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?

____

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____

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

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____

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

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____

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

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____

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

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____

8. Breathing/ lung problems or allergies Yes No

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9. Recent surgery (last 12 months) Yes No

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10. Prostate issues (men) Yes No

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____

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

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

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____

13. Leg pain or ankle swelling Yes No

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____

14. Gastrointestinal disorder/ issues Yes No

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____

15. Any chronic illness or condition Yes No

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____

16. Dizziness or loss of consciousness Yes No

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17. Cigarette smoking habit Yes No

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____

18. Major depression or other mood disorder Yes No

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____

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

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____

Please list your current medications:

____

____

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____

____

____

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.)

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____

____

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: ____
____
____
____

Stress Management & Energy

1. On a scale from 1 (poor) to 10 (excellent), how would you rate your general stress level?: _________
Describe: ____
____
____

2. On a scale from 1 (poor) to 10 (excellent), how would you rate your general energy level?: _________

Describe: ____
____
____

3. On a scale from 1 (poor) to 10 (excellent), how would you rate your quality of sleep?: _________

Describe: ____
____
____

4. Describe the measures you have taken to reduce stress/improve your energy or sleep: ______________________________
____
____
____

5. If you know you stress triggers list them: ____
____
____
_ ____

6. Do you or have you been treated for panic attacks, anxiety, depression? Yes No

7. Are you currently taking medication for the above? Yes No

8. When you are feeling like you are going to have an anxiety attack or feel your stress level rising what is your first course of action? ____
____
____
____

Thinking outside The box.

OK now that we have looked into all the physical stuff, let's look more at stress relation and the emotional making stuff! These may seem personal, but please answer as openly and honestly as possible:

Have you ever had a trauma that has deeply affected you, your family, or significant other? Yes No

If **yes**, please Explain in as much detail as you can: ____
____
____
____

Do you feel like you're stuck, or in a state of chronic misfortune? Yes No

What form of connection to God/Spirit/Universe do you have if any? ____
____
____

Are you open to a varied approach to spirituality? ____
____

Or are you deeply devoted to one calling? ____
____

Does this have relevance for you? Yes No

Do you meditate? Yes No

If yes, what practice do you follow? ____
____

How well or not so well does it work for you? ____
____

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Are you locked into this practice? Yes No

If yes, please explain: ____
____

Do you like guided meditations all the time? Yes No

Or would you prefer a guided meditation that you can make your own as time goes by? Yes No