BodyCentric
a proven path to health, fitness, & fulfillment

WELLBEING PROFILE ©

GENERAL INFORMATION

Name: _____

Address: _____

Home phone: _____Mobile: _____Fax:_____

E-mail: _____

Height _____ Weight_____

Date of Birth: _____

Gender:

Male Female Other:

Race/ Origin

White (non Hispanic) Asian or Pacific Islander

Black (non Hispanic) American Indian/ Alaska Native

Hispanic Other

Number of siblings and birth order: _____ / _____

Martial Status: Single_____Married_____Divorced_____Widowed_____

Children Y___N___How Many? _____

Highest Level Completed:

Grade school ____Jr. High school high school____college 2-4_____

Graduate school_____Advanced/ professional degree_____

Occupation:

Position: _____How many years: _____

Environment: sedentary___somewhat active___active____ very active___

Other working conditions: 1. stressful? Y___/N___ 2. Supportive? Y___/N___

3. Atmosphere/ environment- agreeable? Y___/N___ 4. Ergonomic? Y___/N___

MEDICAL HEALTH HISTORY

Check all that apply. Elaborate where you feel there is a need.

□ Arthritis: If yes, what type and date of onset_____

□ Asthma, bronchitis or emphysema_____

□ Anxiety or depression: IF YES, please list treatment, self medicated and otherwise:
_____

□ Back or spinal problems: LIST: _____

□ Cancer: IF YES, WHAT TYPE Date of ONSET: _____

□ Bi-Polar_____

□ Diabetes if yes what type_____

□ Heart attack, how many years ago? _____

□ Coronary Heart disease _____, Type_____

High blood pressure IF YES: _____/_____

□ High cholesterol IF YES TOTAL: _____

□ Migraine Headaches: IF YES HOW OFTEN_____

□ Stroke: IF YES WHEN_____ and any disabilities_____

□ MS: Symptoms: _____

□ Osteoporosis: _____Date of Onset_____

□ Sinusitis or allergic rhinitis (hay fever) _____

□ Any other serious health problem for which you are receiving medical treatment:
_____

□ Medications currently taking or have taken within the past year:

_____

_____

□ Any surgeries within he past 1- 5 years_____

Overall Health

In general would you say it is?

Excellent___

Above Average___

Good___

Fair ___

Poor___

Family History

Father:

Alive___Deceased____ At what age_____

Health: poor fair____good____excellent____

Reason for poor health: _____

Mother:

Alive____Deceased____At what age_____

Health: Poor____fair____good____excellent_____

Reason for poor health: _____

Adopted or do to have any family health history: _____

DIETARY INFORMATION

Do you eat breakfast regularly?

Yes___ No____

Is your diet heavy in fried, processed, frozen or fast foods?

Yes___ No___ how often do you eat these foods? _____

Does your diet consist of the following?

Fruits: 2-3 times per day: Never___ Occasional___ Often___

Vegetables: 2-3 times per day: Never___ Occasional___ Often___

Water: Never___ Occasional___ Often___

Sweets: Never___ Occasional___ Often___

Lean meats: Never___ Occasional___ Often___

How many times do you drink alcoholic beverages?

Beer: None Occasional Often If often, _____ per week

Wine: None Occasional Often If often, _____ per week

Hard Liquor: None Occasional Often If often, _____ per week

In the past were you a heavy drinker? Yes___ No___

Did you seek treatment? Yes___ No: ___ If yes how long ago

In the last two days, have you had red meat more than four times?

Yes___ No___

Fast Foods? _____How often_____

Drink soda? _____How often_____

Dairy? _____How Often_____

How much water do you intake? _____

Know daily kcal intake? _____Estimate? _____

Most of your meals are eaten? Home_____ If yes, home cooked? _____If out where? _____

PHYSICAL ACTIVITY

Weight History

Current weight:_____

Weight 10 years ago: _____

Weight 5 years ago: _____

Weight 1 year ago_____

Ideal weight:_____

How much has your weight fluctuated in one period of time? _____

Number of meals you eat per day? _____

Estimated number of calories? _____

Are you allergic to any foods or anything else? _____

Are you currently involved in a regular exercise program? Yes___ No___

Would you consider yourself sedentary? Yes____ No____

How long have you been in a regular exercise program?

Never___ 0-1years___ 2-4 years___ 4-6 years___ 6-10 years___

I occasionally engage in light activity? Yes___ How many times / week ____ No____

Do you regularly bike, swim, row, walk or run for 30 minutes at least 3 times per week? Yes___ No ___

Do you practice weight lifting, calisthenics, yoga, Pilates or strength training program? Yes___ No___

Do you know your resting heart rate? Yes___No___IF YES what is it?
_____

Have ever had your body fat assessed? Yes___No___Would you like to know?
_____

Do you know your BMR or BMI? _____

Have you ever had a VO2 max assessment? Yes___No ____Would you like to know? _____

PSYCHOSOCIAL WELLNESS

(According to the President's New Freedom Commission, mental health, is considered under primary care and contributes to our overall heath and wellbeing.)

Do you feel good about yourself? Yes ___ No ___

What area of your life would you like to have developed, grow or transform? Choose all that apply.

Love: ___

Work: ___

Leisure: ___

Emotional: ___

Intellectual: ___

Social: ___

Spiritual: ___

Physical: ___

Have you suffered a personal loss, misfortune, divorce, death, serious injury, financial loss in the past year?

___Yes 2 xs or more

___Yes 1 serious event

___None with in the year

How likely are you to internalize your feelings?

Often___ Rarely___

Sometimes___ Never___

How often do you feel tense, anxious or depressed?

Often___ Rarely___

Sometimes___ Never___

What do you do to resolve/ cope with stress?

Meditate___ Write in a journal___ Other___

Exercise___ Talk with someone___ Nothing___

In the past year how many days were you ill or away from work and or normal activities?

0___ 3-5___ 11-15___

1-2___ 6-10___ 16 +____

Do you like your body?
Y___/N____Explain_____

Do you have a healthy relationship with your body? Y___/ N___.

Do you notice your breath? (Check all that apply)

When exercising? ___

When working? ___

At leisure? ___

When under stress or pressure? ___

When you are angry? ___

Unsure___

In general are you satisfied with your life?

Completely___ Partly____

Mostly___ Not at all____

Job satisfaction:

Total ____ Most of the time____

Somewhat____ Not at all____

Do you need to be in control all the time? Yes___ No___

Do you feel that you are in control of your stress or mostly others?

Would you consider yourself a follower or a leader? Yes___ No___

Do you have trouble falling asleep at night? Often___ Never____ Sometimes____

How many hours of sleep do you usually get daily? Less than 6___ 6-7___7-8___ more than 8___

Would you describe yourself as a people person or a loner? (Circle one)

Can appreciate time spent alone? Yes___ No___

Supplemental Information

Calculate your activity index by measuring your score for each category.

	Score	Activity
Intensity	5	sustained heavy breathing and perspiration
	4	intermittent heavy breathing and perspiration
	3	moderately heavy, cycling or recreational sports
	2	moderate, as in volleyball, softball
	1	light, golf or fishing, or shopping
Duration	4	over 30 minutes
	3	20 - 30 minutes
	2	10 - 20 minutes
	1	less than 10 minutes
Frequency	5	6-7 times per week
	4	3-5 times per week
	3	1 -2 times per week
	2	a few times per month
	1	less than once a month

Intensity x Duration x Frequency = Score Total

Your score: _____x_____x_____=_____

Evaluation of Activity Score:

100	Very active lifestyle	High
60- 80	Active and Healthy	Very good
40 -60	acceptable but could be better	fair
20 -40	not good enough	Poor
Under 20	Sedentary	GET MOVING

Thank you for taking time and completing this form. All data will be read and keep in full confidentiality.

Healthy Regards,

Seth Anne Snider-Copley