BEWELL COACHING/AQUANIMITY

CONFIDENTIAL CLIENT PROFILE AND HEALTH HISTORY

Please note that any information you provide will be held strictly confidential. When completed, email to Carolyn Collman at wellcoach@bewellcoaching.com or click **SEND** at the bottom of the document. If you prefer to fill it out by hand, mail to the address at the end of this document.

DATE:

NAME:

BIRTH DATE: **SEX:** **COUNTRY of BIRTH:**

ADDRESS:

City: State: Zip Code: Country:

PHONE NUMBERS

Home: Office Cell:

E-MAIL: Other:

EMERGENCY CONTACT

Name: Phone: Relationship:

PHYSICIAN'S NAME: **PHONE:**

MEDICAL HISTORY

1. Do you take any prescribed or over-the-counter medication on a permanent or semi-permanent basis?

   Yes ☐ No ☐

   If yes, please list:

2. Do you have any injuries that are not completely healed? ☐ Yes ☐ No
   If yes, please explain:

3. Do you currently have any pain in any part of your body? ☐ Yes ☐ No
   If yes, please explain (If not, go to question #10):

4. If yes, in what way(s) does this pain interfere with your daily activities?

5. Is there any position, activity, exercise or task that causes you concern or pain (e.g. heavy-lifting, prolonged sitting, etc.)? ☐ Yes ☐ No

6. Are you presently receiving physical therapy? ☐ Yes ☐ No
   If Yes, please list your therapist's name and telephone number?

7. Do you experience any tingling, numbness, or feelings of weakness in any part of your body? ☐ Yes ☐ No
   If yes, please explain:

8. Do you experience any problems with your posture or with movement? ☐ Yes ☐ No
   If yes, please explain:

9. Have you had a broken bone or stress fracture in the past 2 years? ☐ Yes ☐ No
   Describe if Yes:

10. Have you been diagnosed with osteoporosis or osteopenia? ☐ Yes ☐ No
11. Do you have other physical conditions causing you pain? ☐ Yes ☐ No
    Describe if Yes:

12. Have you had any surgical procedures? ☐ Yes ☐ No
    Describe (include date(s):

13. (If applicable) Has your physician given you clearance to exercise? ☐ Yes ☐ No ☐ N/A

14. Date of your last physical:

15. Do you now or have you ever experienced any of the following? Put an X next to all that apply for #14/15:

Chest Pains	☐	Daily Coughing	☐
Chest Pressure	☐	Fainting	☐
Heart Palpitations/Skipping Beats	☐	Seizures	☐
Unexplained weight change	☐	Difficulty walking	☐
Dizziness	☐	Allergies	☐
Stumbling	☐	Numbness	☐
Frequent Headaches	☐	Excessive shortness of breath (with exercise)	☐
Shortness of breath	☐		

16. Do you have or did a physician ever diagnose you as having any of the following? apply:

Heart Disease	☐	Diabetes	☐
Heart Murmur	☐	Emphysema	☐
Arrhythmia	☐	Asthma	☐
Circulatory Problems	☐	Chronic Bronchitis	☐
Anemia	☐	Epilepsy	☐
Kidney Disease	☐	Liver Disease	☐
High Blood Pressure	☐	Neurological Problems	☐
High Cholesterol	☐	Arthritis	☐
Osteoporosis	☐	Cancer	☐
Autoimmune Disease	☐	Other	☐

17. Are you presently under a physician's care for any of the above or for any other condition? ☐ Yes ☐ No

18. Do you have a family history of heart disease (heart attack, stroke)? ☐ Yes ☐ No

19. Have you had any other major illnesses? ☐ Yes ☐ No
    If yes, please explain

20. Do you smoke? ☐ Yes ☐ No
    If Yes, how many packs/cigarettes per day?

21. Do you drink alcohol? ☐ Yes ☐ No
    If yes, how often do you drink? (# days per week) How much do you consume?
    Types of alcoholic beverage?

22. What type of work do you do? (occupation)

23. List the physical demands of your job:

24. On a scale from 1-10 (10 being very high), how would you rate your stress level?

25. How many hours of sleep do you average? On a weeknight? On a weekend night?

26. How many hours of private "down-time" do you have per weekday? On the weekends?

27. Do you generally feel rested? ☐ Yes ☐ No Rate your energy level between 1-10:

28. Rate your general health: ☐ Excellent ☐ Good ☐ Fair ☐ Poor

29. Rate your level of physical fitness: ☐ Excellent ☐ Good ☐ Fair ☐ Poor

FOR WOMEN ONLY

30. Do you menstruate regularly? ☐ Yes ☐ No

31. Do you have children? ☐ Yes ☐ No If yes, how many, what are their ages?

32. Are you pregnant? ☐ Yes ☐ No
If yes, approximate due date? Any prior miscarriages?:

33. Have you gone through menopause? ☐ Yes ☐ No If yes, when?:

EXERCISE HISTORY

PAST competition, participation and training: Record onto the following your exercise history including ALL sports/physical activities beginning with most experienced disciplines.

Sport /Physical Activity	Years of Experience	Experience Level (school level, professional etc.)

CURRENT EXERCISE PROGRAM

CURRENT weekly training routine over the past **30** to **90** days:

Record **APPROXIMATE** Volume or Time into each cell

	MON.	TUES.	WED.	THURS.	FRI.	SAT.	SUN.
Swimming/ Water Aerobics							

Cycling							
Running							
Weight Train							
Yoga/Stretch							
Pilates							
Gym Equipment (Treadmill/Elliptical Stationary Bike, etc.							
Other physical Activities: gymnastics martial arts, Tai Chi, dancing gardening housecleaning dog walking OTHER							

2. Have you been tested for your Target Heart Rate Zone or Maximal Heart Rate? ☐ Yes ☐ No

   Enter your results if applicable.

   *Target Heart Rate Zone: Date:

   *Maximal Heart Rate: Date:

   *Morning resting heart rate? Date:

   *Self tests acceptable. Describe method used:

3. Do you currently use a heart monitor? ☐ Yes ☐ No

4. Where do you exercise? ☐ Gym: Name of gym ☐ Home

5. If you exercise at home, what equipment do you have?
   Do you have a heated pool? ☐ Yes ☐ No

6. What is your height?

7. Current weight? Do you weigh yourself everyday? ☐ Yes ☐ No

9. Goal weight? When were you last at that weight?

WELLNESS OBJECTIVES

Describe your overall wellness goals (including, but not limited to exercise, nutrition, sleep and stress reduction).

Do you have any other wellness concerns that haven't been addressed by this questionnaire?

THANK YOU! I LOOK FORWARD TO WORKING WITH YOU.

Carolyn Collman, MS, ATRI-C
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