

The Personal Wellness Center

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Initial Form

Congratulations on taking a major step towards bettering your health! I am excited to begin our partnership.

To make the most out of our first session it would be helpful to have your past medical history and a few other details. If you would be so kind, please answer the questions below in as much detail as possible. Please don't feel overwhelmed by this form, it should take no longer than 20 minutes to complete and is not intended to be stressful.

Please send the completed form back no later than two days prior to our scheduled initial assessment. Note, this form can be typed in as a word document, saved to your computer, and then sent back via email.

List Your Past Medical History? (i.e. medical diagnosis, surgeries)

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List Family Medical History. (i.e. mother, father, grandparents)

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Are you currently taking any medication? If yes, please list with dosages?

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Do you have any food allergies or are you following any dietary restrictions?

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Do You Currently Smoke? If so, how many per day?

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Do you consume any alcohol beverages? If so, how many per week?

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Describe a typical day including eating? (when you wake up, work schedule, when you eat, where you eat, what you eat, kids/family activities, when you go to sleep)

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Have you tried any “diets” in the past and if so why did or didn’t they work?

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Do you have any food rule? (i.e. No eating after dinner? No Carbs at night? Only vegetables for snacks?)

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How often do you obsess or feel anxiety around food? Weekly? Daily? A few times a day? Every Hour?

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How do you feel about your body right now?

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What is your occupation?

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How many hours of sleep on average do you get a night?

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Do you exercise? If so for how long, often, and what form of exercise? (walking counts)

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What is your typical stress level 1-10?

Level 1 - I have no worries, what is stress?

Level 3 - I know I need to get things done but they get done when they get done

Level 5 - I wake up knowing I have a list of things to do and I feel pressure to complete them

Level 7- I daily feel overwhelmed by the things I need to complete, there are moments when I think I am going to snap

Level 9 - I am barely treading water; I feel panicked

Level 10 - I am huddled in a corner crying because I can't handle this pressure

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Do you practice any stress management techniques?

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What do you hope to achieve from our sessions? What would you like to focus on?

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Thank you for taking the time to complete this questionnaire! I look forward to seeing you!