**New Client Wellness Questionnaire**

**Basic Information**

1. **Name:**
2. **Age:**
3. **Occupation:**
4. **Contact Information:**
	* **Email:**
	* **Phone:**

**Wellness Goals**

1. **What are your primary wellness goals? (Select all that apply)**
	* ☐ Stress management
	* ☐ Improving physical fitness
	* ☐ Weight management
	* ☐ Better sleep
	* ☐ Emotional well-being
	* ☐ Mental clarity and focus
	* ☐ Other: \_\_\_\_\_\_\_\_\_\_\_
2. **Please describe your goals in more detail.**
3. **On a scale from 1 to 10, how committed are you to achieving these goals?**
(1 = Not very committed, 10 = Extremely committed)

**Physical Health and Fitness**

1. **How would you describe your current physical health?**
	* ☐ Excellent
	* ☐ Good
	* ☐ Fair
	* ☐ Poor
2. **How often do you engage in physical activity?**
	* ☐ Daily
	* ☐ 3-5 times per week
	* ☐ 1-2 times per week
	* ☐ Rarely or never
3. **What types of physical activities do you enjoy?**
4. **Do you have any physical limitations, injuries, or health conditions?**
	* ☐ Yes (Please specify): \_\_\_\_\_\_\_\_\_\_\_
	* ☐ No

**Mental and Emotional Well-being**

1. **How would you rate your stress level on a typical day?**
(1 = Very low, 10 = Very high)
2. **What are your most common sources of stress?**
	* ☐ Work
	* ☐ Relationships
	* ☐ Finances
	* ☐ Health concerns
	* ☐ Other: \_\_\_\_\_\_\_\_\_\_\_
3. **Do you experience symptoms of anxiety or depression?**
	* ☐ Yes
	* ☐ No
	* ☐ Occasionally
4. **What practices do you currently use to manage stress or emotions?**
	* ☐ Meditation
	* ☐ Yoga
	* ☐ Journaling
	* ☐ Talking with friends/family
	* ☐ Other: \_\_\_\_\_\_\_\_\_\_\_

**Nutrition and Hydration**

1. **How would you describe your eating habits?**
	* ☐ Very healthy and balanced
	* ☐ Moderately healthy
	* ☐ Needs improvement
2. **Do you follow any specific diet or dietary restrictions?**
	* ☐ Vegetarian
	* ☐ Vegan
	* ☐ Gluten-free
	* ☐ Other: \_\_\_\_\_\_\_\_\_\_\_
3. **How often do you consume water throughout the day?**
	* ☐ Frequently (8+ glasses per day)
	* ☐ Moderately (4-7 glasses per day)
	* ☐ Rarely (1-3 glasses per day)

**Sleep and Energy**

1. **How many hours do you sleep each night on average?**
	* ☐ Less than 5 hours
	* ☐ 5-6 hours
	* ☐ 7-8 hours
	* ☐ More than 8 hours
2. **How would you describe your energy levels throughout the day?**
	* ☐ High and consistent
	* ☐ Moderate with occasional dips
	* ☐ Low, with frequent fatigue
3. **Do you have difficulty falling or staying asleep?**
	* ☐ Yes (Please specify): \_\_\_\_\_\_\_\_\_\_\_
	* ☐ No

**Lifestyle and Mindset**

1. **Do you currently have any daily routines or rituals that help you feel balanced?**
	* ☐ Yes (Please describe): \_\_\_\_\_\_\_\_\_\_\_
	* ☐ No
2. **How would you rate your work-life balance?**
(1 = Very poor, 10 = Excellent)
3. **Do you practice any form of mindfulness, meditation, or relaxation regularly?**
	* ☐ Yes (Please describe): \_\_\_\_\_\_\_\_\_\_\_
	* ☐ No

**Do any of these health conditions apply to you? If yes, please give details:**

|  |  |  |
| --- | --- | --- |
| **High blood pressure**  | **Yes/No** |  |
| **Low blood pressure/fainting**  | **Yes/No** |  |
| **Arthritis**  | **Yes/No** |  |
| **Diabetes**  | **Yes/No** |  |
| **Epilepsy**  | **Yes/No** |  |
| **Heart problems**  | **Yes/No** |  |
| **Asthma**  | **Yes/No** |  |
| **Depression**  | **Yes/No** |  |
| **Detached retina/other eye problems**  | **Yes/No** |  |
| **Recent fractures/sprains**  | **Yes/No** |  |
| **Recent operations**  | **Yes/No** |  |
| **Back problems**  | **Yes/No** |  |
| **Knee problems**  | **Yes/No** |  |
| **Neck problems**  | **Yes/No** |  |
| **Recent pregnancies**  | **Yes/No** |  |
| **Are you pregnant?**  | **Yes/No** |  |
| **Do you have any other conditions which affect your mobility or are likely to cause you concern when doing Yoga?** | **Yes/No** |  |

**Additional Questions**

1. **Is there anything else you would like to share about your health or wellness journey?**
2. **What are you hoping to gain from wellness coaching?**
3. **Do you have any specific concerns or areas of focus you’d like to address?**
4. **Preferred method of communication for updates and resources:**
	* ☐ Email
	* ☐ Phone
	* ☐ Text
	* ☐ Other: \_\_\_\_\_\_\_\_\_\_\_

**I take full responsibility for my health during the yoga classes, including any injuries.**

**I will inform my yoga teacher of any medical changes**.

|  |  |
| --- | --- |
| **Sign** | **Date** |

**Thank you very much for filling in this form!**