The following questionnaire covers areas about your skin, health, diet, exercise and sleep to determine where I may best support (or refer) you.

Think of these questions as a conversation prompt so we can find pathways to the improvement of your overall health and wellness

As a Registered Nurse please be assured that all your information will be treated in the strictest confidence.

Wellness Questionnaire

Name: DOB:

Cell PH: Email:

Occupation:

Exercise/Movement

In what activities/exercise are you currently participating? Please also state frequency and duration on a weekly basis.

If you are not exercising, what are your current challenges or barriers?

Do you start exercise programmes and then find it difficult to stick to them?

Yes No

Are there other activities might you be interested in trying?

Physical Health

When was the last time you had a medical check-up with your GP?

Circle any area's that your GP may be concerned about.

Blood Pressure Weight Cholesterol/ lipids Blood Glucose Levels

Smoking Family History Other……

Height:

Weight: Usual Weight Desired Weight:

Have you had any major injuries or health conditions that will affect your long term health and wellness?

Yes No

If yes – Please describe them.

Current medications:

Nutrition

Are you happy with your diet right now?

Yes No

What would you like to change?

On average how many servings of fruit and vegetables do you have per day?

What are your protein sources?

How often do you eat per day?

Would you say your diet is balanced?

Yes No

How many cups of coffee or caffeinated beverages do you usually consume in a day?

0 1-3 4-6 7 or more

What is your water intake per day?

What is your average alcohol intake per week?

What vitamins/nutritional supplements do you use, if any?

Do you smoke? Yes No

If so how many per day?

Stress Levels

What are your current stress levels?

None Low Medium low Medium High Very high

How often do you feel stressed?

Can you identify clearly what is contributing to your stress?

How do you currently manage your stress?

In what other ways are you engaging in self care?

Sleep

Do you have a wind-down (pre sleep) routine?

What time do you go to sleep?

Do you wake during the night?

At what time do you wake up?

Do you wake feeling refreshed?

Play

What do you do for fun or relaxation? Please list frequency per week/or per month?

Reading	Meditation
Cooking	Yoga
Gardening	Volunteer work
Travel	Socialising with friends
Art/music	
Other- please specify	

What other activities help you unwind and disengage (from work)?

What are some ways that you “treat” yourself (not food or money related)

Energy/Vitality

What is your prevailing energy level?

Low Medium High

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

AM PM Evening

If your energy crashes, when does that occur?

AM PM Evening

Skin

How would you describe your skin?

Dry Normal/combo Oily

Do you use sunscreen?

What is your usual skincare regime?

What are your main skin concerns?

Goals

What are your anti-ageing and beauty, health and wellness goals?

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