One's health and well-being are influenced by many different things, including lifestyle, family history, emotional health, and nutrition/eating habits. Please complete the following questionnaire to the best of your ability to give us an overall view of your general lifestyle and health habits.

New Patient Assessment Form

First Name________________ Middle Name________________ Last Name________________

Address_________________________ City____________________ State_____ Zip _________

Please indicate your preferred method of contact (Please circle): home work cell email

Home Phone (____) _____-_______ Birth Date _____/ _____/ _____ Age _____

Work Phone (____) _____-_______ Email Address: _______________________

Cell Phone (____) _____-_______ Height ___'_____" Weight_____ Sex_____

Blood Type (Please circle): A/ AB/ B/ O/ Unk

Occupation ___________________ Marital Status ________________________

Do you have children? Yes No Age of children _______________________

Are you pregnant? Yes No Due date __________

With whom do you live? (Include children, parents, relatives, and/or friends; ages)

Example: Sarah, age 7, sister

____

____

Primary Care Provider _________________ Date of last physical exam _________________

Other doctors or practitioners you see ____

Would you like to receive email notifications regarding how to live healthy? __________

If yes, please sign _______________________________

Past Medical and Surgical History

Please indicate whether you or your relatives* have been diagnosed with any of the following diseases or symptoms (specify which relative and date of diagnosis) *Relatives include: parents, grandparents, siblings.

Illness/Disease/Symptom	Self: Age Diagnosed	Relative: Age Diagnosed	Describe/Specify
Allergies (specify type of allergy)			
Anemia			
Anxiety or Panic Attacks			
Arthritis (osteoarthritis or rheumatoid)			
Asthma			
Autoimmune conditions (specific type)			
Bronchitis			
Cancer			
Chronic Fatigue Syndrome			
Crohn’s Disease or Ulcerative Colitis			
Depression			
Diabetes (specify: Type I, II, Prediabetes, Gestational)			
Dry / Itchy skin, Rashes, Dermatitis			
Eczema			
Emphysema			
Epilepsy, Convulsions, or Seizures			
Eye Disease (specify)			
Fibromyalgia			
Food Allergies or Sensitivities			
Fungal Infection (athlete’s foot, ringworm, other)			
Gallbladder Disease/Gallstones (specify)			
Grout			
Heart Attack/Angina			
Heartburn			
Heart Disease (specify)			
Hepatitis			
High blood fats (cholesterol, triglycerides)			
High blood pressure (hypertension)			
Hypoglycemia (low blood sugar)			
Intestinal Disease (specify)			
Inflammatory Bowel Disease (Crohn’s or Ulcerative Colitis)			
Irritable Bowel Syndrome			
Kidney Disease/failure or Kidney stone			
Lung Disease (specify)			
Liver Disease			
Mononucleosis			

Illness/Disease/Symptom	Self: Age Diagnosed	Relative: Age Diagnosed	Describe/Specify
Osteoporosis			
PMS			
Polycystic Ovarian Syndrome			
Pneumonia			
Prostate Problems			
Psychiatric Conditions			
Seizures or Epilepsy			
Sinusitis			
Sleep apnea			
Stroke			
Thyroid Disease (hypo- or hyperthyroid)			
Urinary Tract Infection			
Other (describe)			
Injuries	**Age**	**Describe/Specify**	
Back injury			
Broken (specify)			
Head injury			
Neck injury			
Other (describe)			
Diagnostic Studies	**Age at study**	**Describe/Specify**	
Barium Enema			
Bone Scan			
CAT Scan: abdomen, brain, spine (specify)			
Chest X-ray			
Colonoscopy or Sigmoidoscopy (specify)			
EKG			
Liver Scan			
NMR/MRI			
Upper GI Series			
Other (describe)			
Operations	**Age at operation**	**Describe/Specify**	
Dental surgery			
Gall Bladder			
Hernia			
Hysterectomy			
Tonsillectomy			
Other (describe)			

Medication, Supplement, and Antibiotic Intake

Please provide the names of any medications, supplements and/or antibiotics and the dosage you are currently taking.

Medication/Supplement/ Antibiotic	Dose	Units	Frequency	Start Date	Stop Date
Example: One-a-Day (brand) Men's Multivitamin	1200	Mg	Daily	08/12/2007	Current

Are you allergic to any medications? Yes No Please list: _______________________________________

Lifestyle: Social support and readiness for change

Physical activity: Using the table, please describe your physical activity

Activity	Type/Intensity (low/moderate/high)	# of Days per Week	Duration (minutes)
Stretching/Yoga			
Cardio/Aerobics (walking, jogging, biking, etc.)			
Strength-training (weight lifting, pilates, some yoga)			
Sports or Leisure			
Other (specify/describe)			

Does anything limit you from being physically active?

____

Indicate daily stressors and rate the level of stress from 1 (extremely low) to 10 (extremely high)

Work ________ Family ________ Social ________ Financial ________ Health ________ Other ________

What helps you unwind? ____

On average, how many hours of sleep do you get? Weekdays ________ Weekends ________

Do you smoke (please circle)? Never In the past Currently How long? ________

Alcohol use: Never In the past Currently Type/amount/frequency ______________________

Drug use: Never In the past Currently Prefer not to discuss Type/frequency _____________

Weight History

Would you like to weight today (please circle)? Yes No

Height ____'______" Weight _______ Desired body weight _______

Highest adult weight _______ When? _______ Weight 1 year ago _______

Have you had any recent changes in your weight that you are concerned about (please circle)? Yes No
If yes, please explain: ____

Diet History:

If I could change three things about my health and nutritional habits, they would be:

1. ____
   ____
2. ____
   ____
3. ____
   ____

In the past, I have tried the following techniques, diets, behaviors, etc. to reach my nutrition goals…

____
____
____

On a scale of 1 (not willing) to 5 (very willing), please indicate your readiness/willingness to do the following:

To improve your health, how ready/willing are you to:	1	2	3	4	5
Significantly modify your diet					
Take nutritional supplements each day					
Keep a record of everything you eat each day					
Modify your lifestyle (ex: work demands, sleep habits, physical activity)					
Practice relaxation techniques					
Engage in regular exercise/physical activity					
Have periodic lab tests to assess your progress					

Do you follow any special diet or have diet restrictions or limitations for any reason (health, cultural, religious or other)? Yes No If so, please describe ______________________________

Please list any food allergies, sensitivities or intolerances ______________________________

____

Who prepares the majority of your meals? ________________ **Who shops for food?** ________________

Where do you shop for food? ____

What percent of the foods you eat are… whole ______% **organic** ______% **convenience** ______%

If you do, how much time do you spend cooking/preparing meals each day? ____________________

Please indicate the materials you use for cooking and food storage (please circle):

Plastic **Glass** **Aluminum** **Styrofoam**

Stainless Steel **Cast-iron** **Teflon/non-stick** **Ceramic**

Do you find cooking difficult? Yes No Please describe ______________________________

Which meals do you eat regularly, circle all of the following that apply:

Breakfast **Lunch** **Dinner/Supper** **Snacks (time__________)**

The nutrition/eating habits that are most challenging for me: ____

____

____

The nutrition/eating habits that I am most pleased with: ____

____

____

Food cravings:

____

Food dislikes:

____

Eating Style: **Based on how you eat on a regular basis, please circle all of the following that apply:**

Fast eater	**Family member(s) have different tastes**
Erratic eater	**Love to eat**
Emotional eater (stressed, bored, sat, etc.)	**Eat too much**
Late night-eater	**Eat because I have to**
Time constraints	**Negative relationship with food**
Dislike "healthy" food	**Struggle with eating issues**
Travel frequently	**Confused about food/nutrition**
Do not plan meals/menu	**Frequently eat fast food**
Rely on convenience items	**Poor snack choices**

The food/nutrition questions that I would like to ask are: ____

____

____

____

____

____

Other

5 Whys for Exercise: This is an exercise we use to help you discover why you truly want to be healthier.

Why have you decided to seek out a fitness/nutrition professional? ___________________________________

____

Why is that important to you? ____

____

Why is that important to you? ____

____

Why is that important to you? ____

____

Why is that important to you? ____

____

List any injuries/hospitalizations in the last 5 years: ____

____

24-Hour Appointment Cancellation Required

Wilmington Performance Lab has a 24-hour cancellation/rescheduling policy. If you miss your appointment, cancel, or change your appointment with less that 24 hours' notice, you will be charged for the visit in full. This policy includes personal training and nutritional counseling sessions.

Thank you for understanding and your cooperation.

I ________________________ have seen and read the Cancelation Policy below and understand it completely.
Please sign: _____________________________ Date: _____________________________

I ________________________ have seen and read the HIPPA from and understand it completely.
(This will be shown when you come in.)
Please sign: _____________________________ Date: _____________________________

I ________________________ have seen and read the WPL Guidelines from and understand it completely.
(This will be shown when you come in.)
Please sign: _____________________________ Date: _____________________________