

## Wellness Assessment Form

The information collected on this Wellness Assessment Form will help inform your Health Coach about your current health status and help them get to know you. Collecting this data will assist in the assessment of your overall wellness and in creating an exercise and nutrition plan to address your specific needs. Please complete the entire form.

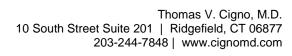
All information contained on this form will be kept strictly confidential. The services and suggestions of the Health Coach are at all times meant to help with your general feeling of wellness and are in no way meant to diagnose or treat any disease.

Member Name:		Se	ex:	DC	B:		
Home Phone:	Work Phone:			Cell Pho	ne:		
Email Address:		Marital Status:					
Occupation:		Travel Required?:					
Please circle the technolog	gies you have access to:	Computer	Internet	Email	Skype	Social Media	
In order of importance to y	ou, what are your main co	oncerns in rega	ards to ph	ysical ac	tivity, eati	ng right, sleeping w	vell, and
being at a healthy weight?							
1							
2							
3							
4							
Do you have family to supple Dietary Habits:							
How many meals do you h	nave per day and when?: _						
How many snacks do you	have per day and when?:						
Do you usually eat meals:							
With family	Home alone	With friend	s	In fro	nt of TV		
At a restaurant	Fast food	On the run		While	e doing ot	her activities	
How many glasses of water	er do you drink per day? _						
Do you consume beverage	es with your meals?	_NoY	es If so,	what do	you drinkí	?	



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Do you feel that there are restrictions on your	r diet?NoYes If so, what are they?
·	Vegetarian Vegan Other:
Do you avoid certain foods?No	_Yes If so, what are they and why do you avoid them?
Do you experience any symptoms after meals	ls?NoYes If so, please explain:
Please complete a seven-day food journal an and snacks each day, noting meal times and	nd bring it to your appointment. List what you eat for breakfast, lunch, dinner portions whenever possible.
Lifestyle:	
How many hours of sleep do you get per nigh	ht?
How do you feel when you awaken?	
How often do you exercise?	
What type of exercise do you do and for how	long?
Do you vacation regularly?	When was your last vacation?
Do you enjoy your work?	What are your typical work hours?
Do you smoke?	If so, how much?
Are you around second-hand smoke?	Do you use recreational drugs?
Please list how many hours you spend in a ty	pical day doing the following:
Driving Watching TV	Reading Using a computer
Hobbies/Relaxing	
Is there anything else you would like to share	e with me?





Name:	Date of Birth:	
Please	be honest with each of the following questions.	
	a check in the box the best describes your current state.	
i idoc i	d officer in the box the bost describes your <u>earrent</u> state.	
<u>Physic</u>	cal Activity	
	I am not active and I do not plan to start.	Pre-Contemplation
	I am not active but I am thinking about starting.	Contemplation
	I am getting ready to become active.	Preparation
	I do some activity but need to do more.	Action
	I have been active regularly for several months.	Maintenance
Eating	Well (Nutrition)	
	I do not eat well and do not plan to change.	Pre-Contemplation
	I do not eat well but I am thinking about changing.	Contemplation
	I am planning to change my diet.	Preparation
	I sometimes eat well but need to do more.	Action
	I have eaten well regularly for several months.	Maintenance
Manad	ging Stress	
	I do not manage stress well and plan no changes.	Pre-Contemplation
	I am thinking about making changes to manage stress.	Contemplation
	I am planning to change to manage stress better.	Preparation
	I sometimes take steps to manage stress better but need to do more.	Action
	I have used good stress-management techniques for several months.	Maintenance
Weigh	t Management	
	I do not manage my weight well and plan no changes.	Pre-Contemplation
	I am thinking about making changes to weight management.	Contemplation
_	I am planning to change to manage my weight better.	Preparation
	I sometimes take steps to manage my weight but need to do more.	Action
	I have used good weight-management techniques for several months.	Maintenance



## How Healthy Is Your Diet?

Circl

le y	your answers after careful thought, then add up your points (numbers in paren	theses).
1.	How many fruits do you <i>normally</i> eat each day (1/2 cup fresh or 1/4 cup piece fresh, 1 cup <i>unsweetened</i> juice)?  A. 0 (-2) B. 1 (0) C. 2 to 3 (+2) D. 4 or more (+3)	dried fruit, 1 medium (score)
2.	How many vegetable servings do you <i>normally</i> eat each day (1 cup leafy other veggie, raw or cooked)?  A. 0 (-4)  B. 1 (0)  C. 2 (+1)  D. 3 (+2)  E. 4 or more (+3)	y greens, 1/2 cup any (score)
3.	How many different varieties of vegetables do you eat in a normal mont A. 2 or less (-4) B. 3 to 4 (0) C. 5 to 6 (+1) D. 7 to 8 (+3) E. 9 or more (+4)	h? (score)
4.	How many times do you eat beans or peas (legumes, lentils, chickpeas, peas, etc.) in a normal week?  A. 0 (-2)  B. 1 to 2 (0)  C. 3 to 4 (+1)  D. 5 to 6 (+2)  E. 7 or more (+3)	kidney beans, green (score)
5.	How many times do you eat red meat in a normal week?  A. 6 or more (-4)  B. 4 to 5 (-3)  C. 1 to 3 (-1)  D. Less than once a week (+2)  E. 0 (+3)	(score)
6.	How many times do you eat in a fast food restaurant in a normal week?  A. 6 or more (-5)  B. 4 to 5 (-4)  C. 1 to 3 (-3)  D. Less than once a week (-2)  E. 0 (0)	(score)



A. B. C. D.	Soda (regular or diet) (-4) Caffeinated coffee or tea (-1) Decaffeinated coffee or tea (0) Milk or fruit juice (0) Herbal tea or water (+3)	(score)
A. B. C. D. E.	w many 12 oz. cans of soda do you drink in a normal day? 6 or more (-5) 4 to 5 (-4) 2 to 3 (-3) 1 (-2) Less than 1 (-1) 0 (0)	(score)
A. B.	Never (-2) Once (+1) Twice (+2)	
	3 to 5 times (+3)	(score)
bro A. B. C. D.	a typical week, how often do you eat whole grains (100% whole grain own rice, quinoa, whole rye crackers)?  Never (-3)  1 to 2 times a week (-1)  3 to 4 times a week (0)  5 to 6 times a week (+1)  1 or more times a day (+3)	bread, whole oats (score)
A. B. C. D. E.	w often do you eat sweets such as cookies, cakes, or ice cream?  1 or more times a day (-3)  Every other day (-2)  Twice a week (-1)  Once a week (0)  2 to 3 times a month (+1)  Rarely (+3)	(score)
Your Tota	I Score	
Scoring:	22–28 – Great eating habits 17–21 – Pretty good eating habits 10–16 – Needs some improvement 9 or less – Needs much improvement; try to change one habit at a til	me

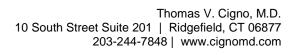
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Name: Date:
Place a 1 in the box to answer YES. If you answer "NO", make no entry.
Physical Activity
I accumulate 30 minutes of moderate physical activity most days of the week. (Brisk walk, stair climbing yard work, home chores)
I do vigorous activity that elevates my heart rate for 20 minutes at least 3 times per week.
I do exercise for flexibility at least 3 days per week.
☐ I do exercises for muscle at least 2 days per week.
Nutrition
I eat three regular meals each day.
☐ I select appropriate serving sizes of a variety of nutritious foods.
☐ I restrict the amount of fat in my diet.
I consume only as many calories as I expend each day.
Stress Management
I am able to identify situations in daily life that cause stress.
☐ I take time out during the day to relax and recover from daily stress.
☐ I find time for family, friends, and things I especially enjoy doing.
☐ I regularly perform exercises designed to relieve tension.

In each category:

Scoring 3 or more is indicative of generally positive lifestyles.





## Therapeutic Readiness to Change Assessment Form

Name:			Date:		
This questionnaire is to help to change and your chances positive will be greatly increa	of being successful. By				
1. Do you see any correlation illness? (Circle one)	n with your current lifest	tyle and habits affectin	g your current sy	mptoms and	
milese. (Girole erro)	YES	NO			
2. Have you ever considered (Circle one)	changing your lifestyle	or habits to improve y	our symptoms a	nd health?	
(Officie offe)	YES	NO			
3. How do you feel about the situation:	first two questions? Ple	ease underline the ans	swer that best fits	s your current	
Unaware & unconcerned to change simultaneously confident, wisdom gained from	Determined to change	<u>-</u>	cautious I am	•	
4. Do you feel that you have	the confidence to chan	ge? (Circle one)	YES	NO	
5. Can you imagine and list the Please make a short list if you		osses (pros/cons) you	may have if you	do change?	
6. If you find there are barrie briefly list what they are and		•	s to those barrier	s? Please	
7. If you were to change, wh for ideas from your provider	·	•	t your ideas. You	can also ask	
	<del></del>				