Wellness Profile

Date:_____

First Name:_____ **Last Name:** _____**Phone #:**_____

Gender:_____**Age:**_____ **Birthday:**_____ **Email:**_____

Address:_____**City:**_____**State:**_____**Zip:**_____

What are your wellness goals?_____

Current Weight:_____Goal Weight:_____ Height:_____

How much weight do you want to lose / gain?_____lbs By a certain time/event?_____

What other wellness programs/products have you tried in the past to achieve your nutrition goals?

_____

What results have you experienced with these programs and what challenges have you faced with them?

_____

Do you eat three meals a day: Yes____ No____ if no, what meals do you skip?_____

What do you have for breakfast?_____

What do you snack on?_____

Daily water intake:_____oz What else?_____coffee _____tea _____juice _____soda _____alcohol

How many times a week do you eat out?_____ Where?_____ Average cost per meal_____

Rate you energy level (scale of 1-10):_____ What time of day is your energy the lowest?_____

CHECK ALL THE HEALTH CONDITIONS THAT APPLY TO YOU:

___Acne ___Acne ___Allegies ___Anemia ___Anxiety ___Arthritis ___Asthma ___Bladder infections ___Bruise easily ___Calcium deficiency ___Cancer, type: ___Cellulite ___Cholesterol (high) ___Chronic constipation ___Chronic fatigue	___Chronic sinusitis ___Chronic sore throat ___Circulation (poor)- cold hands or feet ___Colitis ___Depression ___Diabetes Mellitus ___Gout ___Heartburn ___Heart Disease ___Arteriosclerosis (hardening of arteries ___Heart attack	___Hernia ___Hight blood pressure ___Hypoglycemia ___Infections ___Insomnia ___Kidney Disease ___Kidney stones ___Low energy ___Low sexual stamina ___Lupus ___Menopausal ___Menstrual cramps ___Migraine headaches ___Mood swings ___Nursing mother	___Osteoporosis ___Premenstrual syndrome ___Pregnant ___Skin issues ___Sleep issues ___Smoking ___Stress level: low, medium or high ___Stretch marks ___Ulcers ___Unhealthy gums ___Water retention/ bloating ___Wrinkles

Are your currently take prescription meds? Yes___ No____ If yes, for what?_____

THERE ARE THREE AREAS WE FOCUS ON WHEN WORKING WITH YOU:

MUSCLE DENSITY, DIGESTIVE HEALTH

AND BODY CHEMISTRY/METABOLIC BALANCING

1) Muscle Density: Do you know how much protein you need?

2) Digestive Health: Do know what a healthy digestive system looks like?

3) Body Chemistry/Metabolic balancing (Blood Sugars): Are there particular foods or drinks that you crave?

You need _____ grams of protein on a daily basis (look at protein estimator) BMI_____

Now let's look at your typical diet to see how much protein you are getting:

	Breakfast	AM Snack	Lunch	PM Snack	Dinner	Evening
Usual Time						
What I eat						
What I drink						
How I feel						
Total Protein						

ASK ABOUT OUR REFERRAL PROGRAM!

It's so much fun to do this with "accountability" friends. List 3 people that would be interested in losing weight, gaining muscle, and/or increasing energy:

1. Name_____ Phone #:_____
2. Name_____ Phone #:_____
3. Name_____ Phone #:_____