Wellness Baseline & Assessment

Name: _____

Date of Birth _____ Gender: Male _____ Female _____

Address: _____

Phone Number: ( ) _____ - _____ Alternative: ( ) _____ - _____

Email Address: _____

Please answer the following questions as honest and detailed as possible.

Medical History

When was your last visit to your Primary Care Physician: _____

What was the nature of your visit (ex: checkup, medication, health concern, physical) _____

_____

_____.

Please list any medications you are currently taking, or have in the past 6 months : (Please include any herbal supplements). _____

_____

_____.

Please list any medical diagnosis you have are aware you: (EX: diabetes, hypertension, chest pain, irregular heart beat). _____

_____

_____.

Current Wellness

Please rate your satisfaction with your life in the following areas (1 being the lowest & 5 being optimal)

Emotional	1	2	3	4	5
Social	1	2	3	4	5
Spiritual	1	2	3	4	5
Financial	1	2	3	4	5
Physical	1	2	3	4	5
Intellectual	1	2	3	4	5

List one thing you want MORE of in your life right now: _____

List one thing you want LESS of in your life right now: _____

List 3 things you are "tolerating" right now in your life:

1: _____

2: _____

3: _____

What is one thing you would like to achieve that you have not been able to: _____
_____.

How have you tried to achieve this in the past: _____
_____.

Health Habits – Do You ?	Yes	No	If YES – For how long and/or how often per week?
Exercise			
Smoke – Past/Present			
Drink Alcohol			
Use Recreational Drugs			
Drink soda, coffee, tea			
Drink Diet sod or Diet Food			
Safe Sex Practices			
Follow any dietary modifications			
Follow a spiritual practice			
Have Any Hobbies			

Do You	Yes	No		General Review – Cont.	

Sleep Well?				Current Weight	
Wake Feeling Rested?				Weight One Year Ago	
Eat 3 main meals a day?				Max Adult Weight – Year	
Enjoy your work?				Min Adult Weight – Year	
Spend time outside?				Height	
Take Vacations?				Best Energy Level – Time of Day	
Watch TV? Hours/week __				Lowest Energy Level – Time of Day	
Read? Hours/Week ___				Are you a morning afternoon or night person	
Use a computer? Hours/Week				Are you always cold or hot	

Food and Diet

Favorite Foods: _____

List the 3 healthiest foods you eat during an average week

1.
2.
3.

List the 3 unhealthiest foods you eat during an average week

1.
2.
3.

Do you follow a certain diet? _____ Do you regularly fast? _____

Wellness Goals

Please describe your motivation for seeking Wellness Coaching.

_____
_____
_____.

Please describe your main wellness concerns that you would like support with.

_____
_____
_____.

Wellness Assessment

Please complete each table by circling which is most true for you.

At the end of each table add up your score out of 100. Following all 4 tables convert your final wellness score.

Emotional Wellness	Yes/Almost Always	Very Often	Sometimes	Occasionally	No/Almost Never
I feel positive about myself and my life	10	7	5	3	1
I am able to be the person I choose to be	10	7	5	3	1
I am satisfied that I'm *doing* to the best of my abilities.	10	7	5	3	1
I can cope with life's ups and downs in an effective and healthy manner	10	7	5	3	1
I am nonjudgmental in my approach to others	10	7	5	3	1
I feel there is an appropriate amount of excitement in my life	10	7	5	3	1
When I make mistakes, I learn from them	10	7	5	3	1
I can say no without feeling guilty	10	7	5	3	1
I find it easy to laugh	10	7	5	3	1
I avoid blaming others for my failures or problems	10	7	5	3	1

Your Score _____/ 100

Stress Management	Yes/Almost Always	Very Often	Sometimes	Occasionally	No/Almost Never
I am easily distracted	10	7	5	3	1
I tend to be nervous	10	7	5	3	1
I prepare ahead of time for events or situations that cause stress	10	7	5	3	1
I schedule enough time to accomplish what needs to be done	10	7	5	3	1

I set realistic goals for myself	10	7	5	3	1
I can express my feelings of anger	10	7	5	3	1
I avoid putting off important tasks to the last minute	10	7	5	3	1
I participate in activities that provide relief from stress	10	7	5	3	1
When working under pressure, I can stay calm and present	10	7	5	3	1
I can make decisions with minimal distress and worry.	10	7	5	3	1

Your Score _____/ 100

Spiritual Wellness	Yes/Almost Always	Very Often	Sometimes	Occasionally	No/Almost Never
I know my values and beliefs	10	7	5	3	1
I live by my convictions	10	7	5	3	1
My life has meaning and direction	10	7	5	3	1
I derive strength from my spiritual life each day	10	7	5	3	1
I have life goals that I strive to hit each day	10	7	5	3	1
I view life as a learning experience and look forward to the future	10	7	5	3	1
I have a sense of peace in my life	10	7	5	3	1
I am tolerant of the values and beliefs of others	10	7	5	3	1
I'm satisfied with the degree to which my activities are consistent with my values	10	7	5	3	1
Personal reflection is an important part of my life	10	7	5	3	1

Your Score ____ / 100

Social Wellness	Yes/Almost Always	Very Often	Sometimes	Occasionally	No/Almost Never
I have at least one person in whom I can confide.	10	7	5	3	1
I have a good relationship with my family.	10	7	5	3	1
I have friends at work or school from whom I gain support and with whom I talk regularly.	10	7	5	3	1
I am involved in my community.	10	7	5	3	1
I do something for fun and just for myself at least once a week.	10	7	5	3	1
I am able to develop close, intimate relationships.	10	7	5	3	1
I engage in activities that contribute to the environment	10	7	5	3	1
I am involved in school or work activities	10	7	5	3	1
I provide social support to others	10	7	5	3	1
I am interested in the views, opinions, activities, and accomplishments of others.	10	7	5	3	1

Your Score _____ / 100

TOTAL WELLNESS SCORE _____ / 400