PATIENT MOTIVATION PROFILE

Metagenics
Genetic Potential Through Nutrition

Name: ____________________ **Date:** ____________________

Your Practitioner has asked you to fill in this questionnaire to help determine why you have come to this clinic, what your health priorities are and what you expect from your treatment program. The information you provide in this questionnaire will help your Practitioner formulate a treatment plan specifically designed to help you achieve your health goals.

1. List your top three priorities in life.

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2. What are your top three health goals?

Health goal	**Time frame to achieve** (please note the time by which you hope to achieve this health goal – e.g. 3 months, 6 months)

3. What has stopped you from achieving your health goals in the past? Examples might include lack of time, support or money. Do you think these factors, or anything else may stop you from achieving your current health goals?

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4. Consider what has helped inspire and motivate you to make significant life changes in the past. What might help inspire and motivate you to achieve your current health goals? Examples may include encouragement from your family or friends, a special event such as a wedding or birth of a child, or your current state of health. Please comment on how and why these motivate you.

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5. Please rate the following on a scale of 1 (poor) to 5 (excellent). Please comment on why you have given this rating.

	1	2	3	4	5	Comments
General health and wellbeing	☐	☐	☐	☐	☐	
Overall quality of your diet	☐	☐	☐	☐	☐	
Sense of calm and relaxation	☐	☐	☐	☐	☐	
Quality and quantity of sleep	☐	☐	☐	☐	☐	
Exercise and general activity levels	☐	☐	☐	☐	☐	

6. To improve your health and wellbeing, you may be asked to make some changes to your diet and/or lifestyle. If requested by your Practitioner, how willing would you be to do the following? Please rate on a scale of 1 (not willing at all) to 5 (extremely willing). Please comment on why you have given this rating.

	1	2	3	4	5	Comments
Significantly modify your diet	☐	☐	☐	☐	☐	
Keep a record of everything you eat each day	☐	☐	☐	☐	☐	
Engage in regular exercise/activity	☐	☐	☐	☐	☐	
Alter your work patterns	☐	☐	☐	☐	☐	
Practice relaxation technique(s) on a regular basis	☐	☐	☐	☐	☐	
Modify your sleep habits	☐	☐	☐	☐	☐	
Take nutritional and/or herbal supplements each day	☐	☐	☐	☐	☐	
Have periodic consultations to assess your progress	☐	☐	☐	☐	☐	

7. With your Practitioner's guidance and support, how confident are you in your ability to follow through on the above activities? Please rate on a scale of 1 (not confident at all) to 5 (extremely confident).

	1	2	3	4	5	Comments
Confidence	☐	☐	☐	☐	☐	

8. How supportive do you think your family and friends will be in helping you implement the above changes? Please rate on a scale of 1 (not supportive at all) to 5 (extremely supportive).

	1	2	3	4	5	Comments
Support	☐	☐	☐	☐	☐	

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