6000-CONSULTATION FORM

Name: _____ Date: _____
Street Address: _____
City: _____ Postal Code: _____
Date of Birth: _____ Email Address:_____
Home Phone:_____ Work Phone: _____
Emergency Contact:_____ Phone: _____
Physician's name and phone number: _____

Marital Status: _____ Name of Spouse: _____
Do you have kids? If yes, how many/names: _____
What activities are your children involved in? _____

Existing Medical Conditions – Please check any conditions you may have:

❑ Diabetes	❑ Pregnancy
❑ Asthma	❑ Arthritis
❑ Heart Condition	❑ Obesity
❑ Epilepsy	❑ Cholesterol
❑ Hernia	❑ Eye Problems
❑ Ulcer	❑ Thyroid Problems
❑ Hearing Loss	❑ Other:

Are you currently taking any medications, either prescription or non-prescription, on a regular basis? If yes, please list the medication and for what condition. _____
Also, indicate if the medication affects your ability to exercise or achieve your fitness goals.

INJURIES

Do you have pain in, or have you injured, any of the following areas?

❑ Neck	❑ Wrist R/L
❑ Shoulder R/L	❑ Hip R/L
❑ Upper Back	❑ Knee R/L
❑ Lower Back	❑ Ankle R/L
❑ Elbow R/L	❑ Other:

LIFESTYLE

Do you smoke? Y N If yes, how long? _____
Do you want to Quit - Y N

Do you drink? Y N If yes, socially? Y N

Do you take vitamins? Y N If yes, which ones? _____

Do you have allergies? Y N If yes, what kind? _____

What are your work hours? _____

Did you complete the wellness profile? Y N
If yes… were there any surprises? _____
_____
_____

What is your focus? _____
What do you want to achieve with our help? _____

PHYSICAL ACTIVITY

Are you currently active? Y N
If yes, what do you do? _____
How often? _____
If not, why not? _____
What is the major barrier? (time, motivation, lack of knowledge, support at home, injury/illness, lack of interest)_____

Do you have a gym membership? Y N
Where? _____ Do you use it and how often? _____
Do you find times of the year that are harder to attend and why? _____
_____

Do you have equipment at home? Y N
If yes, what? _____
What activities do you enjoy doing? (Doesn't have to be gym or sports related, incorporate gardening, walking, trail hiking, time with kids, etc) _____
_____

What do you perceive your area of weakness to be? (ie. Breathing, strength, balance, etc):_____
_____
(These are all areas that can be improved with a little commitment!)

What is a realistic amount of time you can give to exercise? _____
(Think small steps. It may be 2 days/ wk/10 minutes....something is better than nothing and consistency is the key! You can always add to it!)

NUTRITION REVIEW

Do you eat breakfast? Y N If yes, what? _____
What do you drink? Y N If yes, what? _____
Do you eat snacks? Y N If yes, what? _____
Do you drink coffee? Y N If yes, how much? _____
What is a normal day of eating for you? What do you consume?
Breakfast: _____
Snack: _____
Lunch: _____
Snack: _____
Dinner: _____
Other including snacks, drink, etc. _____
Do you eat whole wheat or white? (circle)
Do you eat meat? Y N If yes, mainly what kind? _____
Do you eat fish? Y N If yes, how many times per week? _____
Do you take supplements? Y N If yes, what kind?_____

What is your weakness? (ie. eating in front of the TV? portion sizes? sweets or salty? eating in the car? Tell them your demon, this lets them know you are human too) _____
_____

STRESS

How is your stress level? _____
What is causing your stress? _____
_____
Do you have coping mechanisms that you use when you are stressed? Y N
If yes, what? _____
Do you read? Y N
Do you have a close network of people to communicate with? Y N
If yes, who? _____
_____

SLEEP

How many hours do you sleep in a night? _____ Is it sound? _____
Do you fall asleep easily? Y N
If you wake in the night do you fall back asleep easily? Y N
Do you feel rested when you wake up? Y N

Which do you do before bed? (circle one or list another)
- read, watch tv, listen to music, bath, other: _____

If you wake in the middle of the night what wakes you up? (circle one or list another)
- stress, washroom, kids, other: _____

GOALS

What would you like to improve about your current lifestyle? (Decrease health risks, lose weight, start working out, eat better, get more sleep etc.) _____
_____

State your goals and when you would like to achieve them (help them set “smart goals”):_____
_____
_____
What do you feel are the obstacles that may impede your progress towards accomplishing your goals?
_____
_____

List ways you can overcome these obstacles: _____
_____

Once you have accomplished your goals, how do you think you will feel and why?
_____
_____