New Client Questionnaire

Today's Date _____

PATIENT INFORMATION

Last Name	First	MI	Female ( ) Male ( )	Birth Date	Age
Address	Apt#	City	State		Zip
Home Phone	Cell Phone		Primary Care Physician		
E-Mail			Marital Status		
Occupation	Employer		Work Number		
Emergency Contact	Relationship		Phone		

HELPFUL INFO

How Did You Hear Prolean Wellness?			
Internet	Family Member	Friend	Magazine Advertising
Your Doctor	Yellow Pages	Flyer at Store	Radio
TV Segment	Received Ad in Mail	Google Search	Other

FITNESS HISTORY

Number of hours worked per week	*Under 20*	*20-40*	*41-60*	*Over 60*	
More than 25% of the time at your job is spent	*Sitting at desk*	*Lifting loads*	*Standing*	*Walking*	*Driving*
Are you currently exercising?	Yes	No	If yes, please describe what and how long		
What is your current weight?	When did you feel most satisfied with your weight/fitness level?				
What is your desired weight?	What was your weight when you felt your best?				
Do you enjoy Exercise?	Do you find time to exercise when you are busy?				

LIFESTYLE

Do you sleep 7 to 8 hours nightly?	Do you receive regular medical care?
Do you take supplements? Please List	

NUTRITION

How many diets have you been on in the last 3 years?
Describe the diets you've been on.

Describe the results you had with any of these diets.

How much weight did you lose?

Did you gain any of it back?

Did you experience any problems while dieting? Usually Sometimes Rarely

Do you regularly eat breakfast?

Are you ever hungry again within 1 – 2 hours of eating?

Do you ever eat when you are not hungry?
Reasons?

How much water do you drink in a typical day?

TYPICAL DAILY DIET

How many times per day do you eat on average (including snacks)?

What is your typical daily diet?

Breakfast?(Do you eat it and what do you eat?)

Snacks?

Lunch?

Snack Times?

Dinner?

How many times per week do you eat at restaurants (eat in or take out)?

Do you avoid refined sugars? (Sweets, candies, cookies, cakes etc

Please rate the level of your stress:
Low 1 2 3 4 5 High

Do you eat or drink to the point of discomfort?
Do you eat or drink when you are bored or stressed?

What do you do to relieve stress?

Do you rely on stimulants (alcohol, cigarettes) to reduce your stress level?

TYPICAL DAILY DIET

Do you drink alcohol?
If yes, how many days per week?
How many drinks per occasion?

Do you drink coffee, tea or caffeinated soda?
How much daily?

Which best describes your sleeping patterns?
Excellent Average Poor

On average, how many hours do you sleep at night?

Do you wake often at night?

Do you find it difficult to fall asleep at night?

Do you awake feeling rested?

Which describes your energy levels throughout the day?

Morning: High Medium Low
Afternoon: High Medium Low
Evening: High Medium Low

Have you ever had you're metabolic rate measured?

Lean Muscle Mass?

Do you know how many grams of protein you need per day?
If so how many grams?