WELLNESS EVOLUTIONS

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GENERAL INFORMATION

All questions contained in this questionnaire are strictly confidential and will become part of your medical record.

Name:				Height:	Weight:
Preferred Name:			Date:		
Age:	Day of birth		Place of birth:		
Gender: ☐ Male ☐ Female	Marital Status: ☐ Single ☐ Partnered	☐ Married ☐ Separated	☐ Divorced ☐ Widowed		
Occupation:	Hours per week:		Date of last physical exam:		
Address:					
City:	State:	Zip Code:	Home Phone:		
Work Phone:	Cell Phone:		E-mail:		
Nex of kin or other to reach in an emergency:					
Relationship:	Phone:		Address:		
GENETIC BACKGROUND: Please check appropiated box (es):					
☐ African American	☐ Hispanic	☐ Mediterranean	☐ Asian		
☐ Native American	☐ Caucasian	☐ Northern European	☐ Other		
What's your primary medical physician?					
Primary medical physician address & office phone #:					
How did you hear about our clinic?	☐ Book	☐ Website	☐ Friend/Family member	☐ Other	
Describe:					
☐ Other Hospitalizations	☐ Have you ever had a blood transfusion?	☐ Yes ☐ No			

PERSONAL HEALTH HISTORY

Childhood Illness:	☐ Measles ☐ Mumps ☐ Rubella ☐ Chicken Pox ☐ Rheumatic Fever ☐ Polio
Immunization and dates:	☐ Tetanus ☐ Pneumonia ☐ Hepatitis ☐ Shingles ☐ Chicken Pox ☐ Influenza ☐ MMR *Measles Mumps Rubella*

List any medical problems that other doctors have diagnosed

SURGERIES

Year	Reason	Hospital

OTHER HOSPITALIZATIONS

Year	Reason	Hospital

FUNCTIONAL DIAGNOSTIC MEDICINE QUESTIONAIRE

Please indicate the type of medications you are taking now (prescription and non-prescription drugs)

Medication Name	Dose	Frequency	Date Started	Reason for Use

Supplements: List all vitamins, minerals and other nutritional supplements

Supplement Brand/Name	Dose	Frequency	Dated Started	Reason for Use

Have for medications or supplements ever caused you unusual side effects or problems?

Yes ____ No ____ If yes, please describe:

ALLERGIES

Medication / Supplement / Food	Reaction

FUNCTIONAL DIAGNOSTIC MEDICINE QUESTIONNAIRE

Please complete the following functional medicine questionnaire to the best of your ability. You may need family members to help supply information. Your thoroughness and accuracy in answering all appropriate questions will help the doctor evaluate the root cause of your health concerns and determine an effective treatment program.

COMPLAINTS / CONCERNS

Please list your chief symptoms in order of decreasing severity, starting with the worst one.

Problem	On set	Frequency	Severity
1.			
2.			
3.			
4.			
5.			
6.			
7.			

What diagnosis or explanation was given to you?

When was the last time that you felt well?

Did something trigger your change in health?

What makes you feel **worse**?

What makes you feel **better**?

Please all physicians you have seen for the above health conditions:

1.	4.
2.	5.
3.	6.

Please check all the Alternative Treatments you have tried for your condition (s):

☐ None	☐ Massage	☐ Yoga	☐ Environmental Medicine
☐ Chiropractic	☐ Rolfing	☐ Hypnosis	☐ Nutritional Therapy
☐ Acupuncture	☐ Reiki	☐ Ayurveda	☐ Biological Dentistry
☐ Iridology	☐ Homeopathy	☐ Light Therapy	☐ IV (Chelation) Therapy
☐ Colonics	☐ Biofeedback	☐ Meditation	☐ Naturopathic Medicine

FEMALE MEDICAL HISTORY (FOR WOMEN ONLY)

OBSTETRICAL HISTORY

Check box if yes and provide number of

☐ Pregnancies	☐ Caesarean	☐ Vaginal Deliveries
☐ Miscarriage	☐ Abortion	☐ Living Children
☐ Post-partum Depression	☐ Toxemia	☐ Gestational Diabetes
☐ Baby Over 8 pounds	☐ Breast feeding for how long?	

GYNECOLOGYCAL HISTORY

Age at first period:	Menses Frequency:	Length:	Pain: ☐ Yes ☐ No
Clotting: ☐ Yes ☐ No	Has your period skipped? ☐ Yes ☐ No	For how long?	
Last Menstrual Period:			
Do you currently use contraception: ☐ Yes ☐ No If yes, what type do you use?			
☐ Condom	☐ Diaphragm	☐ IUD	☐ Partner Vasectomy
Have you ever used hormonal contraception? ☐Yes ☐ No If yes, when?			
Use of hormonal contraception:	☐Birth Control Pills	☐ Patch	☐ NuvaRing How long?
Are you using the pill now? ☐Yes ☐ No	Did taking the pill agree with you? ☐ Yes ☐ No		
In the 2nd half of your cycle, do you have symptoms of breast tenderness, water retention or irritability (PMS)? ☐ Yes ☐ No			
Last Mammogram	Breast Biopsy/Date?		
Last PAP Test:	Normal	Abnormal	
Date Of Last Bone Density:	Results: ☐ High ☐ Low ☐ Within normal range		
Are you in Menopause? ☐ Yes ☐ No	Age at Menopause:		

Do you Take:	☐ Estrogen	☐ Ogen	☐ Estrace	☐ Premarin	☐ Other:
	☐ Progesterone	☐ Provera	☐ Other:		
How long have you been on hormonal replacement?					

MALE MEDICAL HISTORY (FOR MEN ONLY)

Question	
Do you usually get up to urinate during the night?	☐ Yes ☐ No
If yes, number of times	
Do you feel pain or burning during the urination?	☐ Yes ☐ No
Any blood in your urine	☐ Yes ☐ No
Do you feel burning discharge from penis?	☐ Yes ☐ No
Has the force of your urination decreased?	☐ Yes ☐ No
Have you had any kidney, bladder or prostate infections within the last 12 months?	☐ Yes ☐ No
Do you have any problems emptying your bladder completely?	☐ Yes ☐ No
Any difficulty with erection or ejaculation?	☐ Yes ☐ No
Any testicle pain or swelling?	☐ Yes ☐ No
Date of last or prostate exam:	☐ Yes ☐ No

PAST MEDICAL AND FAMILY HISTORY

Please mark any health problem (s) you or your family has suffered either with now or in the past

Check family members that apply	Father	Mother	Brothers (s)	Sister (s)	Children	Maternal Grandmother	Maternal Grandfather	Paternal Grandmother	Paternal Grandfather	Aunts	Uncles	Self
Age (if still alive)												
Age at death (if deceased)												
Heart Attack												
Stroke												
Uterine Cancer												
Colon Cancer												
Breast Cancer												
Ovarian Cancer												
Prostate Cancer												
Skin Cancer												
ADD/ADHD												
ALS or Other Motor Neuron Diseases												
Alzheimer’s												
Anemia												
Anxiety												
Arthritis												
Asthma												
Autism												
Autoimmune Diseases (like Lupus)												
Bipolar Disease												
Bladder Disease												
Blood Clotting Problems												
Celiac Disease												
Dementia												
Depression												
Diabetes												
Eczema												
Emphysema												
Environmental Sensitivities												
Epilepsy												
Flu												
Food Allergies, Sensitivities, Intolerances												
Genetic Disorders												

Glaucoma												
Headache												
Heart Disease												
High Blood Pressure												
High Cholesterol												
Inflammatory Diseases (Rheumatoid, Psoriatic, Ankylosing Spondylitis)												
Inflammatory Bowel Disease												
Insomnia												
Irritable Bowel Syndrome												
Kidney Disease												
Multiple Sclerosis												
Nervous Breakdown												
Obesity												
Osteoporosis												
Other												
Parkinson’s												
Pneumonia / Bronchitis												
Psoriasis												
Psychiatric Disorder												
Schizophrenia												
Sleep Apnea												
Smoking Addiction												
Stroke												
Substance Abuse (such as Alcoholism)												
Ulcers												

Any other family we should know about? ☐ Yes ☐ No. If yes, please comment.

____

____

____

____

What is your attitude or those close to you about your illness? ☐ Supportive ☐ Non-supportive.

SOCIAL HISTORY

PSYCHOSOCIAL

Do you feel significantly less vital than you did a year ago?	☐ Yes ☐ No
Are you happy?	☐ Yes ☐ No
Do you feel your life has meaning and purpose?	☐ Yes ☐ No
Do you believe stress is presently reducing the quality of your life?	☐ Yes ☐ No
Do you like the work you do?	☐ Yes ☐ No
Have you experienced major loses in your life?	☐ Yes ☐ No

Question	Answer
Do you spend the majority of your time and money to fulfill responsibilities and obligations?	☐ Yes ☐ No

MENTAL HEALTH

Question	Answer
Is a stress a major problem for you?	☐ Yes ☐ No
Do you feel depressed?	☐ Yes ☐ No
Do you panic when stressed?	☐ Yes ☐ No
Do you have problems with eating or your appetite	☐ Yes ☐ No
Do you cry frequently?	☐ Yes ☐ No
Do you ever attempted suicide?	☐ Yes ☐ No
Have you ever seriously thought about hurting yourself?	☐ Yes ☐ No
Do you have trouble sleeping?	☐ Yes ☐ No
Have you ever been to a counselor?	☐ Yes ☐ No
Do you frequently experience anxiety?	☐ Yes ☐ No
Do you suffer from mood swings?	☐ Yes ☐ No
Do you have difficulty getting motivated?	☐ Yes ☐ No
Do you frequently experience feelings of agitation, anger, fear, or worry?	☐ Yes ☐ No
Do you have a family history of divorce as you were growing up?	☐ Yes ☐ No
Do you have a childhood history or any history of trauma in your past (such as rape, violence, natural disaster, bullying)? If yes, describe:	☐ Yes ☐ No
Were there any substance abuse problems in your family as you grew up? If yes, describe	☐ Yes ☐ No
When you were growing up, did anyone in the family, including a parent, suffer from a chronic disease, or a mental disease? If yes, describe:	☐ Yes ☐ No
Overall, did you feel safe as a child and securely bonded to your parents? Did you feel you could completely trust your parents/parent to take care of you?	☐ Yes ☐ No

STRESS AND LIFESTLYE

Question	Answer
Do you feel overlay stressed most days?	☐ Yes ☐ No
Do you feel less able to handle stress or experience more stress now than in the past?	☐ Yes ☐ No

Check off from this list the things you do to handle daily stress:

☐ Exercise	☐ Regular Vacations	☐ Play with pets
☐ Baths/Jacuzzi/Saunas	☐ Comfort Eat / Cook	☐ Get body work (massages, facials, etc)

☐ Long walks / Hikes / Nature	☐ Talk with family / Friends	☐ Other:
☐ Read	☐ Watch tv / Movies	
☐ Meditate / Yoga / Taiichi	☐ Sleep	
Are you having any sexual problems?		☐ Yes ☐ No

DIET AND GASTROINTESTINAL HEALTH

Do you consume at least five servings of fruits and vegetables per day?	☐ Yes ☐ No
Are you on any structured diet at this time?	☐ Yes ☐ No
Have you dieted many times in the past? If yes, what diets were you on?	☐ Yes ☐ No
Are you dieting now? If yes, what is it?	☐ Yes ☐ No
# of meals you eat in an average day__________________	
Do you regularly consume alcohol and caffeine? If yes, how much caffeine and/or alcohol do you drink per day?	☐ Yes ☐ No
How many cups of regular coffee do you drink per day?	
Do you drink mostly ____wine ____beer ____hard liquor?	
Are you prone to "binge" drinking?	☐ Yes ☐ No
Do you drive after drinking?	☐ Yes ☐ No
Do you drink at least 4-6 glasses of water per day?	☐ Yes ☐ No
Have you ever been diagnosed with a chronic GI condition?	☐ Yes ☐ No
Do you typically snack on chips, cookies, crackers or granola bars?	☐ Yes ☐ No
Do you regularly consume soft drinks or fruit juices?	☐ Yes ☐ No
How many regular sodas do you consume per day?	
Do you have frequent sugar cravings?	☐ Yes ☐ No
Do you eat within three hours of bedtime?	☐ Yes ☐ No
Do you regularly eat at restaurants or consume prepared foods from the grocery store?	☐ Yes ☐ No
Do you experience frequent heartburn, burping, gas, pain, constipation/diarrhea, or bloating?	☐ Yes ☐ No
Do you regularly have less than one or more than three bowel movements per day?	☐ Yes ☐ No
Do you take a laxative more than twice a month?	☐ Yes ☐ No
Have you used antibiotic medications within the last two years?	☐ Yes ☐ No
Do you consume alcohol, antacids or anti-inflammatory/pain killer drugs regularly?	☐ Yes ☐ No
Has there been a period when you consumed more alcohol that you presently do?	☐ Yes ☐ No
Have you ever been diagnosed with anemia or any other nutrient deficiency?	☐ Yes ☐ No
Have you ever been placed on a heartburn medication (proton pump inhibitor (PPI) or H2 blocker?	☐ Yes ☐ No
Do you frequently experience indigestion?	☐ Yes ☐ No
Have you ever been diagnosed with chronic fatigue syndrome, fibromyalgia or irritable bowel syndrome?	☐ Yes ☐ No
Do you experience poor memory, difficulty concentrating or brain fog?	☐ Yes ☐ No
Have you ever been diagnosed with depression, anxiety, ADD or ADHD?	☐ Yes ☐ No
Do you suffer from multiple food sensitivities?	☐ Yes ☐ No

Do you experience skin issues such as acne, rosacea or eczema?	☐ Yes ☐ No

OVERALL IMMUNE AND INFLAMMATORY BALANCE

Question	Answer
Do you tend to catch colds and respiratory diseases easily or recover slowly from illness?	☐ Yes ☐ No
Have you been diagnosed with a recent or chronic infection (such as Lyme disease, Epstein-Barr, Candidiasis, and Herpes Simplex)?	☐ Yes ☐ No
Do you have unexplained rashes, redness or itching?	☐ Yes ☐ No
Do you suffer from chronic fatigue, chronic pain, fibromyalgia or migraine headaches?	☐ Yes ☐ No
Do you suffer from any auto-immune condition such as MS, lupus, or rheumatoid arthritis?	☐ Yes ☐ No
Do you suffer from food allergies and seasonal allergies?	☐ Yes ☐ No
Do you suffer from hives, eczema or psoriasis?	☐ Yes ☐ No
Do you tend to put people and family and situations first and your needs and goals second?	☐ Yes ☐ No

ENVIRONMENTAL FACTORS IN HEALTH

Question	Answer
Are you sexually active?	☐ Yes ☐ No
If yes, are you trying for a pregnancy?	☐ Yes ☐ No
Is there any chance of you getting pregnant in the next 3 months?	☐ Yes ☐ No
If not trying for a pregnancy, list contraceptive or barrier method using:	
Do you live alone?	☐ Yes ☐ No
Do you have frequent falls?	☐ Yes ☐ No
Do you have vision or hearing loss?	☐ Yes ☐ No
Do you have an Advance directive or Living Will?	☐ Yes ☐ No
Are there any physical or mental abuses issues in your life that you would like to discuss?	☐ Yes ☐ No
Are you sensitive to smells and fragrances?	☐ Yes ☐ No
Do you regularly have headaches and migraines?	☐ Yes ☐ No
Do you have regular exposure to exhaust fumes, tobacco smoke, pesticides, commercial chemicals, paint, cleaning chemicals, or volatile fumes?	☐ Yes ☐ No
Are you not sleeping enough hours?	☐ Yes ☐ No
Are you not able to fall into a deep sleep?	☐ Yes ☐ No
Do you suffer from light cycle disruption or shift work issues?	☐ Yes ☐ No
Do you frequently feel drowsy throughout the day?	☐ Yes ☐ No
How many root canals do you currently have in your mouth: ___________	
How many silver fillings do you currently have in your mouth: _______________	
Have you been told by your dentist that you have gum disease?	☐ Yes ☐ No
What kind of water do you drink on regular basis? ☐ plastic bottled ☐ tap water ☐ well water ☐ purified water system in the home ☐ filtered water from refrigerator or small counter filter	
Do you use weed killers, pesticides, commercial cleaners in and around the home?	☐ Yes ☐ No
How long is your commute time to work (if applicable)?	

Has anyone told you that you snore loudly?	☐ Yes ☐ No
Do you sleep in a totally dark bedroom?	☐ Yes ☐ No
Do you smoke now? If yes, what kind of smoking and how much?	☐ Yes ☐ No
Did you ever smoke in the past? If yes, how much and for how long?	☐ Yes ☐ No
Do you use commercial personal care products? (lotion, shampoo, cosmetics, etc.)	☐ Yes ☐ No
Women: Do you have breast implants? If yes, what kind?	☐ Yes ☐ No
Do you have any metal devices implanted in your body? If so, describe:	☐ Yes ☐ No
Do you use artificial sweeteners? If yes, what kind?	☐ Yes ☐ No
How often do you barbeque meat on a grill?	
Have you ever had a venereal disease? If yes, what?	☐ Yes ☐ No
Do you have any history of recreational or street drugs and/or drug addiction? If yes, explain	☐ Yes ☐ No
Have you ever given yourself street drugs with a needle?	☐ Yes ☐ No
Do you always wear a seatbelt when driving and as a passenger?	☐ Yes ☐ No
Is any litigation pending regarding a medical condition?	☐ Yes ☐ No
How many cat scans have you had in your life:	☐ Yes ☐ No
What part of the body were they done on?	

HEALTH HABITS AND PERSONAL SAFETY

All questions contained in this questionnaire are optional and will be kept strictly confidential

Exercise	☐ Sedentary (no exercise)		
	☐ Mild exercise (i.e., climb stairs, walk 3 blocks, golf)		
	☐ Occasional vigorous exercise (i.e., work or recreation, less than 4x/week for 30 min)		
	☐ Regular vigorous exercise (i.e., work or recreation 4x/week for 30 minutes)		
Diet	☐ Are you dieting?		☐ Yes ☐ No
	☐ If yes, are you on a physician prescribed medical diet?		☐ Yes ☐ No
	# Of meals you eat in an average day?		
	Rank salt intake	☐ Hi ☐ Med ☐ Low	
	Rank fat intake	☐ Hi ☐ Med ☐ Low	
Caffeine	☐ None	☐ Coffee ☐ Tea ☐ Cola	
	# Of cups/cans per day?		
Alcohol	Do you drink alcohol?		☐ Yes ☐ No
	If yes, what kind?		
	How many drinks per week?		
	Are you concerned about the amount you drink?		☐ Yes ☐ No
	Have you considered stopping?		☐ Yes ☐ No

	Have you ever experienced blackouts?			☐ Yes ☐ No
	Are you prone the “binge” drinking?			☐ Yes ☐ No
	Do you drive after drinking?			☐ Yes ☐ No
Tobacco	Do you use tobacco?			☐ Yes ☐ No
	☐ Cigarettes – pks/day	☐ Chew - #/day	☐ Pipe - #/day	☐ Cigars - #/day
	☐ # of years	☐ Or year quit		
	Have you ever given yourself streets drug with a needle?			☐ Yes ☐ No
Sex	Are you sexually active?			☐ Yes ☐ No
	If yes, are you trying for a pregnancy?			☐ Yes ☐ No
	If not trying for a pregnancy list contraceptive or barrier method used:			☐ Yes ☐ No
	Any discomfort with the intercourse?			☐ Yes ☐ No
	Illness related to the Human Immunodeficiency Virus (HIV), such as AIDS, has become a major public health problem. Risk factors for this illness include intravenous drug use and unprotected sexual intercourse. Would you like to speak with your provider about your risk of this illness?			☐ Yes ☐ No
Personal Safety	Do you live alone?			☐ Yes ☐ No
	Do you have frequent falls?			☐ Yes ☐ No
	Do you have vision or hearing loss?			☐ Yes ☐ No
	Do you have an Advanced Directing or Living Will?			☐ Yes ☐ No
	Would you like information on the preparation of these?			☐ Yes ☐ No
	Physical and/or mental abuse has also become major public health issues in this country. This often takes the form of verbally threatening behavior or actual physical or sexual abuse. Would you like to discuss this issue with your provider?			☐ Yes ☐ No

STRESS / COPING

Unfortunately, abuse and violence of all kinds, verbal, emotional, physical, and sexual are leading contributor to chronic stress, illness, and immunes system dysfunction; witnessing violence and abuse can also be very traumatic. If you have experienced or witnessed any kind of abuse in the past, or if abuse is now an issue in your life it is very important that you feel safe telling us about it, so that we can support you and optimize your treatment outcomes.

Please do your best to answer the following questions:

Did you feel safe growing up?		☐ Yes ☐ No
Have you ever been involved in abusive relationships in your life?		☐ Yes ☐ No
Was alcoholism or substance abuse present in your childhood home?		☐ Yes ☐ No
Is alcoholism or substance abuse present in your relationships now?		☐ Yes ☐ No
Have you ever sought counseling?		☐ Yes ☐ No
Currently? ☐ Yes ☐ No	Previously? ☐ Yes ☐ No	If previously from To:
What kind?		
Comments:		
Do you feel you have any excessive amount of stress in your life?		☐ Yes ☐ No
Daily stressors: Rate in a scale from 1 - 10 (1 not stressful – 10 very stressful)		

Work	Family	Social	Finances	Health	Other

Do you practice medication or relaxation techniques?	☐ Yes ☐ No	How often?

Check all that apply:

☐ Yoga	☐ Meditation	☐ Imagery	☐ Breathing	☐ Tai Chi	☐ Prayer	Other

Hobbies and leisure activities:

How important is your religion (or spirituality) for you and your family life?

a. ☐ Not at all important	b. ☐ Somewhat important	c. ☐ Extremely important

Have you ever been abused, a victim of a crime, or experienced a significant trauma?	☐ Yes ☐ No

How well have things been going for you?

	Very well	Fine	Poorly	Very Poorly	Does not apply
At school					
In your job					
In your social life					
With close friends					
With sex					
With your attitude					
With your boyfriend/girlfriend					
With your children					
With your parents					
With your spouse					

Question	
Do you experience mental fogginess or have trouble concentrating?	☐ Yes ☐ No
Do you have trouble falling or staying asleep?	☐ Yes ☐ No
In the last 6 months, have you unintentionally lost or gained 10 or more pounds?	☐ Yes ☐ No
Do you wake up feeling unrested or depend on caffeine to keep you going throughout the day?	☐ Yes ☐ No
Do you exercise at least 5 days per week?	☐ Yes ☐ No
Generally speaking, do you enjoy exercising?	☐ Yes ☐ No
In the last month, how many exercise sessions did you complete?	☐ Yes ☐ No
What is the average length of time of your exercise sessions?	☐ Yes ☐ No

What is the general intensity of your exercise sessions: 1 to 5. Mild stretching, yoga and walking to intense cardio, weight training, running?

Is your job: ☐ active or ☐ sedentary?

How many hours a day are you sitting down (include travel time)?

What kind of exercise and activity do you mostly do? Include gardening, housework, yard work, recreational activities, etc?

Which of the following provide you emotional support? *Check all that apply.*

☐ Spouse	☐ Family	☐ Friends	☐ Religious/Spiritual	☐ Pets	Other:

SLEEP / REST

Average of hour you sleep	☐ > 10	☐ 8 - 10	☐ 6 – 8	☐ < 6
Do you have trouble falling sleep?				☐ Yes ☐ No
Do you feel rested upon awakening?				☐ Yes ☐ No
Do you have problems with insomnia?				☐ Yes ☐ No
Do you snore?				☐ Yes ☐ No
Do you use sleeping aids? ☐ Yes ☐ No	Explain:			

READINESS / ASSESSMENT

Rate on a scale of: **5** (very willing) to **1** (not willing)

In order to improve your health, how willing are you?

Significantly modify your diet	☐ 5	☐ 4	☐ 3	☐ 2	☐ 1
Take several nutritional supplements each day	☐ 5	☐ 4	☐ 3	☐ 2	☐ 1
Keep a record of everything you eat each day	☐ 5	☐ 4	☐ 3	☐ 2	☐ 1
Modify your lifestyle	☐ 5	☐ 4	☐ 3	☐ 2	☐ 1
Practice relaxation techniques	☐ 5	☐ 4	☐ 3	☐ 2	☐ 1
Engage in regular exercises	☐ 5	☐ 4	☐ 3	☐ 2	☐ 1
Have periodic lab tests to assess progress	☐ 5	☐ 4	☐ 3	☐ 2	☐ 1
Comments:					

Rate on a scale of: **5** (very confident) to **1** (not confident)

How confident are you of your ability to organize and follow through on the above health related activities?	☐ 5	☐ 4	☐ 3	☐ 2	☐ 1
If you not are confident of your ability, what aspects of yourself or your life lead you to question your capacity to fully engage in the above activities?:					

Rate on a scale of: **5** (very supportive) to **1** (not supportive at all)

At the present time how supportive do you think the people in your household will be to your implementing the above changes?	☐ 5	☐ 4	☐ 3	☐ 2	☐ 1
Comments:					

Rate on a scale of: **5** (very frequent contact) to **1** (very infrequent contact)

How much ongoing support and contact (e.g. telephone consults, e-mail correspondence) from your professional staff would be helpful for you as you implement your personal health program?	☐ 5	☐ 4	☐ 3	☐ 2	☐ 1
Comments:					

Thank you for taking the time to complete these health history medical questionnaires. The information derived from these forms will provide invaluable data we will use to support your needs.

Thank you once again and we look forward to helping you achieve true balanced health and wellness