MEDICAL MASSAGE CINCINNATI

(W)HOLISTIC APPROACH TO LIVING

Name:_____ Date:_____

Email:_____

Home Phone: _____

Cell Phone: _____

Work Phone: _____

1) What are the biggest changes you want to make in your life and/or health in the next 3 months?

_____

_____

_____

_____

2) What is the biggest change you want to make in your life over the next year?

_____

_____

_____

_____

Areas of Focus: Check the three areas that are most important to you:

Career ☐	Finances ☐	Family ☐
Leisure ☐	Creativity ☐	Health/Fitness ☐
Home ☐	Life Purpose ☐	Wellness/Wellbeing ☐
Spirituality ☐	Relationships ☐	Service ☐
Character ☐	Reconciliation ☐	Legacy ☐
Learning ☐	Self-Improvement ☐	Other:

For questions 1-19, do you now or have you had in the past: (If **yes**, please explain.)

1. Heart problems, chest pain or stroke Yes ☐ No ☐

_____

_____

2. Increased blood pressure Yes ☐ No ☐

_____

_____

3. Increased cholesterol Yes ☐ No ☐

_____

_____

4. History of heart problems in immediate family (male relative <age 55, female <age 65) Yes ☐ No ☐

_____

_____

5. Abnormal resting or exercise (treadmill) EKG Yes ☐ No ☐

_____

_____

6. Heart palpitations (heart irregularity or racing) Yes ☐ No ☐

_____

_____

7. Diabetes, thyroid, kidney, or liver condition Yes ☐ No ☐

_____

_____

8. Breathing/ lung problems or allergies Yes ☐ No ☐

_____

_____

9. Recent surgery (last 12 months) Yes ☐ No ☐

_____

_____

10. Prostate issues (men) Yes ☐ No ☐

11. Muscle, joint, bone, or back disorder, or any previous injury still affecting you Yes ☐ No ☐

12. Hernia, or any condition that may be aggravated by lifting weights Yes ☐ No ☐

13. Leg pain or ankle swelling Yes ☐ No ☐

14. Gastrointestinal disorder/ issues Yes ☐ No ☐

15. Any chronic illness or condition Yes ☐ No ☐

16. Dizziness or loss of consciousness Yes ☐ No ☐

17. Cigarette smoking habit Yes ☐ No ☐

18. Major depression or other mood disorder Yes ☐ No ☐

19. Anorexia, bulimia, or binge eating disorder Yes ☐ No ☐

_____

_____

Please list your current medications:

_____

_____

_____

_____

_____

_____

Most recent blood pressure? _____

Resting heart rate (if known)? _____

Now list what you normally have for Breakfast, Lunch, and dinner, any snacks and the times you eat them. (If you need to use another page please do so): _____

_____

_____

_____

_____

_____

How much water intake in a 24 HR period? (in ounces) _____

How much caffeine(daily)_____

How much alcohol (daily)_____

Nutrition

1. On a scale from 1 (poor) to 10 (excellent), how would you rate your **satisfaction** with your current eating habits?: _____

2. How would you describe your current eating habits?:

_____

_____

_____

_____

_____

_____

3. **Please check any of the following statements that describe your eating patterns.**

- ☐ I usually don't realize I'm hungry until I'm ravenous.
- ☐ I'm often not satisfied until I'm stuffed.
- ☐ I can't say no to foods like chocolate or chips.
- ☐ I follow the "see food diet": When it's there, I eat it.
- ☐ I usually quit eating when I feel like I've comfortably had enough.
- ☐ I always worry whether the foods I eat will make me gain or lose weight
- ☐ The only way I know to stop eating is when the plate is "clean."
- ☐ I don't really think about what I eat, I just grab whatever is available.
- ☐ Most of the time, I eat only when I am hungry.
- ☐ I often get so hungry that rich foods are more appealing than lighter ones.
- ☐ I usually quit eating because I lose interest in food as I become satisfied.
- ☐ I stop eating because I think I should. ☐ I like nutritious foods, but I forget to have them.
- ☐ I feel that I can never get enough of certain foods I think I shouldn't eat.
- ☐ I often let myself get so hungry that I eat more than I want.

4. Do you eat compulsively or in response to emotions? (If yes, please describe.)

_____

_____

_____

5. Describe in detail your typical weekday meals (breakfast, lunch, dinner, and snacks; typical portions; whether home-cooked, eaten in a restaurant, or purchased as fast food, etc.):

_____

_____

_____

_____

6. Describe your typical weekend meals (as above):

_____

_____

_____

_____

7. Describe your daily beverage intake (# of 8 oz. glasses of water, milk, sodas, coffee, alcohol):

_____

_____

_____

8. List your favorite foods:

_____

_____

_____

_____

9. Foods you dislike:

_____

_____

_____

10. Foods you crave:

_____

_____

_____

☐ Salty? ☐ Sweet?

11. Foods that give you the most sustained energy:

_____

_____

_____

12. List any vitamins and supplements you are currently taking and their health effect:

_____

_____

_____

_____

13. Describe any food allergies or prohibitions (i.e. lactose intolerant, no red meat):

_____

_____

_____

14. List any diet/weight management programs tried in the last 10 years, and their effect:

_____

_____

_____

_____

Health & Weight Management

On a scale from 1 (poor) to 10 (excellent), how would you rate your general health? _____

1. Describe: _____

_____

_____

2. Height: _____

Current Body Weight: _____1 year ago:_____5 years ago: _____10 years ago: _____

3. Goal weight: _____

4. On a scale from 1 (poor) to 10 (excellent), how would you rate your satisfaction with your body? _____

5. Describe:

_____

_____

_____

_____

6. Frame size (if known): Small ☐ Medium ☐ Large ☐

7. Do you exercise daily? Yes ☐ No ☐

If yes, please describe: _____

_____

_____

_____