10-YEARS YOUNGER QUESTIONNAIRE

FOR

name:

OFFICE USE ONLY

main concern:

10-YEARS YOUNGER

01 PERSONAL

first name:

surname:

gender:

address:

town:

county:

postcode:

mobile:

telephone:

work:

email:

fax:

date of birth:

emergency contact name:

emergency contact number:

blood group:

doctor’s name:

doctor’s contact number:

Please list any other relevant personal information:

02 SYMPTOMS

Please indicate if you experience (or have in the past 18 months) any of the following :

1. headaches ❑ allergies ❑ sinus problems ❑ dizziness ❑ hormonal problems ❑

notes: ______

2. insomnia ❑ nervousness ❑ neck pain ❑ weight loss/gain ❑ thyroid problems ❑

notes: ______

3. shoulder pain ❑ arm pain ❑ elbow pain ❑ wrist pain ❑ hand pain ❑

notes: ______

4. asthma ❑ breathing problems ❑ high blood pressure ❑ low blood pressure ❑

notes: ______

5. lack of energy ❑ bloating ❑ digestive problems ❑ stomach problems ❑ heart burn ❑

notes: ______

6. fluid retention ❑ kidney problems ❑ diarrhoea ❑ constipation ❑

notes: ______

7. sterility ❑ impotence ❑ bladder problems ❑

notes: ______

8. low back pain ❑ sciatica ❑ circulation problems ❑

notes: ______

9. hip pain ❑ leg pain ❑ knee pain ❑ ankle pain ❑ foot pain ❑

notes: ______

03 MORE SYMPTOMS

1. Have you ever been diagnosed as having a heart problem, high blood pressure, high cholesterol or circulatory problems?

   no ❑ yes ❑ please specify: ____________

2. Have you ever been advised not to exercise?

   no ❑ yes ❑ please specify: ____________

3. Have you ever been diagnosed as having asthma or any other respiratory condition?

   no ❑ yes ❑ please specify: ____________

4. Have you ever been diagnosed as having diabetes?

   no ❑ yes ❑ please specify: ____________

5. Have you ever been diagnosed as having epilepsy?

   no ❑ yes ❑ please specify: ____________

6. Is there any other condition that may affect your ability to exercise or receive manual treatment?

   no ❑ yes ❑ please specify: ____________

7. Are you currently taking any prescribed medication?

   no ❑ yes ❑ please specify: ____________

8. Are you pregnant or have you had a baby in the last 2 years?

   no ❑ yes ❑ please specify: ____________

9. Have you had any surgery in the last 5 years?

   no ❑ yes ❑ please specify: ____________

10. Have you ever experienced any sensory problems? (eyesight, hearing, balance etc.)

    no ❑ yes ❑ please specify: ____________

The above information is correct and to the best of my knowledge:

signed:	date:

04 LIFESTYLE

1. Do you smoke?

no ❑ yes ❑ how many per week ______

2. Do you ever feel all ‘bunged up’?

no ❑ yes ❑

3. Are your bowel movements regular and firm?

no ❑ yes ❑

4. What time do you go to bed at night?.. And what time do you rise?

Go to sleep: ______ rise: ______

5. Do you have trouble sleeping at night?

no ❑ yes ❑

6. Does your job involve working shifts, unusual or extremely long hours?

no ❑ yes ❑ please specify: ______

7. Do you travel more than 60 minutes to work every day?

no ❑ yes ❑

8. Do you find that you have little resistance to illness?

no ❑ yes ❑

9. Do you find that you lose your temper regularly over small things?

no ❑ yes ❑

10-YEARS YOUNGER

05 MORE LIFESTYLE

10. What percentage of fresh (unprocessed) foods do you buy ?

10% ❑ 20% ❑ 30% ❑ 40% ❑ 50% ❑ 60% ❑ 70% ❑ 80%❑ 90% ❑ 100%❑

11. Do you buy organic foods ?

no ❑ yes ❑

12. What fats or oils do you use for spreading or cooking ?

olive oil ❑ butter ❑ margarine ❑ vegetable oil ❑ coconut oil ❑ other: ____________

13. How much water do you drink per day?

less than 1 litre ❑ 1 - 2 litres ❑ 2 litres ❑ more than 2 litres ❑

14. Do you add sugar to:

tea or coffee ❑ cereal ❑ don't use sugar ❑

15. How often do you eat dessert ?

everyday ❑ 2 – 3 times per week ❑ once a week ❑ less / rarely ❑

16. On an average day how many of the following would you eat ?

cakes / muffins etc: ____________ chocolate bars: ____________ sweets / confectionary: ____________

17. How often do you eat cereal grains (bread, pasta, cereals etc) ?

everyday ❑ 2 – 3 times per week ❑ once a week ❑ less / rarely ❑

18. Do you use artificial sweeteners?

no ❑ yes ❑

06 EVEN MORE LIFESTYLE

19. Do you add salt to your food?

no ❑ yes ❑

20. Do you drink alcohol?... No ❑ yes ❑ if so on which days:

mon ❑ tues ❑ weds ❑ thur ❑ fri ❑ sat ❑ sun ❑

21. In what form?

wine ❑ spirits ❑ beer / lager ❑ champagne ❑ alco-pops ❑

22. How many units per day?

mon _____ tues _____ weds _____ thur _____ fri _____ sat _____ sun _____

23. How many caffeinated drinks do you have each day ?

mon _____ tues _____ weds _____ thur _____ fri _____ sat _____ sun _____

24. How often do you drink carbonated drinks (coke, lemonade, sparkling water etc) ?

everyday ❑ 2 – 3 times per week ❑ once a week ❑ less / never ❑

25. Do you ever experience bloating, discomfort or wind after eating?

frequently ❑ sometimes ❑ rarely ❑

26. I often:

sleep well ❑ wake up refreshed ❑ have trouble sleeping ❑ wake up tired ❑

18. Which foods do you tend to crave ?

dairy products ❑ sweets or starches ❑ salty or greasy ❑ spicy ❑

07 OBJECTIVES

1. What is your primary objective?

2. What prompted this objective?

3. Please list the activities or tasks that you need & want to be able to perform?

needs:		wants:	
1.		4.	
2.		5.	
3.		6.	

4. What will achieving this goal mean for you? (How will it change your life?)

5. What is your greatest concern in relation to this objective?

6. Are you process or goal orientated?

7. Please list the current actions that are taking you further away from your goal?

1.		4.	
2.		5.	
3.		6.	

08 FURTHER OBJECTIVES

Please indicate which positive actions you are prepared to take to reach your goal ?

1.	stretch & exercise daily	4.	reduce my alcohol intake
2.	prepare my own food	5.	program relaxation into my day
3.	eat nutrient-rich food regularly	16.	go to bed earlier

What are your expectations of **10-Years Younger** ?

10-YEARS YOUNGER

CLIENT TERMS OF AGREEMENT

General Health

Up-to-date information about your health and wellbeing is vital in allowing **10-Years Younger** to safely construct and develop your health and fitness experience.

1. I confirm that I have provided accurate information regarding my past medical history and current state of health.

2. I agree to inform **10-Years Younger** if any of the following are relevant, or become relevant at any time in the future:

- I am taking prescribed medication
- I have been advised by a medical professional not to participate in exercise
- I am suffering from an injury
- I feel unwell or uncomfortable before, during or after a movement therapy session

3. I understand that **10-Years Younger** has the right to cancel or suspend a session at any time, should they feel that continuing with the session would be detrimental to my health or wellbeing.

Punctuality

Due to the personal and exclusive nature of **10-Years Younger** services and our dependence upon time allocation, we respectfully ask clients to allow plenty of space in their busy schedules to attend and start each session at the agreed time.

1. I understand that arriving late will result in the forfeit of the missed portion of my session.

Session booking & cancellations

To keep your experience with **10-Years Younger** as rewarding as possible:

1. I understand that booking a session will enter me into an agreement with my therapist.

2. I understand that if I need to rearrange or cancel a session, I will give **10-Years Younger** a minimum of 48 hours notice in order for the space to be re-assigned.

3. I understand that failure to give at least 24-hours notice, irrespective of reason, will result in the forfeit of one of my pre-paid block sessions or payment in full upon attending my next session.

Illness

In order to protect your therapist and the other patrons of **10-Years Younger** from risk of infection, we respectfully ask clients to cancel or suspend sessions if they feel unwell.

1. I understand that if I am unwell I will contact **10-Years Younger** as soon as possible to cancel or suspend my session.

2. I understand that if I attend my session feeling unwell **10-Years Younger** has the right to cancel my treatment.

3. I understand that if I am unwell, failure to give at least 24-hours notice will result in the forfeit of one of my pre-paid block sessions or payment in full upon attending my next session.

I have read, understood and I am in agreement with the terms above.

Client Name: ______________________________

Signature: ______________________________ Date: ______________