or food in general.

Please list 1) all supplements that you are currently taking 2) why you are taking each and 3) if you feel they are working.

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Do you have any known allergies to food, herbs, medications, etc.?

Toxins

Do you smoke? yes / no Are you regularly exposed to secondhand smoke? yes / no

If you ever smoked in the past, how long / much?________/day for _______ years _______ years ago

Have you had any amalgam fillings? yes / no If so, how many?_______ Any removed?_______

How many cavities did you have growing up? ___________ Did you have braces? yes / no

Describe any other dental issues:

Are there any other toxins you have been exposed to? ____

How often do you fly?____________________How often do you swim in pools?_____________________

Please circle all that you have suffered with you now or in the past: eczema candida infection

Lyme infection Epstein Barr virus prolonged mold exposure other: ____________________________

Lifestyle

Do you sleep well? yes / no Do you wake during the night? yes / no What time? _________________

What time do you usually go to bed?_________pm What time do you usually wake up? _________am

Do you wake on your own? yes / no How do you feel when you wake up?________________________

What kind of activities are you doing on a daily basis?

What do you do for fun / recreation? How often?

What things in your life stress you the most?

On average, how much time do you spend in prayer and/or meditation per day?

Would you like to pray together in our sessions? yes / no Briefly, describe yourself spiritually.

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Rate yourself on a 1-10 scale in the following areas (10 is optimal):

energy _____ diet _____ brain function _____ sleep _____ weight _____ stress _____ joy_____.

relationships_____ spiritual_____digestion_____ coordination_____ strength _____flexibility_____balance_____.

Movement

What kind of movement do you enjoy most?

What kind of movement activities do you do regularly and how often do you do each?

Describe why you feel you should exercise and what you think you should do for exercise (regardless of whether you are doing it).

If you have trouble maintaining a regular exercise schedule, what do you think the primary reasons are why?

Have you ever done Pilates before? yes / no If yes, what kind? Mat Reformer All Equipment

How much time do you spend sitting per day on average? _________hours / day

What areas of your body currently give you problems?

Are there any other areas of your body that have given you problems within the last year?

What do you hope to achieve from Pilates?

Please list any previous serious injuries, hospitalizations, surgeries, diseases, etc. along with the approximate date.

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List all of your children and their ages.

Women Only

Do you feel your libido is appropriate? yes / no

Describe what an average monthly period (frequency, flow, regularity, PMS, cramps, etc.) would be or would have been.

Are you currently pregnant or trying to get pregnant? yes / no If so, when are you due? ____________

Have you ever given birth? yes / no If so, vaginally or c-section? ______________________________

Did you receive antibiotics during labor? yes / no Were there any birth complications?

Have you ever had a miscarriage? yes / no Have you undergone fertility treatments? yes / no

Are you perimenopausal? yes / no If so, when did changes begin?

Are you menopausal? yes / no If so, when was your last period?

Describe any perimenopausal or menopausal symptoms.

Men Only

Approximate age of onset of puberty.

Do you wake at night to urinate? yes / no If so how often?

Do you any of the following apply to you? (circle all that apply)

pain or difficulty with urination diminished volume or flow loss of interest in hobbies/activities

feel more agitated or irritable feel less assertive lower libido higher libido

Please list any additional concerns that were not covered.

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