Please rate your Nutrition knowledge: ____Excellent____ Good __✓__ Average ____ Poor____

Please explain KNOW THAT HIGH CONTENT SUGARS NOT GOOD, FRUITS, VEGS GOOD, WHOLE GRAINS

How often do you snack each day? 3-5 x /day

What kinds of foods do you eat when you snack? FRUIT, GRANOLA BARS, NUTS

Do you find your work stressful? ____No __✓__Yes

If Yes: Why? LOTS GOING ON OVERLY BUSY

Occupation: PROCUREMENT COORDINATOR Hours Worked Per Week: 40

Do you have Employer Health Insurance? ____No __✓__Yes

If yes, which company? MANULIFE

Do you smoke? __✓__No ____Yes If yes, how often? ____

Do you drink alcohol? ____No __✓__Yes If yes, how often? WEEKENDS

Do you drink coffee/tea? ____No __✓__Yes If yes, which and how often? DAILY 3-5 cups

I, KAREN LASCU affirm all the information on this form to be accurate and true to the best of my knowledge. I will not hold Dalewood Health Clinics or any of their staff responsible for any of my errors or omission.

Date: March 14/2017 Client Signature Karen Lascu

ALL INFORMATION IS HELD IN THE STRICTEST CONFIDENCE. PLEASE COMPLETE THIS HEALTH QUESTIONNAIRE IN AS MUCH DETAIL AS POSSIBLE AND RETURN IT TO THE DALEWOOD STAFF MEMBER.

THANK YOU.

DALEWOOD HEALTH & WELLNESS CENTRE

PERSONAL INFORMATION

Name Maureen Baustad

Address Box 72 SITE 2 RR 2

Apt _____ City OKOTOKS Province AB Postal Code T1S 1A2

Date of Birth Jan 18/62 Age 55 Sex: ____ Male ✓ Female

Home Tel: (587) 435-1818 Work or Cell (403) 613-6644

MEDICAL HISTORY

Do you have any health concerns ? ✓ No ____ Yes

If yes, please specify:

Do you have a history of:

- ☐ Asthma
- ☐ Frequent Infections
- ☐ Hormone Imbalances
- ☑ Overweight/Obesity
- ☐ Heart Disease/pacemaker
- ☐ Epilepsy
- ☐ Rheumatoid Arthritis
- ☐ Cancer (type _____)
- ☐ High Blood pressure
- ☐ Kidney Disease
- ☐ Bone Disease
- ☐ Intestinal Disorder
- ☐ Diabetes
- ☑ Thyroid problem
- ☐ HIV / AIDS
- ☐ Colitis
- ☐ Lupus
- ☐ Attention Deficit/Hyperactivity
- ☑ Mental Illness
- ☐ Other (Depression)

Have you had any surgeries recently? Y ✓ N ____ Approximate date(s): Oct 2015

Current medications and supplements:

Effexor Rx 75, Thyroid Medicine

Applicable for Women:

Are you pregnant? ____ Yes ✓ No

Are you nursing? ____ Yes ✓ No

LIFESTYLE – Nutrition / Exercise

How would you rate your current health? ____ Poor ✓ Average ____ Good

Has there been any change in your health in the last year? ____ No ✓ Yes

If yes, please explain:

Weight gain

Are you satisfied with you physical appearance? ✓ No ____ Yes.

What areas would you like to improve?

Stomach / hips

How much weight and how many inches would you like to lose?

Weight 65 Inches ____

How often do you weigh yourself? once/a week measure yourself? never

What programs have you tried in the past for weight loss?

Jenny Craig, weight watchers, Herbal Magic

Please describe your experience: ____

Are you presently exercising? ✓ No ____ Yes

If Yes: How often do you exercise? ____

What type of exercise? ____

Please rate your Fitness knowledge: ____ Excellent ✓ Good ____ Average ____ Poor ____

Please explain: ____

Are any other members of your household overweight? ✓ Yes ____ No

If Yes, which members? Husband

Please rate your Nutrition knowledge: ____Excellent ✓ Good ____Average ____Poor____

Please explain_____

How often do you snack each day? 2:00 pm

What kinds of foods do you eat when you snack? Chips maybe, chocolate.

Do you find your work stressful? ✓No ____Yes

If Yes: Why?_____

Occupation: laid off Hours Worked Per Week:_____

Do you have Employer Health Insurance? ✓No ____Yes

If yes, which company?_____

Do you smoke? ✓No ____Yes If yes, how often?_____

Do you drink alcohol? ____No ✓Yes If yes, how often? Maybe once a month/Social only

Do you drink coffee/tea? ____No ✓Yes If yes, which and how often?_____

I, Maureen Baustad affirm all the information on this form to be accurate and true to the best of my knowledge. I will not hold Dalewood Health Clinics or any of their staff responsible for any of my errors or omission.

Date: April 18/17 Client Signature Maureen Baustad

ALL INFORMATION IS HELD IN THE STRICTEST CONFIDENCE. PLEASE COMPLETE THIS HEALTH QUESTIONNAIRE IN AS MUCH DETAIL AS POSSIBLE AND RETURN IT TO THE DALEWOOD STAFF MEMBER.

THANK YOU.

DALEWOOD HEALTH & WELLNESS CENTRE

PERSONAL INFORMATION

Name Rosa DiFiore

Address 3920 2nd St. NW

Apt _____ City Calgary Province AB Postal Code T2K 0L6

Date of Birth June 17, 1962 Age 54 Sex: _____ Male ✓ Female

Home Tel: (403) 277-0222 Work or Cell (403) 861-3535 *

MEDICAL HISTORY

Do you have any health concerns ? ✓ No _____ Yes

If yes, please specify:

thyroid, anxiety

Do you have a history of:

- ☐ Asthma
- ☐ Frequent Infections
- ☐ Hormone Imbalances
- ☐ Overweight/Obesity
- ☐ Heart Disease/pacemaker
- ☐ Epilepsy
- ☐ Rheumatoid Arthritis
- ☐ Cancer (type _____)
- ☒ High Blood pressure
- ☐ Kidney Disease
- ☐ Bone Disease
- ☐ Intestinal Disorder
- ☐ Diabetes
- ☒ Thyroid problem
- ☐ HIV / AIDS
- ☐ Colitis
- ☐ Lupus
- ☐ Attention Deficit/Hyperactivity
- ☐ Mental Illness
- ☐ Other (_____)

Have you had any surgeries recently? Y _____ N ✓ Approximate date(s): _____

Current medications and supplements: see attached

Applicable for Women:

Are you pregnant? _____ Yes ✓ No Are you nursing? _____ Yes ✓ No

LIFESTYLE – Nutrition / Exercise

How would you rate your current health? _____ Poor ___✓___ Average _____ Good

Has there been any change in your health in the last year? ___✓___ No ____Yes

If yes, please explain:

Are you satisfied with you physical appearance? ___✓___ No _____ Yes.

What areas would you like to improve?

need to lose weight

How much weight and how many inches would you like to lose?

Weight 30-40 Inches _____

How often do you weigh yourself ? weekly measure yourself ? _____

What programs have you tried in the past for weight loss?

weight watchers, weightwise clinic, gastric sleeve

Please describe your experience: _____

Are you presently exercising? _____No ___✓___ Yes

If Yes: How often do you exercise? daily walk

What type of exercise? walk

Please rate your Fitness knowledge: _____ Excellent _____ Good _____ Average _____ Poor ___✓___

Please explain: _____

Are any other members of your household overweight? _____ Yes ___✓___ No

If Yes, which members? _____

Please rate your Nutrition knowledge: ____Excellent____ Good ____ Average ✓ Poor____

Please explain ____

How often do you snack each day? 3

What kinds of foods do you eat when you snack? granola Bars, chips

Do you find your work stressful? ____No ✓Yes

If Yes: Why? direct Boss difficult

Occupation: Dir. of Catering hotel Hours Worked Per Week: 50

Do you have Employer Health Insurance? ____No ✓Yes

If yes, which company? Blue Cross (SK)

Do you smoke? ✓No ____Yes If yes, how often? ____

Do you drink alcohol? ____No ✓Yes If yes, how often? 1 x month

Do you drink coffee/tea? ____No ✓Yes If yes, which and how often? 1 latté per day

I, Rosa DiFide affirm all the information on this form to be accurate and true to the best of my knowledge. I will not hold Dalewood Health Clinics or any of their staff responsible for any of my errors or omission.

Date: april 18, 2017 Client Signature Rosa DiFide

ALL INFORMATION IS HELD IN THE STRICTEST CONFIDENCE. PLEASE COMPLETE THIS HEALTH QUESTIONNAIRE IN AS MUCH DETAIL AS POSSIBLE AND RETURN IT TO THE DALEWOOD STAFF MEMBER.

THANK YOU.

DALEWOOD HEALTH & WELLNESS CENTRE

PERSONAL INFORMATION

Name Dolores Herman

Address ~~#306~~ 2425 90 Ave S.W.

Apt 306 City Calgary Province AB. Postal Code T2V 4X8.

Date of Birth May 22, 1953 Age 63 Sex: ~~F~~ Male ✓ Female

Home Tel: ( ) Work or Cell (403) ~~2~~ 919 3809.

MEDICAL HISTORY

Do you have any health concerns ? ___ No ✓ Yes

If yes, please specify: bad knees.

Do you have a history of:

- ☐ Asthma
- ☐ Frequent Infections
- ☐ Hormone Imbalances
- ☐ Overweight/Obesity
- ☐ Heart Disease/pacemaker
- ☐ Epilepsy
- ☐ Rheumatoid Arthritis
- ☐ Cancer (type _____)
- ☐ High Blood pressure
- ☐ Kidney Disease
- ☐ Bone Disease
- ☐ Intestinal Disorder
- ☐ Diabetes
- ☐ Thyroid problem
- ☐ HIV / AIDS
- ☐ Colitis
- ☐ Lupus
- ☐ Attention Deficit/Hyperactivity
- ☐ Mental Illness
- ☐ Other (_____)

Have you had any surgeries recently? Y_____ N ✓ Approximate date(s):_____

Current medications and supplements: various vitamins → cholesterol reducer + asprin.

Applicable for Women:

Are you pregnant? ____ Yes ✓ No Are you nursing? ____ Yes ____ No

LIFESTYLE – Nutrition / Exercise

How would you rate your current health? ____ Poor ____✓____ Average ____ Good

Has there been any change in your health in the last year? ✓ No ____ Yes

If yes, please explain:

Are you satisfied with you physical appearance? ✓ No ____ Yes.

What areas would you like to improve?

reduce weight

How much weight and how many inches would you like to lose?

Weight ____ Inches ____

How often do you weigh yourself ? rarely measure yourself ? never

What programs have you tried in the past for weight loss?

weight watchers, jenny craig, dr. bernstein, etc.

Please describe your experience:

Are you presently exercising? ____No ____Yes

If Yes: How often do you exercise? ____

What type of exercise? stretches

Please rate your Fitness knowledge: ____ Excellent ____ Good ____ Average ✓ Poor ____

Please explain: I know what to do, I just dont do it!

Are any other members of your household overweight? ____ Yes ✓ No

If Yes, which members? ____

Please rate your Nutrition knowledge: ____ Excellent ____ Good ____ Average ✓ Poor ____

Please explain ____

How often do you snack each day? Once.

What kinds of foods do you eat when you snack? Cheerios, chips.

Do you find your work stressful? ____ No ✓ Yes

If Yes: Why? Very busy, high expectations

Occupation: Human Resources Hours Worked Per Week: 45-50

Do you have Employer Health Insurance? ____ No ✓ Yes

If yes, which company? Sun life or GWL

Do you smoke? ✓ No ____ Yes If yes, how often? ____

Do you drink alcohol? ____ No ✓ Yes If yes, how often? 3-4 times/week

Do you drink coffee/tea? ____ No ✓ Yes If yes, which and how often? coffee, every day

I, Dolores Herman affirm all the information on this form to be accurate and true to the best of my knowledge. I will not hold Dalewood Health Clinics or any of their staff responsible for any of my errors or omission.

Date: Mar 14/17 Client Signature D Herman

ALL INFORMATION IS HELD IN THE STRICTEST CONFIDENCE. PLEASE COMPLETE THIS HEALTH QUESTIONNAIRE IN AS MUCH DETAIL AS POSSIBLE AND RETURN IT TO THE DALEWOOD STAFF MEMBER.

THANK YOU.

DALEWOOD HEALTH & WELLNESS CENTRE

PERSONAL INFORMATION

Name Laura Brianne Harris (given name: Brianne)

Address 2204 24 Ave NW

Apt _____ City Calgary Province AB Postal Code T2M 1Z7

Date of Birth May 4, 1987 Age 30 Sex: _____ Male ✓ Female

Home Tel: ( ) _____ Work or Cell (403) 512-8095

MEDICAL HISTORY

Do you have any health concerns ? X No _____ Yes

If yes, please specify:

Do you have a history of:

- ☑ Asthma
- ☐ Frequent Infections
- ☐ Hormone Imbalances
- ☐ Overweight/Obesity
- ☐ Heart Disease/pacemaker
- ☐ Epilepsy
- ☐ Rheumatoid Arthritis
- ☐ Cancer (type _____)
- ☐ High Blood pressure
- ☐ Kidney Disease
- ☐ Bone Disease
- ☐ Intestinal Disorder
- ☐ Diabetes
- ☐ Thyroid problem
- ☐ HIV / AIDS
- ☐ Colitis
- ☐ Lupus
- ☐ Attention Deficit/Hyperactivity
- ☐ Mental Illness
- ☐ Other (_____)

Have you had any surgeries recently? Y _____ N ✓ Approximate date(s): _____

Current medications and supplements:

Alesse (birth control)

Applicable for Women:

Are you pregnant? _____ Yes X No Are you nursing? _____ Yes X No

LIFESTYLE – Nutrition / Exercise

How would you rate your current health? ✗ Poor ✓ Average ____ Good

Has there been any change in your health in the last year? ✓ No ____ Yes

If yes, please explain:

Are you satisfied with you physical appearance? ✓ No ____ Yes.

What areas would you like to improve?

weight (general) - body fat - eating habits

How much weight and how many inches would you like to lose?

Weight 20 pounds Inches not sure

How often do you weigh yourself? weekly measure yourself? never

What programs have you tried in the past for weight loss?

personal - nothing else

Please describe your experience:

Are you presently exercising? ✓ No ____ Yes

If Yes: How often do you exercise?

What type of exercise?

Please rate your Fitness knowledge: ____ Excellent ____ Good ____ Average ____ Poor ____

Please explain:

Are any other members of your household overweight? ____ Yes ✗ No

If Yes, which members?

Please rate your Nutrition knowledge: ____Excellent ____Good __X__Average ____Poor____

Please explain lots of pops & large portion sizes

How often do you snack each day? most 1-3 times/day

What kinds of foods do you eat when you snack? toast / sweets salty snack

Do you find your work stressful? __X__No ____Yes

If Yes: Why?

Occupation: legal assistant Hours Worked Per Week: 40 hrs/week

Do you have Employer Health Insurance? ____No __X__Yes

If yes, which company? Sun life

Do you smoke? __X__No ____Yes If yes, how often?

Do you drink alcohol? ____No __X__Yes If yes, how often? casual

Do you drink coffee/tea? __X__No ____Yes If yes, which and how often?

I, L. Brianne Harris affirm all the information on this form to be accurate and true to the best of my knowledge. I will not hold Dalewood Health Clinics or any of their staff responsible for any of my errors or omission.

Date: December 1, 2017 Client Signature

ALL INFORMATION IS HELD IN THE STRICTEST CONFIDENCE. PLEASE COMPLETE THIS HEALTH QUESTIONNAIRE IN AS MUCH DETAIL AS POSSIBLE AND RETURN IT TO THE DALEWOOD STAFF MEMBER.

THANK YOU.

PERSONAL INFORMATION

Name Grace Su

Address 212 Canterbury Court SW

Apt _____ City Calgary Province AB Postal Code T2W 6C4

Date of Birth 13 March 1965 Age 52 Sex: ~~M~~ Male F Female

Home Tel: (403) 251-9422 Work or Cell (403) 629-3669

MEDICAL HISTORY

Do you have any health concerns ? ____ No X Yes

If yes, please specify:

A bit high with my cholesterol

Do you have a history of:

- □ Asthma
- □ Frequent infections
- □ Hormone Imbalances
- □ Overweight/Obesity
- □ Heart Disease/pacemaker
- □ Epilepsy
- □ Rheumatoid Arthritis
- □ Cancer (type _____)
- □ High Blood pressure
- □ Kidney Disease
- □ Bone Disease
- □ Intestinal Disorder
- □ Diabetes
- □ Thyroid problem
- □ HIV / AIDS
- □ Colitis
- □ Lupus
- □ Attention Deficit/Hyperactivity
- □ Mental Illness
- □ Other (_____)

Have you had any surgeries recently? Y____ N ✓ Approximate date(s):_____

Current medications and supplements:

Applicable for Women:

Are you pregnant? ____ Yes ✓ No

Are you nursing? ____ Yes ✓ No

LIFESTYLE – Nutrition / Exercise

How would you rate your current health? _____ Poor ___✓___ Average _____ Good

Has there been any change in your health in the last year? ___✓___ No ___✓___ Yes

If yes, please explain:

_____

Are you satisfied with you physical appearance? ___✓___ No _____ Yes.

What areas would you like to improve?

Slimmer and lighter

How much weight and how many inches would you like to lose?

Weight 25 lbs Inches _____ 2 sizes down

How often do you weigh yourself ? one/wk measure yourself ? N:1

What programs have you tried in the past for weight loss?

Self - 17 day Diet

Please describe your experience: Was successful and lost 12 lbs

_____

Are you presently exercising? _____No ___✓___Yes

If Yes: How often do you exercise? 2 to 3 times a week

What type of exercise? netball, squash

Please rate your Fitness knowledge: _____ Excellent _____ Good _____ (Average) _____ Poor _____

Please explain: _____

Are any other members of your household overweight? _____ (Yes) _____ No

If Yes, which members? Mother

_____

PERSONAL INFORMATION

Name Mysoon Barhat

Address 130 Citadel Meadow Grove NW

Apt: _____ City Calgary Province AB Postal Code T3G4K8

Date of Birth Sept 2, 1994 Age 23 Sex: ____ Male ✓ Female

Home Tel: (Cell) (403) 477-5450 Work or Cell ( ) _____

MEDICAL HISTORY

Do you have any health concerns ? ✓ No ____ Yes

If yes, please specify:

Do you have a history of:

- ☐ Asthma
- ☐ Frequent Infections
- ☐ Hormone Imbalances
- ☐ Overweight/Obesity
- ☐ Heart Disease/pacemaker
- ☐ Epilepsy
- ☐ Rheumatoid Arthritis
- ☐ Cancer (type _____)
- ☐ High Blood pressure
- ☐ Kidney Disease
- ☐ Bone Disease
- ☐ Intestinal Disorder
- ☐ Diabetes
- ☐ Thyroid problem
- ☐ HIV / AIDS
- ☐ Colitis
- ☐ Lupus
- ☐ Attention Deficit/Hyperactivity
- ☐ Mental Illness
- ☒ Other (Factor 5 Lidan)

Have you had any surgeries recently? Y ____ N ✓ Approximate date(s): _____

Current medications and supplements:

Applicable for Women:

Are you pregnant? ____ Yes ✓ No

Are you nursing? ____ Yes ✓ No

LIFESTYLE – Nutrition / Exercise

How would you rate your current health? ____ Poor ✓ Average ____ Good

Has there been any change in your health in the last year? ✓ No ____ Yes

If yes, please explain:

Are you satisfied with you physical appearance? ✓ No ____ Yes.

What areas would you like to improve?

Everything, my weight.

How much weight and how many inches would you like to lose?

Weight 150 lbs. – what I want to be. Inches ____

How often do you weigh yourself? weekly measure yourself? ____

What programs have you tried in the past for weight loss?

Ideal Protein, Online health plan, research Healthy eating On my own

Please describe your experience:

Lost weight + gained it right back.

Are you presently exercising? ____ No ✓ Yes

If Yes: How often do you exercise? 3-5 weekly

What type of exercise? cardio, weight lifting (light weights), classes (yoga/spin)

Please rate your Fitness knowledge: ____ Excellent ✓ Good ____ Average ____ Poor ____

Please explain: ?

Are any other members of your household overweight? ✓ Yes ____ No

If Yes, which members? Siblings

Please rate your Nutrition knowledge: ____ Excellent ____ Good ✓ Average ____ Poor ____

Please explain Eat fairly healthy, but have my days.

How often do you snack each day? 2 times

What kinds of foods do you eat when you snack? apples/peanut butter, crackers.

Do you find your work stressful? ____ No ✓ Yes

If Yes: Why? at times like any job.

Occupation: Dental Assistant Hours Worked Per Week: 40 hrs

Do you have Employer Health Insurance? ____ No ✓ Yes

If yes, which company? GWL - through fiance

Do you smoke? ✓ No ✓ Yes If yes, how often? Shisha rarely.

Do you drink alcohol? ____ No ✓ Yes If yes, how often? rarely - ~3 times a year.

Do you drink coffee/tea? ____ No ✓ Yes If yes, which and how often? daily.

I, Mysoon Barhat affirm all the information on this form to be accurate and true to the best of my knowledge. I will not hold Dalewood Health Clinics or any of their staff responsible for any of my errors or omission.

Date: Feb 8, 2018 Client Signature

ALL INFORMATION IS HELD IN THE STRICTEST CONFIDENCE. PLEASE COMPLETE THIS HEALTH QUESTIONNAIRE IN AS MUCH DETAIL AS POSSIBLE AND RETURN IT TO THE DALEWOOD STAFF MEMBER.

THANK YOU.

PERSONAL INFORMATION

Name Crystal Chambers

Address 110 Silvergrove Rd NW

Apt _____ City Calgary Province AB Postal Code T3B 4K1

Date of Birth 1984/09/22 Age 32 Sex: ___ Male ✓ Female

Home Tel: (587) 777 5006 Work or Cell ( ) _____

MEDICAL HISTORY

Do you have any health concerns ? ___ No ✓ Yes

If yes, please specify:

Do you have a history of:

- ☐ Asthma
- ☐ Frequent Infections
- ☐ Hormone Imbalances
- ☑ Overweight/Obesity
- ☐ Heart Disease/pacemaker
- ☐ Epilepsy
- ☐ Rheumatoid Arthritis
- ☐ Cancer (type _____)
- ☐ High Blood pressure
- ☐ Kidney Disease
- ☐ Bone Disease
- ☐ Intestinal Disorder
- ☐ Diabetes
- ☐ Thyroid problem
- ☐ HIV / AIDS
- ☐ Colitis
- ☐ Lupus
- ☐ Attention Deficit/Hyperactivity
- ☐ Mental Illness
- ☐ Other ( )

Have you had any surgeries recently? Y ___ N ✓ Approximate date(s): _____

Current medications and supplements:

LIFESTYLE – Nutrition / Exercise

How would you rate your current health? ____ Poor ____ Average ✓ Good

Has there been any change in your health in the last year? ____ No ✓ Yes

If yes, please explain:
lost 90 lbs

Are you satisfied with you physical appearance? ✓ No ____ Yes.

What areas would you like to improve?
Stomach

How much weight and how many inches would you like to lose?

Weight 30 Inches ____

How often do you weigh yourself ? depends measure yourself ? ____

What programs have you tried in the past for weight loss?
Ideal weight loss

Please describe your experience: Great experience

Are you presently exercising? ____ No ✓ Yes

If Yes: How often do you exercise? 6 x a week

What type of exercise? Cardio / weight

Please rate your Fitness knowledge: ____ Excellent ____ Good ✓ Average ____ Poor

Please explain: I know how to use machines

Are any other members of your household overweight? ____ Yes ✓ No

If Yes, which members? ____

Please rate your Nutrition knowledge: ____Excellent ✓ Good ____Average ____Poor____

Please explain I eat Clean regularly

How often do you snack each day? 2: Morning / Afternoon

What kinds of foods do you eat when you snack? Cottage Cheese / protein Shake

Do you find your work stressful? ____No ✓Yes

If Yes: Why? _____

Occupation: Corrections / Social Work Hours Worked Per Week: 60 or more

Do you have Employer Health Insurance? ✓No ____Yes

If yes, which company? _____

Do you smoke? ✓No ____Yes If yes, how often? _____

Do you drink alcohol? ✓No ____Yes If yes, how often? _____

Do you drink coffee/tea? ____No ✓Yes If yes, which and how often? one daily orange pekoe tea

Crystal Chambers affirm all the information on this form to be accurate and true to the best of my knowledge. I will not hold Dalewood Health Clinics or any of their staff responsible for any of my errors or omission.

Date: 2018/02/05 Client Signature C Chambers

ALL INFORMATION IS HELD IN THE STRICTEST CONFIDENCE. PLEASE COMPLETE THIS HEALTH QUESTIONNAIRE IN AS MUCH DETAIL AS POSSIBLE AND RETURN IT TO THE DALEWOOD STAFF MEMBER.

THANK YOU.

PERSONAL INFORMATION

Name Dana Keast

Address 156 Tuscany Valley Dr. NW

Apt _____ City Calgary Province AB Postal Code T3L 2C1

Date of Birth NOV 8 1967 Age 50 Sex: _____ Male ✓ Female

Home Tel: (403 280 0070 Work or Cell (403 280 0070

MEDICAL HISTORY

Do you have any health concerns ? ____ No ✓ Yes

If yes, please specify: High Blood pressure Mild Cardiomyopathy

Do you have a history of:

- ☐ Asthma
- ☐ Frequent Infections
- ☐ Hormone Imbalances
- ☑ Overweight/Obesity
- ☐ Heart Disease/pacemaker
- ☐ Epilepsy
- ☐ Rheumatoid Arthritis
- ☐ Cancer (type _____)
- ☑ High Blood pressure
- ☐ Kidney Disease
- ☐ Bone Disease
- ☐ Intestinal Disorder
- ☐ Diabetes
- ☐ Thyroid problem
- ☐ HIV / AIDS
- ☐ Colitis
- ☐ Lupus
- ☐ Attention Deficit/Hyperactivity
- ☐ Mental Illness
- ☐ Other (_____)

Have you had any surgeries recently? Y ____ N X Approximate date(s): N/A

Current medications and supplements: Candesartan, Bisoprolol benign brain tumour removed 2010.

Vit D, Probiotic, Multivit, Omega 6

Applicable for Women:

Are you pregnant? ____ Yes ✓ No Are you nursing? ____ Yes ✓ No

HEALTH & WELLNESS CENTRE

LIFESTYLE – Nutrition / Exercise

How would you rate your current health? ____ Poor ____✓____ Average ____ Good

Has there been any change in your health in the last year? ____ No ✓ Yes

If yes, please explain:
Blood pressure up have some arthritis in shoulder

Are you satisfied with you physical appearance? ✓ No ____ Yes. gained weight I had recently lost

What areas would you like to improve?
Core strength – extra weight around middle

How much weight and how many inches would you like to lose?
Weight 50lbs Inches Not sure would like to be a size 12/13

How often do you weigh yourself ? 1x week measure yourself ? rarely

What programs have you tried in the past for weight loss?
Weight watchers, LA weight loss, ? recent program like, Ideal protein can't remember the name.

Please describe your experience: last program lost 50 went off gained back quickly

Are you presently exercising? ____ No ✓ Yes

If Yes: How often do you exercise? 3-5x week

What type of exercise? Walk outside treadmill Yoga Stretching

Please rate your Fitness knowledge: ____ Excellent ____ Good ✓ Average ____ Poor

Please explain: I know about the benefits

Are any other members of your household overweight? ____ Yes ✓ No

If Yes, which members? ____

Please rate your Nutrition knowledge: ____Excellent ✓ Good ____Average ____Poor____

Please explain N/A

How often do you snack each day? 2+3x

What kinds of foods do you eat when you snack? crave carbs sugar - try to eat protein

Do you find your work stressful? ✓ No ____Yes

If Yes: Why?

Occupation: Ed Assistant Hours Worked Per Week: 30hrs

Do you have Employer Health Insurance? ____No ✓ Yes

If yes, which company? Sunlife

Do you smoke? ✓ No ____Yes If yes, how often? ____

Do you drink alcohol? ✓ No ____Yes If yes, how often? ____

Do you drink coffee/tea? ✓ No ____Yes If yes, which and how often? ____

I, Ciara Kearl affirm all the information on this form to be accurate and true to the best of my knowledge. I will not hold Dalewood Health Clinics or any of their staff responsible for any of my errors or omission.

Date: Jan 30/18 Client Signature Ciara Kearl

ALL INFORMATION IS HELD IN THE STRICTEST CONFIDENCE. PLEASE COMPLETE THIS HEALTH QUESTIONNAIRE IN AS MUCH DETAIL AS POSSIBLE AND RETURN IT TO THE DALEWOOD STAFF MEMBER.

THANK YOU.

PERSONAL INFORMATION

Name JOAN ERICKSON

Address 1217 - 18 ST. NW

Apt / City CALGARY Province AB Postal Code T2N 2G8

Date of Birth May 20, 1956 Age 61 Sex: ___ Male ✓ Female

Home Tel: ( ) Work or Cell (403) 818-5757

MEDICAL HISTORY

Do you have any health concerns ? ___ No Meh Yes

If yes, please specify: High Blood Pressure. NOT HISTORY - OVERWEIGHT.

Do you have a history of:

- ☐ Asthma
- ☐ Frequent Infections
- ☐ Hormone Imbalances
- ☐ Overweight/Obesity
- ☐ Heart Disease/pacemaker
- ☐ Epilepsy
- ☐ Rheumatoid Arthritis
- ☐ Cancer (type ___)
- ☐ High Blood pressure
- ☐ Kidney Disease
- ☐ Bone Disease
- ☐ Intestinal Disorder
- ☐ Diabetes
- ☐ Thyroid problem
- ☐ HIV / AIDS
- ☐ Colitis
- ☐ Lupus
- ☐ Attention Deficit/Hyperactivity
- ☐ Mental Illness
- ☐ Other ( )

Have you had any surgeries recently? Y ✓ N ___ Approximate date(s): 10 + yrs ago

Current medications and supplements: High Blood Pressure Meds

Applicable for Women:

Are you pregnant? ___ Yes ● No

Are you nursing? ___ Yes ● No

LIFESTYLE – Nutrition / Exercise

How would you rate your current health? ____ Poor ____ Average ✓ Good Pretty

Has there been any change in your health in the last year? ✓ No ____ Yes

If yes, please explain:

Are you satisfied with you physical appearance? ✓ No ____ Yes.

What areas would you like to improve? Weight. – Botox on brows.

How much weight and how many inches would you like to lose?

Weight: ____ Inches ____

How often do you weigh yourself? I DON'T measure yourself? NOPE

What programs have you tried in the past for weight loss?

CURVES.

Please describe your experience: GREAT. FOLLOWED THEIR EXERCISE Program + Food Recommendations.

Are you presently exercising? ✓ No ____ Yes

If Yes: How often do you exercise? ____

What type of exercise? ____

Please rate your Fitness knowledge: ____ Excellent ✓ Good ____ Average ____ Poor ____

Please explain: WAS FITNESS INSTRUCTOR YEARS AGO- KNOW ANATOMY.

Are any other members of your household overweight? ____ Yes ✓ No

If Yes, which members? ____

Please rate your Nutrition knowledge: ____Excellent ✓ Good ____Average ____Poor____

Please explain KNOW ABOUT PROTEIN + SODIUM.

How often do you snack each day? meh

What kinds of foods do you eat when you snack? FRUIT NUTS, PROTEIN BAR

Do you find your work stressful? ____No ____Yes SOMETIMES

If Yes: Why? FRUSTRATION WITH STUFF

Occupation: HOMEMAKER Hours Worked Per Week: 125

Do you have Employer Health Insurance? ✓ No ____Yes

If yes, which company? _____

Do you smoke? ✓ No ____Yes If yes, how often? _____

Do you drink alcohol? ____No ✓ Yes If yes, how often? Depends

Do you drink coffee/tea? ____No ✓ Yes If yes, which and how often? coffee 1-2 c day

_____

_____

I, [signature] affirm all the information on this form to be accurate and true to the best of my knowledge. I will not hold Dalewood Health Clinics or any of their staff responsible for any of my errors or omission.

Date: Jan 31, 2018 Client Signature [signature]

ALL INFORMATION IS HELD IN THE STRICTEST CONFIDENCE. PLEASE COMPLETE THIS HEALTH QUESTIONNAIRE IN AS MUCH DETAIL AS POSSIBLE AND RETURN IT TO THE DALEWOOD STAFF MEMBER.

THANK YOU.

PERSONAL INFORMATION

Name Janet Jessiman

Address 97 Arbour Ridge Hts NW

Apt _____ City Calgary Province AB Postal Code T3G 3Z2

Date of Birth May 18/56 Age 61 Sex: ~~F~~ Male ____ Female ✓

Home Tel: (403) 239-6747 Work or Cell (403) 816-3369

MEDICAL HISTORY

Do you have any health concerns ? ✓ No _____ Yes

If yes, please specify:

Do you have a history of:

- □ Asthma
- □ Frequent infections
- □ Hormone Imbalances
- □ Overweight/Obesity
- □ Heart Disease/pacemaker
- □ Epilepsy
- □ Rheumatoid Arthritis
- □ Cancer (type _____)
- ~~□~~ High Blood pressure
- □ Kidney Disease
- □ Bone Disease
- □ Intestinal Disorder
- □ Diabetes
- □ Thyroid problem
- □ HIV / AIDS
- □ Colitis
- □ Lupus
- □ Attention Deficit/Hyperactivity
- □ Mental Illness
- □ Other (_____)

Have you had any surgeries recently? Y_____ N ✓ Approximate date(s):_____

Current medications and supplements: Crestor.

Colesteral D vit, RHA, calcium

Applicable for Women:

Are you pregnant? ____ Yes ✓ No

Are you nursing? ____ Yes ____ No

LIFESTYLE – Nutrition / Exercise

How would you rate your current health? _____ Poor ___✓___ Average _____ Good

Has there been any change in your health in the last year? ___✓___ No ____Yes

If yes, please explain:

_____

Are you satisfied with you physical appearance? ___✓___ No _____ Yes.

What areas would you like to improve?

Mid Section.

How much weight and how many inches would you like to lose?

Weight _____ Inches _____

How often do you weigh yourself ? 3x w/k measure yourself ? _____

What programs have you tried in the past for weight loss?

Weight Watchers

Please describe your experience: good.

_____

Are you presently exercising? _____No ___✓___Yes

If Yes: How often do you exercise? daily.

What type of exercise? walking

Please rate your Fitness knowledge: _____ Excellent _____ Good ___✓___ Average _____Poor_____

Please explain: home always tried to keep active.

Are any other members of your household overweight? ___✓___ Yes _____ No

If Yes, which members? husband

_____

Please rate your Nutrition knowledge: _____Excellent_____ Good ___✓___ Average _____ Poor_____

Please explain_____

How often do you snack each day? 2 x midmorning mid afternoon.

What kinds of foods do you eat when you snack? egg, fruit, carbs in afternoon.

Do you find your work stressful? ___✓___No ____Yes

If Yes: Why? _____

Occupation: _____ Hours Worked Per Week: _____

Do you have Employer Health Insurance? ____No ___✓___Yes

If yes, which company? Mutual Life.

Do you smoke? ___✓___No ____Yes If yes, how often? _____

Do you drink alcohol? ____No ___✓___Yes If yes, how often? daily.

Do you drink coffee/tea? ____No ___✓___Yes If yes, which and how often? both morning coffee. Pm tea.

I, Janet Jessiman. affirm all the information on this form to be accurate and true to the best of my knowledge. I will not hold Dalewood Health Clinics or any of their staff responsible for any of my errors or omission.

Date: Feb 20/18 Client Signature _____

ALL INFORMATION IS HELD IN THE STRICTEST CONFIDENCE. PLEASE COMPLETE THIS HEALTH QUESTIONNAIRE IN AS MUCH DETAIL AS POSSIBLE AND RETURN IT TO THE DALEWOOD STAFF MEMBER.

THANK YOU.

DALEWOOD HEALTH & WELLNESS CENTRE

PERSONAL INFORMATION

Name Amber Lashinski

Address 534 - 25 Avenue NW

Apt _____ City Calgary Province AB Postal Code T2M 2A8

Date of Birth 08/18/1989 Age 28 Sex: _____ Male ✓ Female

Home Tel: ( ) _____ Work or Cell (403) 827 - 6893

MEDICAL HISTORY

Do you have any health concerns ? ____ No ✓ Yes

If yes, please specify:

Heart murmur (only restriction is no blood donation, avoid caffeine / alcohol)

Do you have a history of:

- ☑ Asthma
- ☐ Frequent infections
- ☐ Hormone Imbalances
- ☐ Overweight/Obesity
- ☐ Heart Disease/pacemaker
- ☐ Epilepsy
- ☐ Rheumatoid Arthritis
- ☐ Cancer (type _____)
- ☐ High Blood pressure
- ☐ Kidney Disease
- ☐ Bone Disease
- ☐ Intestinal Disorder
- ☐ Diabetes
- ☐ Thyroid problem
- ☐ HIV / AIDS
- ☐ Colitis
- ☐ Lupus
- ☐ Attention Deficit/Hyperactivity
- ☑ Mental Illness
- ☐ Other (_____)

Have you had any surgeries recently? Y_____ N ✓ Approximate date(s):_____

Current medications and supplements:

OMEGA 3, multi-vitamin, ~~et~~calcium, biotin, Vitamin D, maca root, ashwaghanda root / setraline, weilbutrin, birth control, 1 more

Applicable for Women:

Are you pregnant? ____ Yes ✓ No Are you nursing? ____ Yes ✓ No

Please rate your Nutrition knowledge: _____Excellent__✓__ Good _____ Average _____ Poor_____

Please explain_____

How often do you snack each day? ~~2/3~~ twice

What kinds of foods do you eat when you snack? fruit, cheese/crackers

Do you find your work stressful? __✓__No ____Yes

If Yes: Why? Recently changed jobs July 2017

Occupation: Office Administrator Hours Worked Per Week: 40

Do you have Employer Health Insurance? ____No __✓__Yes

If yes, which company? _____

Do you smoke? __✓__No ____Yes If yes, how often? _____

Do you drink alcohol? ____No __✓__Yes If yes, how often? 1 per week / two weeks

Do you drink coffee/tea? ____No __✓__Yes If yes, which and how often? _____

_____

I, [signature] Amber Lashinski affirm all the information on this form to be accurate and true to the best of my knowledge. I will not hold Dalewood Health Clinics or any of their staff responsible for any of my errors or omission.

Date: February 21 /2018 Client Signature [signature]

ALL INFORMATION IS HELD IN THE STRICTEST CONFIDENCE. PLEASE COMPLETE THIS HEALTH QUESTIONNAIRE IN AS MUCH DETAIL AS POSSIBLE AND RETURN IT TO THE DALEWOOD STAFF MEMBER.

THANK YOU.

DALEWOOD HEALTH & WELLNESS CENTRE

PERSONAL INFORMATION

Name Donna Kuhnen.

Address 622 - 8 AVE NE.

Apt _____ City Calgary. Province AB Postal Code T2E 0R6.

Date of Birth May 1. 1963 Age 54 Sex: ____ Male ✓ Female

Home Tel: (AB) 975. 8068. Work or Cell ( ) _____

MEDICAL HISTORY

Do you have any health concerns ? ____ No ✓ Yes

If yes, please specify:
Diabetes. in family. maternal Side (mom, grandma)
. High BP. for. 6 years. Circulation issues.

Do you have a history of:

- ☐ Asthma
- ☐ Frequent infections
- ☐ Hormone Imbalances
- ☑ Overweight/Obesity
- ☐ Heart Disease/pacemaker
- ☐ Epilepsy
- ☐ Rheumatoid Arthritis
- ☐ Cancer (type _____)
- ☑ High Blood pressure
- ☐ Kidney Disease
- ☐ Bone Disease
- ☐ Intestinal Disorder
- ☐ Diabetes
- ☐ Thyroid problem
- ☐ HIV / AIDS
- ☐ Colitis
- ☐ Lupus
- ☐ Attention Deficit/Hyperactivity
- ☑ Mental Illness Depression.
- ☐ Other (_____)

Have you had any surgeries recently? Y ✓ N _____ Approximate date(s): 2014. gallbladder.

Current medications and supplements:
High Blood Pressure Pills.
Anti Depressants.

Applicable for Women:

Are you pregnant? ____ Yes ✓ No Are you nursing? ____ Yes ✓ No

LIFESTYLE – Nutrition / Exercise

How would you rate your current health? _____ Poor ___✓___ Average _____ Good

Has there been any change in your health in the last year? ____ No ✓ Yes

If yes, please explain:

Weight gain - 15 lbs to 20 lbs.

Are you satisfied with you physical appearance? ✓ No _____ Yes.

What areas would you like to improve?

lose weight - tone muscles.

How much weight and how many inches would you like to lose?

Weight 40 lbs. Inches _____

How often do you weigh yourself ? once a month. measure yourself ? rarely.

What programs have you tried in the past for weight loss?

Jenny Craig, Weight Watchers, Gym, Isagenix

Please describe your experience: Jenny Craig very good first time lost 20 lbs

---

Are you presently exercising? ____No ✓Yes light exercise. hiking, walking.

If Yes: How often do you exercise? every day.

What type of exercise? _____

Please rate your Fitness knowledge: _____ Excellent ✓ Good _____ Average _____Poor_____

Please explain: years ago much more active. fit, hiking tennis, cycling.

Are any other members of your household overweight? ✓ Yes _____ No

If Yes, which members? partner.

Please rate your Nutrition knowledge: _____Excellent ✓ Good _____ Average _____ Poor_____

Please explain try to eat healthy · read labels.

How often do you snack each day? - evening's. mostly

What kinds of foods do you eat when you snack? salty, sweets.

Do you find your work stressful? ____No ✓ Yes

If Yes: Why? own business, still partner, just me to do the work.

Occupation: HR / Recruiter. Hours Worked Per Week: 50+

Do you have Employer Health Insurance? ____No ✓ Yes

If yes, which company? manulife.

Do you smoke? ✓ No ____Yes If yes, how often? _____

Do you drink alcohol? ____No ✓ Yes If yes, how often? once a month 2 drinks.

Do you drink coffee/tea? ____No ✓ Yes If yes, which and how often? coffee · twice a day.
green tea · once a day.

Donna Kuhnert.

I, _____ affirm all the information on this form to be accurate and true to the best of my knowledge. I will not hold Dalewood Health Clinics or any of their staff responsible for any of my errors or omission.

Date: Feb. 21. 2018 Client Signature _____

ALL INFORMATION IS HELD IN THE STRICTEST CONFIDENCE. PLEASE COMPLETE THIS HEALTH QUESTIONNAIRE IN AS MUCH DETAIL AS POSSIBLE AND RETURN IT TO THE DALEWOOD STAFF MEMBER.

THANK YOU.

DALEWOOD HEALTH & WELLNESS CENTRE

PERSONAL INFORMATION

Name Ameeta Sudan

Address 26 Harvest Park Way NE

Apt _____ City Calgary Province AB Postal Code T3K4K8

Date of Birth Feb. 21, 1981 Age 36 Sex: F Male ___ Female ✓

Home Tel: ( ) _____ Work or Cell (403) 305-7345

MEDICAL HISTORY

Do you have any health concerns ? X No ___ Yes

If yes, please specify:

Do you have a history of:

- ☐ Asthma
- ☐ Frequent Infections
- ☐ Hormone Imbalances
- ☒ Overweight/Obesity
- ☐ Heart Disease/pacemaker
- ☐ Epilepsy
- ☐ Rheumatoid Arthritis
- ☐ Cancer (type _____)
- ☐ High Blood pressure
- ☐ Kidney Disease
- ☐ Bone Disease
- ☐ Intestinal Disorder
- ☐ Diabetes
- ☐ Thyroid problem
- ☐ HIV / AIDS
- ☐ Colitis
- ☐ Lupus
- ☐ Attention Deficit/Hyperactivity
- ☒ Mental Illness
- ☒ Other (~~Thal~~ Thalassemia minor

Have you had any surgeries recently? Y ___ N X Approximate date(s): _____

Current medications and supplements:

Escitalopram 10 mg, Trazadone 100 mg, Bupropian 300 mg
Zopiclone 7.5 mg.

Applicable for Women:

Are you pregnant? ___ Yes X No Are you nursing? ___ Yes X No

LIFESTYLE – Nutrition / Exercise

How would you rate your current health? X Poor _____ Average _____ Good

Has there been any change in your health in the last year? ~~X~~ No X Yes

If yes, please explain:

gained a lot of weight

Are you satisfied with you physical appearance? X No _____ Yes.

What areas would you like to improve?

lose weight

How much weight and how many inches would you like to lose?

Weight: 100lbs Inches: _____

How often do you weigh yourself? not often measure yourself? never

What programs have you tried in the past for weight loss?

exercise and food changes.

Please describe your experience: hard

Are you presently exercising? _____ No X Yes

If Yes: How often do you exercise? 4-5 / week

What type of exercise? treadmill and weight training.

Please rate your Fitness knowledge: _____ Excellent _____ Good _____ Average X Poor _____

Please explain: just what I read

Are any other members of your household overweight? X Yes _____ No

If Yes, which members? mom

Please rate your Nutrition knowledge: ____Excellent ____ Good ____ Average ____ Poor X

Please explain Fruits and veggies are ok - bad portion sizes.

How often do you snack each day? 2 / day

What kinds of foods do you eat when you snack? chips and chocolate

Do you find your work stressful? X No ___ Yes

If Yes: Why? _____

Occupation: Nanny Hours Worked Per Week: 20-30

Do you have Employer Health Insurance? X No ___ Yes

If yes, which company? _____

Do you smoke? ___ No X Yes If yes, how often? 2 packs / week

Do you drink alcohol? ___ No X Yes If yes, how often? 1 / week

Do you drink coffee/tea? ___ No X Yes If yes, which and how often? Tea, one cup everyday

I, Ameeta Sudan affirm all the information on this form to be accurate and true to the best of my knowledge. I will not hold Dalewood Health Clinics or any of their staff responsible for any of my errors or omission.

Date: Feb, 12, 2018 Client Signature Sudan

ALL INFORMATION IS HELD IN THE STRICTEST CONFIDENCE. PLEASE COMPLETE THIS HEALTH QUESTIONNAIRE IN AS MUCH DETAIL AS POSSIBLE AND RETURN IT TO THE DALEWOOD STAFF MEMBER.

THANK YOU.

LIFESTYLE – Nutrition / Exercise

How would you rate your current health? _____ Poor ___✓___ Average _____ Good

Has there been any change in your health in the last year? ___✓___ No ____Yes

If yes, please explain:

_____

Are you satisfied with you physical appearance? ___✓___ No _____ Yes.

What areas would you like to improve?

_____ Weight _____

How much weight and how many inches would you like to lose?

Weight ___60lb___ Inches _____

How often do you weigh yourself ? ___daily___ measure yourself ? _____

What programs have you tried in the past for weight loss?

___Trym Gym good results, pills, drink_____

Please describe your experience: ~~Walk~~, 1/wk barre.

_____

Are you presently exercising? _____No ____Yes same

If Yes: How often do you exercise? _____

What type of exercise? ___Walk / 1 wk barre_____

Please rate your Fitness knowledge: _____ Excellent ___✓___ Good _____ Average _____Poor_____

Please explain:_____

Are any other members of your household overweight? ___✓___ Yes _____ No

If Yes, which members?___all.

_____

DALEWOOD HEALTH & WELLNESS CENTRE

4
4
2

Please rate your Nutrition knowledge: _____Excellent_____ Good ___✓___ Average _____ Poor_____

Please explain_____

How often do you snack each day? 1

What kinds of foods do you eat when you snack? bread / chip

Do you find your work stressful? ____No ___✓___Yes

If Yes: Why? busy / change / deadlines

Occupation: Ops Manager Hours Worked Per Week: 60

Do you have Employer Health Insurance? ____No ___✓___Yes

If yes, which company? Sunlife

Do you smoke? ___✓___No ____Yes If yes, how often? _____

Do you drink alcohol? ____No ___✓___Yes If yes, how often? 1/wk.

Do you drink coffee/tea? ____No ___✓___Yes If yes, which and how often? 2/day

---

I, Sharon Barrett affirm all the information on this form to be accurate and true to the best of my knowledge. I will not hold Dalewood Health Clinics or any of their staff responsible for any of my errors or omission.

Date: Feb 14 2018 Client Signature _____

ALL INFORMATION IS HELD IN THE STRICTEST CONFIDENCE. PLEASE COMPLETE THIS HEALTH QUESTIONNAIRE IN AS MUCH DETAIL AS POSSIBLE AND RETURN IT TO THE DALEWOOD STAFF MEMBER.

THANK YOU.

DALEWOOD HEALTH & WELLNESS CENTRE

PERSONAL INFORMATION

Name Carmen Chiu

Address 63 Edgeridge Terr. NW

Apt _____ City Calgary Province AB Postal Code T3A 6C3

Date of Birth June 4, 1991 Age 26 Sex: ~~M~~ Male X Female

Home Tel: ( ) _____ Work or Cell (587) 896-2084

MEDICAL HISTORY

Do you have any health concerns ? X No _____ Yes

If yes, please specify:

Do you have a history of:

- ☐ Asthma
- ☐ Frequent infections
- ☐ Hormone Imbalances
- ☐ Overweight/Obesity
- ☐ Heart Disease/pacemaker
- ☐ Epilepsy
- ☐ Rheumatoid Arthritis
- ☐ Cancer (type _____)
- ☐ High Blood pressure
- ☐ Kidney Disease
- ☐ Bone Disease
- ☐ Intestinal Disorder
- ☐ Diabetes
- ☐ Thyroid problem
- ☐ HIV / AIDS
- ☐ Colitis
- ☐ Lupus
- ☐ Attention Deficit/Hyperactivity
- ☐ Mental Illness
- ☐ Other (_____)

Have you had any surgeries recently? Y X N _____ Approximate date(s): June, 2017 Laser Eye surgery

Current medications and supplements:

Birth Control,

Applicable for Women:

Are you pregnant? _____ Yes X No Are you nursing? _____ Yes X No

LIFESTYLE – Nutrition / Exercise

How would you rate your current health? _____ Poor __X__ Average _____ Good

Has there been any change in your health in the last year? __X__ No ____Yes

If yes, please explain:

_____

Are you satisfied with you physical appearance? ____ No __X__ Yes.

What areas would you like to improve?

overall, yes. However, I would like to fit into my old clothes and change my overall lifestyle habits!

How much weight and how many inches would you like to lose?

Weight ~~BA lbs~~ 45 lbs Inches not sure

How often do you weigh yourself ? _____ measure yourself ? n/a

What programs have you tried in the past for weight loss?

nothing official. I did try 21 day Fix and lost 12 lbs in 2015

Please describe your experience: overall very good

_____

Are you presently exercising? _____No __X__Yes

If Yes: How often do you exercise? 5x/week

What type of exercise? fitness classes – HIIT, bootcamp, circuit training

Please rate your Fitness knowledge: _____ Excellent _____ Good __X__ Average ~~__X__~~ Poor_____

Please explain: I workout regularly but need to focus more on diet.

Are any other members of your household overweight? _____ Yes __X__ No

If Yes, which members?_____

_____

PERSONAL INFORMATION

Name Faith Jahelka

Address 103 Noble Ave

Apt _____ City Red Deer Province AB Postal Code T4P 2H4

Date of Birth Sept 12/51 Age 66 Sex: ___ Male ✓ Female

Home Tel: (403) 755 0966 Work or Cell ( ) _____

MEDICAL HISTORY

Do you have any health concerns ? ____ No ✓ Yes

If yes, please specify:
Knees, Sinus / Allergy to cleaning chemicals

Do you have a history of:

- ☐ Asthma
- ☐ Frequent infections
- ☐ Hormone Imbalances
- ☒ Overweight/Obesity Since Menopause
- ☐ Heart Disease/pacemaker
- ☐ Epilepsy
- ☐ Rheumatoid Arthritis
- ☐ Cancer (type _____)
- ☐ High Blood pressure
- ☐ Kidney Disease
- ☐ Bone Disease
- ☐ Intestinal Disorder
- ☐ Diabetes
- ☐ Thyroid problem
- ☐ HIV / AIDS
- ☐ Colitis
- ☐ Lupus
- ☐ Attention Deficit/Hyperactivity
- ☐ Mental Illness
- ☐ Other (_____)

Have you had any surgeries recently? Y_____ N ✓ Approximate date(s):_____

Current medications and supplements:
Calcium, Vit D, Mg, Multivitamin, Glucosamine, Chelated Omega 3/6/9

Applicable for Women:

Are you pregnant? ____ Yes ✓ No Are you nursing? ____ Yes ✓ No

LIFESTYLE – Nutrition / Exercise

How would you rate your current health? _____ Poor ___/___ Average _____ Good

Has there been any change in your health in the last year? ___/___ No ____Yes

If yes, please explain:

_____

Are you satisfied with you physical appearance? ___/___ No _____ Yes.

What areas would you like to improve?

Weight loss - Muscle improvement

How much weight and how many inches would you like to lose?

Weight at least 40 lbs Inches ?

How often do you weigh yourself ? varies measure yourself ? rarely

What programs have you tried in the past for weight loss?

Jenny Craig / La Weight Loss

Please describe your experience: Jenny Craig - lost weight but food was enough to go on LA Weight Loss - went out of business so end of that

Are you presently exercising? ___X___ No ____Yes

If Yes: How often do you exercise? occ

What type of exercise? mostly walking occ biking

Please rate your Fitness knowledge: _____ Excellent _____ Good _____ Average ___X___ Poor_____

Please explain:_____

Are any other members of your household overweight? ___X___ Yes _____ No

If Yes, which members? Spouse

PERSONAL INFORMATION

Name Faith Jahelka

Address 103 Noble Ave

Apt _____ City Red Deer Province AB Postal Code T4P 2H4

Date of Birth Sept 12/51 Age 66 Sex: F Male ___ ✓ Female

Home Tel: (403) 755 0966 Work or Cell ( ) _____

MEDICAL HISTORY

Do you have any health concerns ? ____ No ✓ Yes

If yes, please specify:
Knees, Sinus / Allergy to cleaning chemicals

Do you have a history of:

- ☐ Asthma
- ☐ Frequent infections
- ☐ Hormone Imbalances
- ☒ Overweight/Obesity Since Menopause
- ☐ Heart Disease/pacemaker
- ☐ Epilepsy
- ☐ Rheumatoid Arthritis
- ☐ Cancer (type _____)
- ☐ High Blood pressure
- ☐ Kidney Disease
- ☐ Bone Disease
- ☐ Intestinal Disorder
- ☐ Diabetes
- ☐ Thyroid problem
- ☐ HIV / AIDS
- ☐ Colitis
- ☐ Lupus
- ☐ Attention Deficit/Hyperactivity
- ☐ Mental Illness
- ☐ Other (_____)

Have you had any surgeries recently? Y_____ N X Approximate date(s):_____

Current medications and supplements:
Calcium, Vit D, Mg, Multivitamin, Glucosamine, Chelated Omega 3/6/9

Applicable for Women:

Are you pregnant? ____ Yes ✓ No Are you nursing? ____ Yes ✓ No

PERSONAL INFORMATION

Name Michelle De Groot

Address 267 Stage Coach Lane

Apt _____ City Rocky View MD Province AB Postal Code T2A 0P2

Date of Birth Nov 6, 1971 Age 46 Sex: ____ Male ____ (Female)

Home Tel: (403) 730-6116 Work or Cell (403) 617-8469

MEDICAL HISTORY

Do you have any health concerns ? ____ No ✓ Yes

If yes, please specify: Lack of energy
Hair loss

Do you have a history of:

- ☐ Asthma
- ☐ Frequent Infections
- ☐ Hormone Imbalances
- ☐ Overweight/Obesity
- ☐ Heart Disease/pacemaker
- ☐ Epilepsy
- ☐ Rheumatoid Arthritis
- ☐ Cancer (type _____)
- ☐ High Blood pressure
- ☐ Kidney Disease
- ☐ Bone Disease
- ☐ Intestinal Disorder
- ☐ Diabetes
- ☐ Thyroid problem ?
- ☐ HIV / AIDS
- ☐ Colitis
- ☐ Lupus
- ☐ Attention Deficit/Hyperactivity
- ☐ Mental Illness
- ☐ Other _____

Have you had any surgeries recently? Y ____ (N) Approximate date(s): _____

Current medications and supplements:

Multi Vitamins, Fish Oils

Applicable for Women:

Are you pregnant? ____ Yes ____ (No) Are you nursing? ____ Yes ____ (No)

LIFESTYLE – Nutrition / Exercise

How would you rate your current health? ____ Poor ✓ Average ____ Good

Has there been any change in your health in the last year? ✓ No ____ Yes

If yes, please explain:

Are you satisfied with you physical appearance? ✓ No ____ Yes.

What areas would you like to improve?

Lose Weight, Tighten Flab

How much weight and how many inches would you like to lose?

Weight 40-50 lbs Inches 7

How often do you weigh yourself? 1/month measure yourself? never

What programs have you tried in the past for weight loss?

Herbal Magic

Please describe your experience: Worked well Lost 30 pounds but gained it all back

Are you presently exercising? (No) ____ Yes

If Yes: How often do you exercise? ____

What type of exercise? ____

Please rate your Fitness knowledge: ____ Excellent ____ Good ____ Average ✓ Poor ____

Please explain: ____

Are any other members of your household overweight? (Yes) ____ No

If Yes, which members? Husband

Please rate your Nutrition knowledge: ____Excellent ____Good ____Average ✓ Poor ____

Please explain ____

How often do you snack each day? several times

What kinds of foods do you eat when you snack? cookie, sometimes fruit, cheese

Do you find your work stressful? ____No ____Yes

If Yes: Why? ____

Occupation: Home Maker - Mother of 8 children Hours Worked Per Week: ____

Do you have Employer Health Insurance? + No ____Yes

If yes, which company? ____

Do you smoke? + No ____Yes If yes, how often? ____

Do you drink alcohol? ____No x Yes If yes, how often? 1-2 times per week

Do you drink coffee/tea? ____No ✓ Yes If yes, which and how often? coffee - 4/5 cups per day tea 1-2 cups per day - generally herbal tea.

I, Michelle De Groot affirm all the information on this form to be accurate and true to the best of my knowledge. I will not hold Dalewood Health Clinics or any of their staff responsible for any of my errors or omission.

Date: Jan. 11, 2018 Client Signature M. DeGroot

ALL INFORMATION IS HELD IN THE STRICTEST CONFIDENCE. PLEASE COMPLETE THIS HEALTH QUESTIONNAIRE IN AS MUCH DETAIL AS POSSIBLE AND RETURN IT TO THE DALEWOOD STAFF MEMBER.

THANK YOU.

PERSONAL INFORMATION

Name Joyce Franke

Address 120 300 Chinook Winds Place SW

Apt _____ City Airdrie Province AB Postal Code T4B 4B7

Date of Birth Sept. 18/64 Age 53 Sex: ☐ Male ✓ Female

Home Tel: (403) 948-4091 Work or Cell (403) 999-8736

MEDICAL HISTORY

Do you have any health concerns ? ✓ No ____ Yes

If yes, please specify:

Do you have a history of:

- ☐ Asthma
- ☐ Frequent Infections
- ☐ Hormone Imbalances
- ☐ Overweight/Obesity
- ☐ Heart Disease/pacemaker
- ☐ Epilepsy
- ☐ Rheumatoid Arthritis
- ☐ Cancer (type _____)
- ☐ High Blood pressure
- ☐ Kidney Disease
- ☐ Bone Disease
- ☐ Intestinal Disorder
- ☐ Diabetes
- ☐ Thyroid problem
- ☐ HIV / AIDS
- ☐ Colitis
- ☐ Lupus
- ☐ Attention Deficit/Hyperactivity
- ☐ Mental Illness
- ☐ Other (_____)

Have you had any surgeries recently? Y ✓ N ____ Approximate date(s): June

Current medications and supplements: Arthrotec, Glucosamine, Calcium D3

Applicable for Women:

Are you pregnant? ____ Yes ✓ No

Are you nursing? ____ Yes ____ No

LIFESTYLE – Nutrition / Exercise

How would you rate your current health? ____ Poor ✓ Average ____ Good

Has there been any change in your health in the last year? ✓ No ____ Yes

If yes, please explain:

Are you satisfied with you physical appearance? ✓ No ____ Yes.

What areas would you like to improve?

Lose weight - Tone

How much weight and how many inches would you like to lose?

Weight 30 lbs Inches ____

How often do you weigh yourself? daily measure yourself? ____

What programs have you tried in the past for weight loss?

Dr. Bernstein - Weight watchers - LA Weight Loss.

Please describe your experience: positive - but lifestyle changed + put weight back on.

Are you presently exercising? ____ No ____ Yes not as consistently.

If Yes: How often do you exercise? 2x/wk

What type of exercise? treadmill

Please rate your Fitness knowledge: ____ Excellent ____ Good ____ Average ✓ Poor

Please explain: ____

Are any other members of your household overweight? ____ Yes ____ No

If Yes, which members? ____