



Breath Body Works, LLC

Providing effective therapeutic body work since 1988.

Wellness Profile

Please take the time to carefully fill out this questionnaire and bring the completed form with you on your first therapy appointment. This information will be treated confidentially. Please check the boxes.

Name: _____ Today's Date: ____ / ____ / ____

1. Daily Activities

The following items are about activities you might do during a typical day. Does your health limit you in these activities? If so, how much?

1 - Limited a lot; 2 - Limited a little; 3 - Not limited at all

- 1 2 3 Lifting or carrying groceries. (Check one.)
- 1 2 3 Moving a table, vacuuming. (Check one.)
- 1 2 3 Climbing several flights of stairs. (Check one.)
- 1 2 3 Walking several blocks. (Check one.)

2. Exercise

How many days per week do you engage in aerobic exercises of at least 20 to 30 minutes in duration (brisk walking, cycling, jogging, swimming, aerobic dance, active sports, or gardening)? (Check one.)

- No exercise program
- One day a week
- Two days a week
- Three days a week
- Four days a week
- Five days a week
- Six days a week
- Seven days a week

3. Strength

How many times per week do you do strength-building exercises such as sit-ups, push-ups, or use strength-training equipment? (Check one.)

- None
- Once a week
- Twice a week
- Three plus times weekly

4. Stretching

How many times per week do you do stretching exercises to improve flexibility of your back, neck, shoulders, and legs? (Check one.)

- None
- Once a week
- Twice a week
- Three plus times weekly

5. Activities

- Walking
- Running
- Bicycling
- Canoeing
- Paddleboard
- Aerobics with music
- Dancing
- Golf
- Racquetball
- Hiking/Backpacking
- Calisthenics
- Skiing
- Stair Stepping
- Swimming
- Tennis
- Wt. Training
- Yard work
- Volleyball
- Baseball
- Football
- Active Sports
- Triathlon
- Yoga

6. Referral Source

How did you find out about Postural Alignment Therapy/ Egoscue®? _____

7. Dieting

Do you diet at least 1 -2 times per year? (Check one.)

Yes No

8. Hydration

How much water a day do you drink?

8 oz 9 oz – 24 oz 25 oz or more

9. Group Activities

Do you participate in group workouts? (Check one.)

Yes No No, but I would like to

10. Training

Do you workout with a trainer? (Check one.)

Yes No No, but I would like to

11. Additional Information

Aside from correcting your posture, is there health related information that you are interested in getting from Egoscue®? If so, please explain: _____

12. Posture

Have you been informed about your posture prior to coming to this appointment?

Yes No

13. Symptom

Have you seen a physician or other healthcare practitioner about your symptoms? (Check one.)

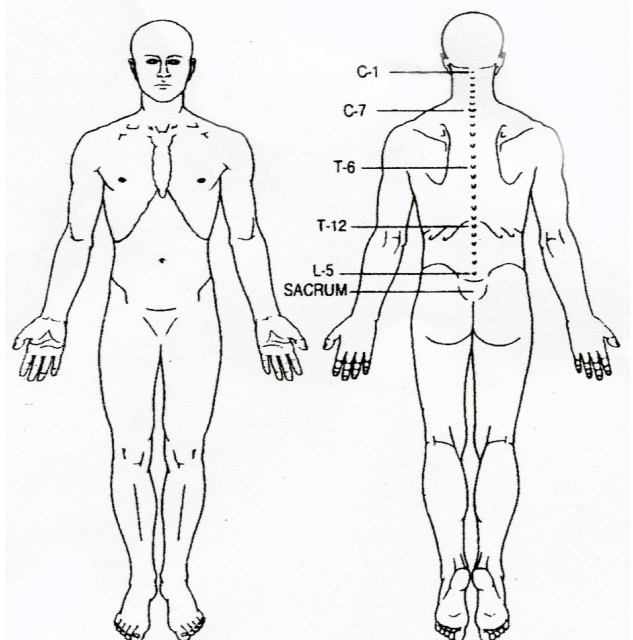
Yes No If yes, explain?

14. Pains and Discomfort Chart

1. Please indicate the areas where you have pain and describe the level of discomfort using a scale of 1 – 10. (A score of 1 being almost no pain and 10 being the highest level of discomfort.) If your pain seems to refer or “shot out” to another area of your body please indicate with arrows.

2. For how long have you experienced pain/discomfort in the areas indicated above?

3. Describe what you do that causes pain and what activities make it worse: _____



15. Sleep

On average, how often do you get at least 7 – 8 hours of sleep each night? (Check one.)

- Always
- Most of the time
- Less than half the time
- Seldom or never

16. Do you smoke? (Check one.)

- Yes
- No

17. Stress (Check all that apply.)

- Minor problems throw me for a loop
- I find it difficult to get along with people I used to enjoy
- Nothing seems to give me pleasure anymore
- I am unable to stop thinking about my problems
- I feel frustrated, impatient, or angry much of the time
- I feel tense or anxious much of the time

18. Medicine

Are you taking any medications?

- Yes
- No
- If yes, please list: _____

19. Occupation

Please list your current job as well as any others that may have placed physical or repetitive demands on you.

20. Doctor Visits

How many visits have you made during the past 13 months to a doctor, emergency room, psychiatrist, chiropractor or other healthcare professional?

21. Contact Preference

How would you prefer we contact you?

- Email: _____

- Phone: _____

- Both are good

PLEASE READ THE FOLLOWING AND SIGN BELOW:

- I understand that postural alignment therapy, Egoscue®, is not a replacement for medical care and that no diagnosis will be made.
- I am responsible for paying for any appointment cancellation of less than 24 hours.

Date: _____ Signature: _____