Wellness Questionnaire and Assessment

One a scale of 1-10, with 10 being supremely happy, how would you rate your happiness in each of the wellness areas below?

<table>
<thead>
<tr>
<th>Area</th>
<th>Happiness:</th>
<th>1</th>
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</thead>
<tbody>
<tr>
<td>Exercise/Movement</td>
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<tr>
<td>Physical Health</td>
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<tr>
<td>Stress Level</td>
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<tr>
<td>Nutrition</td>
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<tr>
<td>Sleep</td>
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<tr>
<td>Play</td>
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<tr>
<td>Body Image</td>
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Now, let's look at each wellness area individually. Answer the questions below to help you reflect and uncover possible areas you might want to improve upon.

Exercise/Movement

What activities are you currently participating in:

Walking  Yoga or Pilates  Individual/Team Sports:
Running  Group Fitness
Cycling  Strength Training  Other:
Cross-Fit  Martial Arts

With what frequency are you participating in the above? Please circle frequency and duration:

1-2 times per week  Less than 15 minutes
3-4 times per week  16-30 minutes
4-5 times per week  31-45 minutes
More than 5 times per week  More than 45 minutes

The current exercise recommendations are that individuals engage in moderate cardiovascular activity for 150 minutes per week, strength or resistance training 2-3 times per week, and flexibility exercises 2-3 times per week.
Are you engaging in this amount of exercise on a weekly basis?  
Yes  No

If you are not, what are the current challenges or barriers to doing so?


Do you start exercise programs and then find it difficult to stick with them?  
Yes  No

What other activities might you be interested in trying?


**Physical Health**

When was the last time you had a physical exam? _________________

Circle any area(s) that your doctor may have been concerned about?

<table>
<thead>
<tr>
<th>Blood Pressure</th>
<th>Cholesterol</th>
<th>Weight</th>
<th>Blood Glucose Level</th>
</tr>
</thead>
<tbody>
<tr>
<td>Triglyceride levels</td>
<td>Smoking</td>
<td>Family History</td>
<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Height:</th>
<th>Usual Weight:</th>
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</thead>
<tbody>
<tr>
<td>Weight:</td>
<td>Desired Weight:</td>
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</table>

Have you had any major injuries, surgeries, or health conditions that will affect your long-term health and wellness?  
Yes  No

If so, please describe them:
# Stress Level

What is your current stress level?

<table>
<thead>
<tr>
<th>NONE</th>
<th>LOW</th>
<th>MEDIUM LOW</th>
<th>MEDIUM</th>
<th>HIGH</th>
<th>VERY HIGH</th>
</tr>
</thead>
</table>

What is contributing to your current stress?

How do you currently managing your stress?

In what other ways are you engaging in self-care?

# Nutrition

Are you happy with your diet right now?  
Yes  
No  

What would you like to change?

How often do you eat per day?______________

How often do you eat fast food or at a restaurant?______________

Where do you typically eat out?

How often do you eat homemade meals (even for lunch)?______________
Who does the grocery shopping at your home?______________________________

Where do you do your grocery shopping?_______________________________

Describe a typical breakfast


Describe a typical lunch


Describe a typical dinner


What do you eat for snacks?


On average, how many fruits and vegetables do you eat per day?______________________

What are your primary protein sources?______________________________________

Circle any substances that you use:

  Alcohol   Tobacco   Marijuana   Other______________________________

How often do you use these substances?


Sleep

<table>
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<th>Time you go to sleep:</th>
<th>Do you wake in the middle of the night?</th>
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<table>
<thead>
<tr>
<th>Time you wake up:</th>
<th>Do you wake feeling rested?</th>
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</table>
Play

What do you do for fun and to play?

How often do you play, and for how long?

What other activities help you unwind and disengage from work?

How often and for how long do you engage in these activities?

What are some ways that you “treat” yourself? (Not food or monetarily related)

Body Image

What are the first words that come to mind when you see yourself naked?

What is your best physical attribute?

If you could, what would you change about your body or physical appearance?
How often do you get on the scale and weigh yourself?

What are your initial thoughts when you see the number on the scale?

**Energy/Vitality**

What is your prevailing energy level?

- LOW
- MEDIUM
- HIGH

If your energy has a peak, when does that occur?

- MORNING
- AFTERNOON
- EVENING

If your energy crashes, when does that occur?

- MORNING
- AFTERNOON
- EVENING

**Now that you have answered all these questions, let's rate your happiness in each of the wellness areas again.**

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*This questionnaire and assessment is for your own reflection.*
If you are interested in recommendations and suggestions from a Thrive Within, please fill out the information below, then email this entire assessment to theresa@thrivewithin.com. All information will be kept confidential. Thrive Within will then follow up with a phone call, and email you a list of recommendations within 7 days. The fee for this service is $100. You will be billed electronically.

<table>
<thead>
<tr>
<th>Name:</th>
<th>Date of Birth:</th>
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<tbody>
<tr>
<td>Home Phone:</td>
<td>Cell Phone:</td>
</tr>
<tr>
<td>Email:</td>
<td>Occupation:</td>
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I, __________________________________________, request the recommendations and suggestions of Theresa Destrebecq, and Thrive Within, in order to improve my overall health and wellness. I understand that a wellness coach is not a psychologist or psychiatrist and they do not diagnose, prescribe, or in any other way take the place of a medical or mental health provider. I understand that it is my responsibility to inform my medical or health care provider whenever I have a change in my health status or when I have concerns of my health status.

I understand that all information I provided will be kept confidential.

I recognize it is my sole responsibility to obtain an examination by a physician prior to involvement in any exercise program. If I have chosen not to obtain a physician’s permission prior to beginning this exercise program, and I acknowledge I am doing so at my own risk.

I understand that I am not obligated to perform, nor participate in any activity or recommendation given by Theresa Destrebecq and Thrive Within. If I chose to undertake any suggestions or advice given by Theresa Destrebecq, I am doing so of my own volition.

I agree that Theresa Destrebecq and Thrive Within shall not be liable or responsible for any injuries to me or health concerns, resulting from following any of their recommendations or suggestions, and I expressly release and discharge Thrive Within, its owners, employees, agents and/or assigns, from all claims, actions, judgments and the like which I or my heirs, executors, administrators or assigns may have or claim to have as a result of any injury or other damage which may occur in connection with their recommendations, excepting only an injury caused by the gross negligence or intentional act of such person or persons. This release shall be binding upon my heirs, executors, administrators and assigns.

I acknowledge that I have carefully read this waiver and release and fully understand that it is a release of liability. I agree to voluntarily give up any right that I may otherwise have to bring a legal action against the wellness coach and personal trainer for negligence, or any other personal injury or property damage or loss action.

**Client Signature**  ________________________________

**Client Printed Name**  ________________________________

**Date**  ______/______/______