Floating Lotus Women's Wellness
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INTAKE FORM

Name: _____ Date: _____

Mailing Address: _____ Home Phone: _____

_____ Cell Phone: _____

_____ Email: _____

Date of Birth: _____/_____/_____ Marital Status: ❑ S ❑ M ❑ D ❑ W

Emergency Contact: _____ Children? ❑ Yes ❑ No

Relationship: _____ Age(s) _____

PERSONAL WELLNESS PROFILE

What is the primary reason for your visit? _____

Are you currently under medical care (Physician, Therapist, Chiropractor, Physical Therapist, Acupuncturist?) ❑ Y ❑ N

Practitioner name(s) and phone(s): _____

_____

Conditions/ Prescribed Medications: _____

_____

Is there anything else I should know about your medical history (surgeries, injuries, etc) ? _____

_____

Do you take OTC medications, dietary supplements, vitamins, herbs, tinctures, etc.? Please list: _____

_____

_____

_____

(Attach additional sheet if needed.)

Physical Conditions: Do you have any current or past Musculoskeletal issues or injuries in the following areas?

	Now	Past	Right	Left	Description
Toes	❑	❑	❑	❑	
Top of foot	❑	❑	❑	❑	
Arch of foot	❑	❑	❑	❑	
Heel	❑	❑	❑	❑	
Ankle	❑	❑	❑	❑	
Shins	❑	❑	❑	❑	
Calf	❑	❑	❑	❑	
Knee	❑	❑	❑	❑	
Thigh	❑	❑	❑	❑	
Buttock	❑	❑	❑	❑	
Hip	❑	❑	❑	❑	
Lower Back	❑	❑	❑	❑	
Mid-Back	❑	❑	❑	❑	
Upper Back	❑	❑	❑	❑	
Neck	❑	❑	❑	❑	
Shoulder	❑	❑	❑	❑	
Elbow	❑	❑	❑	❑	
Wrist	❑	❑	❑	❑	
Hand	❑	❑	❑	❑	
Jaw	❑	❑	❑	❑	

Habits: Please check any which apply to you:

❑ **Tobacco** # of cigarettes/week: _____❑ For how many years? _____ ❑ Quit _____ months/years ago

❑ **Alcohol** # of drinks/week: _____ _____

❑ **Caffeine** # of sodas: ____ # coffee/tea : _____ Total per week: _____

❑ **How often do you eat out at restaurants and parties?** ❑ 1-3x ❑ 4-6x ❑ 7+ x/week

❑ **Recreational Drug Use** Type(s)/amounts per day _____

_____

Nutrition:

Please list the foods you eat most frequently in a day, and the amounts: _____

_____

_____

_____

And now, the beverages you drink in an average day, and the amounts: _____

_____

If you changed your current diet, what would you change?

_____

_____

Activities

Occupation(s)? _____ Retired? ❑ Yes ❑ No

Describe your physical activity at work: _____

_____

Hours worked/week? _____ Days per week? _____ Hours commuting per day? _____

Do you work a set schedule? ❑ Yes ❑ No If yes, what hours? _____

Do you work from home? ❑ Yes ❑ No If yes, how much? _____

What leisure activities, sports, or hobbies do you enjoy? _____

QUALITY OF LIFE

We know that many factors affect your wellness as much as your physical fitness level — your relationships, work, stresses, emotions, and your inner life. Please reflect on these aspects of your life so we tailor your work to your needs.

1. How is your general attitude toward your life?
   ❑ Excellent ❑ Very good ❑ Mostly good ❑ I've been up and down
   ❑ Mostly in low spirits ❑ Struggling almost always

2. Are you satisfied with your life at present?
   ❑ Not satisfied ❑ Partly satisfied ❑ Mostly satisfied ❑ Very satisfied

3. How would you rate your overall satisfaction with your work or career, if applicable?
   ❑ Not satisfied ❑ Partly satisfied ❑ Mostly satisfied ❑ Very satisfied

4. How much accomplishment do you feel in your life in general?
   ❑ A lot ❑ A moderate amount ❑ Relatively little ❑ Almost none

5. How much stress do you normally experience?
   ❑ A lot ❑ A moderate amount ❑ Relatively little ❑ Almost none

6. How much effect does stress have on your health?
   ❑ A lot ❑ A moderate amount ❑ Relatively little ❑ Almost none

7. On average, how many hours of sleep do you usually get in a 24-hour period?
   ❑ 6 or less ❑ 6 to 7.5 ❑ Between 7.5 to 9 ❑ 9 or more

8. Does a lack of sleep affect your ability to function efficiently?
   ❑ Less than weekly ❑ Usually 1 night/week ❑ 2-3 nights/week ❑ 4+ nights/week

9. How many friends and relatives (including your spouse) do you feel close to (people that you feel at ease with, can talk to about private matters, and can call on for help?)
   ❑ 10 or more ❑ 5 to 9 ❑ 1 to 4 ❑ None

10. How would you describe your spiritual health – your ability to discover, articulate and act on your purpose in life; to give and receive love, joy, and peace; and to help improve the spiritual health of others?

❑ Good to excellent ❑ Fair to poor ❑ Very poor

Self-Nurturing:

11. What do you do to relieve stress? _____

12. What do you do to reward yourself? _____

13. What do you do to re-charge yourself? _____

YOUR WELLNESS GOALS

1. What is your ideal health and fitness vision? When you see yourself a few years from now, what do you see?

_____

2. How would being more fit affect your life? _____

_____

3. What activities would you like to increase? _____

4. How important is achieving your vision in relation to other priorities in your life (1 - 10 scale?) _____

5. How committed are you to achieving your vision (1 - 10 scale?) _____

6. Are there external obstacles that might get in the way of reaching your goals? _____

_____

7. Are there strategies you can use to overcome those obstacles? _____

_____

8. How have you found ways to avoid reaching goals in the past? _____

_____

9. Are there methods to short-circuit those avoidances that you recognize? _____

_____

10. Do you recognize and acknowledge your successes in daily ways? _____

_____

11. How can I help make your journey to wellness a positive experience? _____

_____

12. What is important to you in your personal wellness journey? *(Check all that apply.)*

- ❑ To have fewer aches and pains
- ❑ To be more flexible and strong
- ❑ To replace old habits with healthier ones
- ❑ To have more stamina
- ❑ To live longer and enjoy the journey
- ❑ To understand my body better
- ❑ To enjoy my body more
- ❑ To see movement toward my goals
- ❑ To have better balance
- ❑ To return to sports or exercise that I miss
- ❑ To balance my physical health with my mental, emotional and spiritual self
- ❑ Other: _____

_____

FINAL STATEMENT

Please share any additional information you believe is important to your health and wellness.

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INTAKE NOTES

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