MY WELLNESS PROFILE

Please bring this completed form with you on your first therapy appointment. Your information will be kept confidential and will not be shared with any other organization. You may use pen or pencil to check the boxes.
(Example: ☑)

1. **Daily Activities**
   The following items are about activities you might do during a typical day. Does your health now limit you in these activities? If so, how much?

   1) Yes, limited a lot; 2) Yes, limited a little; 3) No, not limited at all

   ☐ 1 ☐ 2 ☐ 3 - Lifting or carrying groceries (Check one.)
   ☐ 1 ☐ 2 ☐ 3 - Moving a table, vacuuming (Check one.)
   ☐ 1 ☐ 2 ☐ 3 - Climbing several flights of stairs (Check one.)
   ☐ 1 ☐ 2 ☐ 3 - Walking several blocks (Check one.)

2. **Exercise**
   How many days per week do you engage in aerobic exercise of at least 20 to 30 minutes in duration (brisk walking, cycling, jogging, swimming, aerobic dance, active sports, or gardening)? (Check one.)

   ☐ No exercise program
   ☐ One day a week
   ☐ Two days a week
   ☐ Three days a week
   ☐ Four days a week
   ☐ Five days a week
   ☐ Six days a week
   ☐ Seven days a week

3. **Strength**
   How many times per week do you do strength-building exercises such as sit-ups, push-ups, or use strength training equipment? (Check one.)

   ☐ None
   ☐ Once a week
   ☐ Twice a week
   ☐ Three plus times weekly

4. **Stretching**
   How many times per week do you do stretching exercises to improve flexibility of your back, neck, shoulders, and legs? (Check one.)

   ☐ None
   ☐ Once a week
   ☐ Twice a week
   ☐ Three plus times a week

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5. Activities

Which activities do you prefer? (Check all that apply.)

- ☐ Walking
- ☐ Running
- ☐ Bicycling
- ☐ Canoeing
- ☐ Surfing
- ☐ Aerobics with Music
- ☐ Dancing
- ☐ Golf
- ☐ Handball / Racquetball
- ☐ Hiking / Backpacking
- ☐ Calisthenics
- ☐ Skating
- ☐ Skiing - X country
- ☐ Skiing - downhill
- ☐ Stair Stepping
- ☐ Swimming
- ☐ Tennis
- ☐ Weight training
- ☐ Yard work / gardening
- ☐ Active Sports
- ☐ Volleyball
- ☐ Baseball
- ☐ Football
- ☐ Triathlalon
- ☐ Patch

6. Referral source

How did you find Egoscue? (Check all that apply.)

- ☐ Family member
- ☐ Friend
- ☐ Co-Worker
- ☐ Radio
- ☐ TV
- ☐ Advertisement
- ☐ Newspaper or Magazine Article
- ☐ Internet or email
- ☐ An Egoscue book
- ☐ Physician or Medical professional

7. Dieting

Do you diet often, at least 1-2 times per year? (Check one.)

- ☐ Yes
- ☐ No

8. Hydration

How much water a day do you drink? (Check one.)

- ☐ 8 oz or less
- ☐ 9 oz - 24 oz
- ☐ 25 oz or more

9. Group activities

Do you participate in group workouts? (Check one.)

- ☐ Yes
- ☐ No
- ☐ No - but I would like to

10. Training

Do you workout with a trainer? (Check one.)

- ☐ Yes
- ☐ No
- ☐ No - but I would like to

11. Additional information

Aside from correcting your posture, is there health related information that you are interested in getting from Egoscue? (Check one.)

- ☐ Yes
- ☐ No

12. Posture

Have you been informed about your posture prior to coming to Egoscue? (Check one.)

- ☐ Yes
- ☐ No

13. Symptom

Have you seen a physician or other healthcare practitioner about your particular symptom(s)? (Check one.)

- ☐ Yes
- ☐ No

14. Symptom location

Where do you hurt? To the best of your ability please tell us the area closest to the symptom. (Check all that apply.)

- ☐ Head and Neck
- ☐ Shoulder
- ☐ Upper Arm
- ☐ Elbow
- ☐ Forearm
- ☐ Wrist and Hand
- ☐ Chest
- ☐ Stomach
- ☐ Upper Back
- ☐ Lower Back
- ☐ Hip and pelvis
- ☐ Thigh Front or Back
- ☐ Knee
- ☐ Ankle and foot
- ☐ Nerve Pain down arm
- ☐ Nerve Pain down leg
- ☐ Dizziness or ringing in ears

15. Sleep

On average, how often do you get at least 7 - 8 hours of sleep each day? (Check one.)

- ☐ Always or nearly always
- ☐ Most of the time
- ☐ Less than half of the time
- ☐ Seldom or never

16. Do you smoke? (Check one.)

- ☐ Yes
- ☐ No

17. Stress (Check all that apply.)

- ☐ Minor problems throw me for a loop
- ☐ I find it difficult to get along with people I used to enjoy
- ☐ Nothing seems to give me pleasure anymore
- ☐ I am unable to stop thinking about my problems
- ☐ I feel frustrated, impatient, or angry much of the time
- ☐ I feel tense or anxious much of the time

18. Medicine

Are you taking any medications? (Check one.)

- ☐ Yes
- ☐ No

19. Job description

Select description that best describes the kind of work you do. (Check one.)

- ☐ Sales - Office worker
- ☐ Sales - Outside
- ☐ Delivery / Driver
- ☐ Health Professional
- ☐ Manager / Professional
- ☐ Technical
- ☐ Service
- ☐ Homemaker
- ☐ Skilled craft / Trade
- ☐ Agriculture / Laborer
- ☐ Equipment Operator
- ☐ Factory Worker
- ☐ Unemployed
- ☐ Student
- ☐ Retired
- ☐ Professional Athlete
- ☐ Clergy
- ☐ Other

20. Doctor Visits

How many visits have you made during the past 12 months to a doctor, emergency room, psychiatrist, chiropractor, or other healthcare professional? (Check one.)

- ☐ None
- ☐ One
- ☐ Two
- ☐ Three
- ☐ Four
- ☐ Five
- ☐ Six
- ☐ Seven
- ☐ Eight
- ☐ Nine
- ☐ Ten or more

21. Time

If needed, when is the best time to contact you? (Check one.)

- ☐ Morning
- ☐ Afternoon
- ☐ Evening

22. Contact preference

Which mode of communication would you prefer to use for follow up conversations with a therapist? (Check one.)

- ☐ Email
- ☐ Phone
- ☐ Both - email and phone