**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!**