Wellness & Weight Loss - OPTIONAL

Name: _____ Date of Birth: _____ Height: _____

Your overall health is of utmost importance to us, and your weight can significantly affect your treatment plan in our clinic. For this reason, we are including at no additional cost, a health consult to help you create an action plan for any of the below issues.

Thrive Physical Therapy will assist you in scheduling this complimentary consultation. Once this appointment is scheduled our health coach will contact you to confirm.

Please select if you have had or currently have any of the following conditions:

_____ Migraines	_____ Heart Problem	_____ Eating Disorder
_____ Diabetes	_____ High Cholesterol	_____ Depression
_____ High Blood Pressure	_____ Stress	_____ GERD
_____ Thyroid disorder	_____ Indigestion	_____ Cancer
_____ Food Allergies	_____ Constipation	_____ Sleep APNEA

Do you have any other medical conditions not listed above? _____

Health / Weight Goals and History

Present weight? _____ **Desired weight?** _____ **Goal for desired weight? (month/year)** _____

Highest weight in past 3 years _____ **Lowest weight in the past 3 years?** _____

Have you had long term success (kept weight off longer than a year)? YES NO

What type of work do you do? _____

How often do you exercise? ____ Rarely ____ 1-2 days/week _____ 3-5 days/week ____ 6-7 days/week

How long is your exercise per session? _____ None _____ <30 min _____ 30-60 min _____1 hr ___ >1hr

Types of Exercise? (select all that apply) _____ Walk ____Jog/Run _____Weight Train _____Bike ____ Other

How would you describe your general stress level? _____ High Stress _____ Moderate _____ Low Stress
How many hours of sleep do you get per night? _____ <4 hrs. _____ 4-5 hrs. _____ 6-8 hrs. _____ >8 hrs.
How do you feel mostly throughout the day? _____ Tired & Fatigued _____ Energetic & Alert
How many times do you eat a day? _____ **Do you often have cravings for sugary or foods?** _____
Do you struggle with eating healthy and regularly? _____

Select the statement that best describes you (check one)

____ I eat a very healthy balanced diet, consisting mostly of fresh fruit and vegetables, lean meats and plenty of water. I rarely eat "junk food" or fast food.

____ I eat a moderately healthy diet, but on occasion eat unhealthy foods. I eat fast food/restaurant food more than 3 times a week. I drink sodas sometimes.

____ I eat a mostly poor and unhealthy diet. I eat junk food almost everyday and fast food more than 4 times a week. I drink sodas often instead of water.

I hereby give my permission to Thrive Physical Therapy to share the information I have provided on this Wellness & Weight Loss form to share with their Health Coach.

Signature of Patient, Parent or Guardian _____ **Date** _____

Contact number _____ **Best time to call** _____ **Email** _____

For Office Use Only:

Interested in a 45-minute free consultation: Yes No

Best Day: M T W Time: _____

THRIVE PHYSICAL THERAPY