Wellness Questionnaire

Personal Information:

First Name: ______________________ Last Name: ______________________

Email: ______________________

Phone: ______________ Preferred communication form (email, phone, text) __________

Age: ____ Relationship Status: ________ City of Residence: ______________

Children/Ages: ______________________ Pets: ______________

Occupation: ______________________ Hours of work per week: ________

Wellness Information:

Please list your main wellness concerns: ______________________

____

Please list your top wellness goals: ______________________

____

At what point in your life did you feel your best? Why? ______________________

____

Any serious illnesses/hospitalizations/injuries? ______________________

____

How many caffeinated drinks per day/week? ____

How many alcoholic beverages to you consume per week/day? ____

Do you smoke? If so, how often? ____

Any pain, stiffness, or swelling?

____

____

____

Tell me about your sleep patterns:

____

____

Any allergies or sensitivities?

____

____

Do you take any supplements or medications? Please list:

____

____

____

Any healers, helpers, or therapists with which you are involved?

____

____

What role do sports, and exercise play in your life?

____

____

All client information will remain confidential

Food Information:

What foods did you eat often as a child?

Breakfast	Lunch	Dinner	Snacks	Liquids
________________	________________	________________	________________	______________
________________	________________	________________	________________	______________
________________	________________	________________	________________	______________

What do you eat today?

Breakfast	Lunch	Dinner	Snacks	Liquids
________________	________________	________________	________________	______________
________________	________________	________________	________________	______________
________________	________________	________________	________________	______________

Do you cook?

____

____

Do you experience cravings? If so, what?

____

____

The most important thing I can do for my/my families wellbeing?

____

____

Anything else you would like to share?

____

____

____

All client information will remain confidential