**Wellness Questionnaire**

Personal Information

Name age birth date Address home phone# cell#

Email place of birth single/married Height Weight children pets

Health Information

Please list your health concerns:

Please explain any illnesses/injuries:

Parents’ health: Mom alive or deceased (date & age)

 Father alive or deceased (date & age) Blood type: Date of your last physical with a doctor: Explain how you do the “healthy you” suggestions for routine screenings - annual physicals, mammograms and pap tests or prostrate screenings, 6 month dental cleanings and exams, along with prescribed use of vitamins and supplements. Do you follow treatments recommended by your conventional medical care providers as well as recommended complementary approaches such as but not limited to acupuncture, osteopathy, massage, hypnosis etc…

 Describe your sleep:

# hours of sleep: Explain any pain, stiffness, inflammation:

Explain any gastrointestinal troubles – constipation/diarrhea/gas… etc:

List any food/substance sensitivities/allergies and reactions:

Female – periods regular? # of flow days frequency any trouble?

List current medications and/or supplements taking and why:

Lifestyle Information

Explain your physical activity – activities of daily living like cleaning and gardening as well as dancing, yoga, walking, running, weight training, cycling, etc: type: frequency:

How is your personal and/or professional development – are you growing and developing your own abilities, talents, and interests, both in “being” and “doing” as well as living with a balance:

Sources of stress:

Your reactions to stress:

Ways you have tried to manage stress:

Explain your relationships and communication situations and/or challenges – do you spend time with family, friends and/or co-workers who are supportive and with whom you can communicate freely and effectively:

Explain your spirituality – are you seeing purpose and meaning in something larger than one’s self; may include religious affiliation or other areas such as nature or the arts:

Food/Drink Intake

Describe your typical time consumed

 breakfast:

 lunch:

 dinner:

 snacks:

 drinks:

What reactions do you expect from your family/friends in your desire to make food and/or lifestyle changes?

How do you feel about resting and/or relaxation?

Describe your intake challenges (food cravings, cigarettes, alcohol, drugs etc.):

Are there any other concerns that you would like to share?