

Wellness Survey

Name _____ Male ____ or Female ____ Age _____

Name of Parent/Guardian if filling out for a minor: _____

Address: _____ City: _____

State: _____ Zip: _____ Phone Number: _____

E-mail: _____

Nutritional / Activity Assessment

- | | | | | |
|---|-----|--------|--------|-------|
| 1. Do you take a multivitamin? | Yes | No | | |
| 2. Do you exercise on a regular basis? | Yes | No | | |
| 3. Do you watch TV daily? | Yes | No | | |
| 4. Do you eat 4-5 servings of vegetables daily? | Yes | No | | |
| 5. Do you eat 2-3 servings of fruit per day? | Yes | No | | |
| 6. Do you drink 6-8 cups of water per day? | Yes | No | | |
| 7. Do you drink pop or energy drinks? | No | Rarely | Weekly | Daily |
| 8. Do you eat packaged/processed snacks daily? | Yes | No | | |
| 9. Do you have a bowel movement daily? | Yes | No | | |
| 10. Do you take antibiotics frequently? | Yes | No | | |
| 11. Do you take any prescription medication? | Yes | No | | |

Do you have any symptoms or are you concerned about any of the following?

- Acid Reflux
- Acne
- Anxious
- Attention
- Allergies
- Asthma
- Blood Sugar Maintenance
- Cancer
- Constipation
- Decreased Sex Drive
- Defiant
- Diarrhea
- Digestive Issues
- Difficulty with Texture
- Dislike Change in Their Routine
- Ear Infections
- Eczema
- Episodes of Rage
- Fears/Phobias
- Food Allergies
- Frequent Flu/Colds
- Frequent Heart Burn
- Frequent Nightmares
- Fidgety

- Headaches/Migraines
- Heart Health
- Hyperactivity
- Low Energy
- Indigestion
- Infertility
- In Trouble Frequently
- Impulsive
- Itches Frequently
- Joint Pain
- Mood Swings
- Muscle Cramps
- Negative Self-Talk
- Pain/Inflammation
- Pervasive Development Disorder
- Picky Eater
- PMS/Cramps
- Poor Sleep
- Poor Dental Health
- Postpartum Struggles
- Puts Self Down Frequently
- Restless Leg
- Risk Taking Behaviors
- Sadness
- Sensory Difficulties
- Separation Anxiety
- Sinus Difficulties
- Sleep Difficulties
- Social Anxiety
- Social Difficulties
- Stomach Aches/Pain
- Stress
- Thought of Suicide
- Weight Concerns
- Worries Easily or Frequently

If there was one thing you could change about your health today or prevent in the future, what would it be?

Any other comments:

We are lucky to have wonderful trainings in your area. Would you like to be added to an e-mail list for wellness education and seminars? Yes No