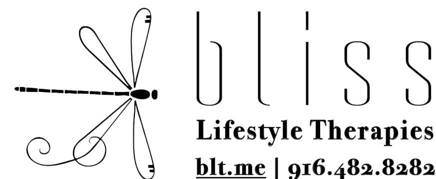
Health & Fitness Information



FOR YOUR PRIVACY, PLEASE SEND AS AN ENCRYPTED PDF AND TEXT US THE EMAIL AND CODE YOU CHOSE ALONG WITH ANY QUESTIONS TO: 916-482-8282

Name:____

Height:__________ DOB: ____________ Age:________ Sex: M F

Address:____

Email:__________________________________ Phone: ________________________(best)

Current occupation: __________________Hours/week? ____ Hobbies/Interests: __________________

____

Circle one:

No Yes Are you currently under the care of a physician? If yes, for what reason(s)__________________

No Yes Have you had any surgeries in the last 6 months?__________________________

No Yes Do you feel tired, run down, or out of energy? If yes, explain__________________

No Yes Are you currently on any medications? For...? (Please include OTC meds such as Ibuprofen)

____

No Yes Do you take any vitamin or herb supplements? Please list: __________________________

____

No Yes Have you exercised regularly in the last 6 months? How often? _____ x/wk. What type? __________

No Yes Have you ever had a hard time attaining results or motivating yourself?

No Yes Will your significant other/family/friends be supportive of your health goals?

No Yes Have you ever used a personal trainer before? ❏ 1-3 times ❏ 4+ times

If over weight, for how long? __________ Are other family members overweight? ❏ No ❏ Yes

On a scale of 1 to 10, where 10 is the most important — How important is weight or size reduction to you? _____

While trying to lose weight, have you ever experienced: (check any) ❏ food cravings ❏ headaches ❏ fatigue ❏ lightheadedness ❏ water retention/swelling ❏ irritability ❏ other ______________

Do you: smoke or vape? ❏ No ❏ Yes use recreational drugs? ❏ No ❏ Yes drink Alcohol? ❏ No ❏ Yes, _____ drinks/week. In the past 12 months, how many times have you been on antibiotics? _______

How stressed are you 0 to 10? (10 is as stressed as you can imagine) ______ How often? ❏ Daily ❏ Weekly ❏ Monthly

What are your primary health & fitness goals? ❏ Strength ❏ Endurance ❏ Energy ❏ Libido ❏ Other ________

On a scale of 1 - 10, how committed are you to achieving theses goals? ________ (10 = 100% committed)

What area of your body do you want to focus on?

❏ Abdomen ❏ hips/thighs ❏ Chest ❏ Arms ❏ Neck ❏ Cellulite ❏ Heart ❏ GI ❏ Detox ❏ Brain ❏ All

What might have prevented you from reaching your health and fitness goals in the past?

❏ Time ❏ Money ❏ lack of support ❏ lack of motivation ❏ no plan ❏ Other ______________

How many times per week do you plan on exercising? ___________

For Staff use:

PLEASE CONTINUE HEALTH INFO ON REVERSE —>

Date	**Weight**	**PH**	Fasting **Blood Sugar**	**BP: / P**
chest	waist	hips	Zinc	Other:

Name: ______________________________

(Continued from reverse...)

How many times per day do you eat? ____ How often do you eat out? ❏ never ❏ rarely ❏ 3+ times/week ❏ daily

What is your caffeine intake? _____ cups daily/weekly/monthly. (circle one)

How much water do you drink daily? _______ liters/cups/ounces (circle)

Do you currently have, or have a history of:

- ❏ High Cholesterol
- ❏ High Blood pressure
- ❏ Heart disease
- ❏ Stroke
- ❏ Chest pain
- ❏ Diabetes
- ❏ Pre-diabetes
- ❏ Hypoglycemia
- ❏ TBI/Concussion
- ❏ Depression
- ❏ Liver problems
- ❏ Kidney problems
- ❏ Osteoporosis/penia
- ❏ Arthritis
- ❏ Spine/Disc issues
- ❏ Joint replacements
- ❏ Plantar fasciitis
- ❏ Scoliosis
- ❏ Rotator cuff tear
- ❏ Tennis Elbow
- ❏ Carpal tunnel
- ❏ Bladder prolapse
- ❏ SI joint dysfunction
- ❏ Balance issues
- ❏ Glaucoma
- ❏ Numbness
- ❏ Seizures
- ❏ Migraines
- ❏ Asthma
- ❏ Sleep apnea
- ❏ Chronic cough
- ❏ Shortness of breath
- ❏ Digestive disorder

____

❏ Cancer ________________

When? __________________

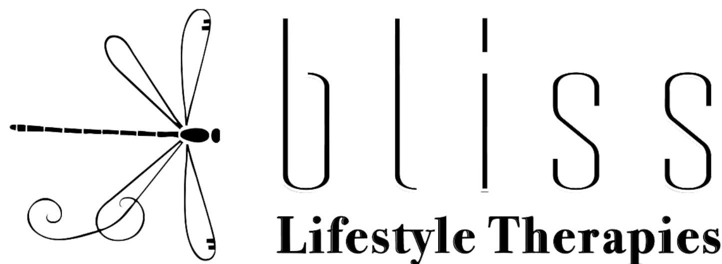
Please list any allergies (food, seasonal, medication, etc.):

____

Are there any other health issues or concerns that may be relevant? ______________________

____

Thank you very much for your time in helping us to better understand your health needs. We want to make sure you have a positive experience, and look forward to helping you to achieve your health goals!



Health is happiness! Get the health you need to live the life you want.

bliss
Lifestyle Therapies
blt.me | 916.482.8282

Stress Test

Stress dramatically affects hormone balance, sleep quality, heart health, immune strength, nutritional needs, physical performance, ability to focus and concentrate, blood pressure, blood sugar handling and many other aspects of health.

Sometimes life just isn't fair. The side effects of stress can dramatically affect your health, quality of life and the rate at which you age. Sometimes we are unaware of, or take for granted, all the things that add to our stress. Listed below are some of the many stressful events that can lead you to become over-stressed.

Check any items below that you've experienced in the last 12 months. The more you things checked, the higher the risk that you are over-stressed.

- ☐ Sleep less than 8 hours per night
- ☐ Work more than 40 hours per week
- ☐ Car accident
- ☐ Serious injury or illness
- ☐ Ongoing illness of a spouse or close family member
- ☐ Substance addiction
- ☐ Prolonged exposure to loud noise
- ☐ Menopause
- ☐ Relationship difficulties
- ☐ Divorce
- ☐ Marriage
- ☐ Pregnancy/new child
- ☐ A new pet
- ☐ Death of a spouse or someone close
- ☐ Financial problems
- ☐ Foreclosure of mortgage or loan
- ☐ Fired at work
- ☐ Retirement
- ☐ Job change
- ☐ Change in responsibility at work
- ☐ Trouble with boss or co-worker
- ☐ Trouble with neighbors
- ☐ Legal problems
- ☐ Difficulties in school
- ☐ Major environment change (i.e. remodeling, epidemic, pandemic, etc.)

Are you

Sleep Deprived?

Take the quiz below and find out! If you check *three or more* items you're probably not getting enough sleep.

- ☐ I need an alarm clock to wake up
- ☐ It's hard to get out of bed in the morning
- ☐ Mornings I hit the snooze bar repeatedly
- ☐ I feel tired irritable and stressed during week
- ☐ I have trouble concentrating and remembering
- ☐ I feel slow with critical thinking, problem-solving & creativity.
- ☐ I often fall asleep while watching TV/Reading
- ☐ I fall asleep within 5 minutes of getting in bed
- ☐ I often fall asleep in meetings/lectures or warm rooms.
- ☐ I often fall asleep after a heavy meal or a low dose of alcohol.
- ☐ I often feel drowsy when driving
- ☐ I often sleep extra hours on weekends
- ☐ I often need a nap to get through the day
- ☐ I have dark circles around my eyes

Please complete the reverse page with more specifics to help with planning for relief. ▶

(Continued from reverse)

Please list your top 5 stresses in order of how you feel they are affecting you. "1" being the most taxing:

	Within my control? Y	N
1. ______________________	☐	☐
2. ______________________	☐	☐
3. ______________________	☐	☐

While no one experiences the same tolerance to stress, you may be feeling the impact of stress and find a great deal of relief with the right support.

There are some things we can control and others we cannot. Typically the things out of our control can be the most stressful. Bliss Lifestyle Therapies works with you to create the best approach to help get stress out of the way, so you are able to more fully enjoy your good health and quality of life.

The right nutrition can help support you while under stress. Exercise programs designed to take into account your stress levels will also support you and help you to survive and recover. The most important thing is listening to your body and providing the right level of challenge and support.

FINAL NOTE:

Please share what you most hope to get from this weekend retreat experience:

____

____

Please contact us with any questions or concerns at: *916-482-8282*

Thank you. We look forward to sharing health with you and are excited to have you join us at our Wellness Retreat!