LIFESTYLE SCREEN FOR HEALTH PRESERVATION

We have TWO specific goals at Active Back to Health:

1. **Effective treatment strategies for current health concerns, and**
2. **Health preservation strategies for ACTIVE living.**

Please fill out this form and return it to the front desk once completed

Name: _____ **Date:** _____

Birthdate: _____ **Gender:** _____

PART 1: CHRONIC HEALTH CONDITIONS

Do you have any chronic health conditions? Please check those applicable:

- ☐ High cholesterol
- ☐ High blood pressure
- ☐ Cardiovascular disease
- ☐ Osteoporosis
- ☐ Arthritis
- ☐ Autoimmune disease: _____
- ☐ Diabetes (type 1 or type 2)
- ☐ Thyroid disease
- ☐ Muscle pain or weakness
- ☐ Other: _____

PART 2: WEIGHT MANAGEMENT

How do you feel about your weight?

- ☐ I am comfortable with my present weight
- ☐ I would like to lose a few pounds
- ☐ I feel I have a significant amount of weight to lose
- ☐ I would like to gain weight

Yes	No	
☐	☐	Has your weight changed by more than 10 pounds in the past 5 years?
☐	☐	Do you diet or use commercial weight loss programs? Please specify: _____
☐	☐	Do you engage in regular physical activity?
☐	☐	Do you skip meals?
☐	☐	Are you interested in a structured meal plan to incorporate into your lifestyle?

PART 3: GENERAL HEALTH

Yes	No	
☐	☐	Do you suffer from fatigue?
☐	☐	Do you experience high stress levels in your job or at home?
☐	☐	Do you have difficulty concentrating or a poor memory?
☐	☐	Do you suffer from a low mood, anxiety, irritability, depression or fluctuations in mood?
☐	☐	Do you experience female hormonal symptoms related to menopause, PMS, fertility or other conditions?
☐	☐	Do you experience male hormonal symptoms related to fertility, low testosterone or other conditions?
☐	☐	Do you experience frequent headaches or dizziness?
☐	☐	Do you suffer from frequent colds, flus or sinusitis?
☐	☐	Do you have any skin conditions such as acne, eczema, dermatitis, bumps on arms and/or rashes?
☐	☐	Do you experience slow wound healing or easy bruising?
☐	☐	Is your hair dry, brittle, breaking or have you experienced any hair loss?
☐	☐	Do you have ridges or white spots on your nails?
☐	☐	Do you suffer from gas, bloating, cramps, diarrhea, or constipation?
☐	☐	Do you suffer from heartburn, nausea or vomiting?
☐	☐	Do you crave sugar or salt?