Patient Motivation Profile

Name: **Date:**

Your practitioner Virginia has asked you to fill in this questionnaire to help determine why you have come to Virginia's Apothecare, what your health priorities are and what you expect from your treatment program. Please answer all questions as honestly as you can and provide as much information as you can. The information you provide in this questionnaire will help your Practitioner Virginia formulate a treatment plan specifically designed to help you achieve your health goals.

1. **List your top three priorities in life.**
   a.

   b.

   c.

2. **What three health goals can we help you achieve? How long do you think it might take you to achieve these health goals?**

Health Goal	Time frame to achieve

3. **Has anything stopped you from achieving your health goals in the past? Examples of things that could stop you achieving your health goals include not enough time, lack of support or not enough money. Do you think any of these may stop you from achieving your current health goals?**

4. **What has helped motivate and inspire you to make significant life changes in the past and /or what could help motivate and inspire you to make changes now? Examples may be your family or friends, a 'health scare' or a special event such as a wedding or birth of a child. Please comment on how/why these motivate you.**

Health goal achieved	Time frame to achieve

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 &wellbeing	☐	☐	☐	☐	☐	
Quality of your diet	☐	☐	☐	☐	☐	
Sense of calm &relaxation	☐	☐	☐	☐	☐	
Quality & quantity of sleep	☐	☐	☐	☐	☐	
Exercise & 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 Virginia, 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	☐	☐	☐	☐	☐	
Record everything you eat each day	☐	☐	☐	☐	☐	
Engage in regular exercise/ activity	☐	☐	☐	☐	☐	
Alter your work patterns	☐	☐	☐	☐	☐	
Practice relaxation techniques on a regular basis	☐	☐	☐	☐	☐	
Modify your sleep habits	☐	☐	☐	☐	☐	
Take nutritional and/or herbal supplements each day	☐	☐	☐	☐	☐	
Have periodic consultations to access your progress	☐	☐	☐	☐	☐	

7. **With our 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 ☐ ☐ ☐ ☐ ☐