purewellness group

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purewellnessgroup.ca

To help us serve your health needs, please take 10-15 minutes to complete the following questionnaire as accurately as possible. All of your answers will be held ***absolutely confidential.*** If you have any questions, please ask. Thank you!

GENERAL INFORMATION

Date: YYYY / MM / DD

Name: FIRST MIDDLE LAST Health Card #: 0000 - 000 - 000 - XX

Date of Birth: YYYY / MM / DD Gender: Blood Type: XX -

Address: STREET APT. #

CITY PROVINCE POSTAL CODE

Home Phone: (000) 000-0000 Work Phone: (000) 000-0000

Cell Phone: (000) 000-0000 E-mail Address: YOU@SITE.COM

Marital Status:

Emergency Contact: NAME RELATIONSHIP

PHONE NUMBER

Physician: NAME PHONE NUMBER

Chiropractor: NAME PHONE NUMBER

Naturopath: NAME PHONE NUMBER

Specialist(s): NAME PHONE NUMBER

NAME PHONE NUMBER

How did you hear about our clinic?

◯ Tradeshow ◯ Drive-by/Walk-in ◯ Medical Doctor/Nurse Practitioner ◯ TruBalance/TruTina

◯ Internet ◯ Facebook ◯ Instagram ◯ Twitter ◯ Google ◯ Midwife ◯ Website

◯ Another patient or professional:

ALLERGIES

MEDICATION/SUPPLEMENT/FOOD	REACTION

COMPLAINTS/CONCERNS

Please state your reason for attending our clinic:

Did something trigger your change in health?

What aggravates it?

What improves it?

Have you been given a diagnosis?

Please list current and ongoing problems in order of severity:

Describe Problem(s)	Mild	Moderate	Severe	*Prior Treatment/Approach*	Excellent	Good	Fair
EXAMPLE: POST NASAL DRIP		X			X		

Dr. Allan Price #934 & Dr. Tara O'Brien #1725

Members in Good Standing with the Canadian Association of Naturopathic Doctors and the Ontario Association of Naturopathic Doctors
Pure Wellness Group is located at 1933 Regent St. Unit#10, Sudbury, ON P3E5R2

MEDICAL HISTORY

Please check the appropriate box and provide the date of onset
P = Past Condition O = Ongoing Condition

DISEASES/DIAGNOSES

P O GASTROINTESTINAL

- ◯◯ Irritable Bowel Syndrome
- ◯◯ Inflammatory Bowel Syndrome
- ◯◯ Crohn's
- ◯◯ Ulcerative Colitis
- ◯◯ Gastric or Peptic Ulcer Disease
- ◯◯ GERD *(reflux)*
- ◯◯ Celiac Disease
- ◯◯ Gallstones
- ◯◯ OTHER

P O GENITAL AND URINARY SYSTEMS

- ◯◯ Kidney Stones
- ◯◯ Gout
- ◯◯ Interstitial Cystitis
- ◯◯ Frequent Urinary Tract Infections
- ◯◯ Frequent Yeast Infections
- ◯◯ Erectile Dysfunction or Sexual Dysfunction
- ◯◯ OTHER

P O CARDIOVASCULAR

- ◯◯ Heart Attack
- ◯◯ Other Heart Disease
- ◯◯ Stroke
- ◯◯ Elevated Cholesterol
- ◯◯ Arrhythmia *(irregular heart rate)*
- ◯◯ Hypertension *(high blood pressure)*
- ◯◯ Rheumatic Fever
- ◯◯ Mitral Valve Prolapse

P O CANCER

- ◯◯ Lung Cancer
- ◯◯ Breast Cancer
- ◯◯ Colon Cancer
- ◯◯ Ovarian Cancer
- ◯◯ Prostate Cancer
- ◯◯ Skin Cancer
- ◯◯ OTHER

P O METABOLIC/ENDOCRINE

- ◯◯ Type 1 Diabetes
- ◯◯ Type 2 Diabetes
- ◯◯ Hypoglycemia
- ◯◯ Metabolic Syndrome *(insulin resistance or Pre-Diabetes)*
- ◯◯ Hypothyroidism *(low thyroid)*
- ◯◯ Hyperthyroidism *(overactive thyroid)*
- ◯◯ Endocrine Problems
- ◯◯ Polycystic Ovarian Syndrome *(PCOS)*
- ◯◯ Infertility
- ◯◯ Weight Gain
- ◯◯ Weight Loss
- ◯◯ Eating Disorder *(specify)*

P O INFLAMMATION/AUTOIMMUNE

- ◯◯ Chronic Fatigue Syndrome
- ◯◯ Autoimmune Disease
- ◯◯ Rheumatoid Arthritis
- ◯◯ Lupus SLE
- ◯◯ Immune Deficiency Disease
- ◯◯ Herpes (Genital)
- ◯◯ Severe Infectious Disease
- ◯◯ Poor Immune Function *(frequent infections)*
- ◯◯ Food Allergies
- ◯◯ Environmental Allergies
- ◯◯ Multiple Chemical Sensitivities

P O MUSCULOSKELETAL/PAIN

- Osteoarthritis
- Fibromyalgia
- Chronic Pain
- OTHER

P O SKIN DISEASES

- Eczema
- Psoriasis
- Acne
- Melanoma
- Skin Cancer
- OTHER

P O NEUROLOGIC/MOOD

- Depression
- Anxiety
- Bipolar Disorder
- Schizophrenia
- Headaches
- Migraines
- ADD/ADHD
- Autism
- Mild Cognitive Impairment
- Memory Problems
- Parkinson's Disease
- Multiple Sclerosis
- ALS
- Seizures
- OTHER

P O RESPIRATORY DISEASES

- Asthma
- Chronic Sinusitis
- Bronchitis
- Emphysema
- Pneumonia
- Tuberculosis
- Sleep Apnea
- OTHER

PREVENTATIVE TESTS

Check box if yes and provide date of last test

- Full Physical Exam YYYY / MM / DD
- Bone Density YYYY / MM / DD
- Colonoscopy YYYY / MM / DD
- Cardiac Stress Test YYYY / MM / DD
- EKG YYYY / MM / DD
- Hemoccult Test (blood in stool) YYYY / MM / DD
- MIR YYYY / MM / DD
- CT Scan YYYY / MM / DD
- Upper Endoscopy YYYY / MM / DD
- Ultrasound YYYY / MM / DD

SURGERIES

Check box if yes and provide date of last test

- Appendectomy YYYY / MM / DD
- Hysterectomy +/- Ovaries YYYY / MM / DD
- Gall Bladder YYYY / MM / DD
- Hernia YYYY / MM / DD
- Tonsillectomy YYYY / MM / DD
- Dental Surgery YYYY / MM / DD
- Joint Replacement YYYY / MM / DD
- Angioplasty or Stent YYYY / MM / DD
- Pacemaker YYYY / MM / DD
- None YYYY / MM / DD

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HOSPITALIZATIONS/INJURIES

Date	Reason/Event
YYYY / MM / DD	
YYYY / MM / DD	

COMMENTS

GYNECOLOGIC HISTORY (for women only)

OBSTETRIC HISTORY *(check and provide number of if applicable)*

◯ Pregnancies XX ◯ Cesarean XX ◯ Miscarriages XX ◯ Abortions XX

◯ Vaginal Deliveries XX ◯ Living Children XX ◯ Post-Partum Depression ◯ Toxemia

◯ Gestational Diabetes ◯ Breastfeeding XX *if so, for how long?* _____

MENSTRUAL HISTORY

Age at first period: Frequency: Length: Pain: ◯ Yes ◯ No Clotting: ◯ Yes ◯ No

Have you ever skipped a cycle?: *If so, for how long?:*

First day of last menstrual period: Days between menses:

Do you use hormonal contraception?: ◯ Yes ◯ No *If so, what type?:* *For how long?:*

Do you use contraception?: ◯ Yes ◯ No If so, what type?: ◯ Condom ◯ Diaphragm ◯ Partner Vasectomy ◯ IUD ◯ Tubal Ligation ◯ OTHER

WOMEN'S DISORDERS/HORMONAL IMBALANCES

◯ Fibrocystic Breasts ◯ Endometriosis ◯ Fibroids ◯ Infertility ◯ Painful Periods ◯ Heavy Periods

◯ PMS ◯ Spotting ◯ Vaginal Discharge ◯ Low Sex Drive

Last Mammogram: YYYY / MM / DD Last Breast Biopsy: YYYY / MM / DD Last Self Breast Exam: YYYY / MM / DD

Last PAP Test: YYYY / MM / DD Results: ◯ Normal ◯ Abnormal

Last Bone Density Test: YYYY / MM / DD Results: ◯ High ◯ Low ◯ Within Normal Range

Describe any changes to body/psyche prior to menses:

Are you in menopause?: ◯ Yes ◯ No Age at menopause:

WOMEN'S DISORDERS/HORMONAL IMBALANCES *cont. check all that apply*

Symptoms

◯ Hot Flashes ◯ Mood Swings ◯ Concentration/Memory Problems ◯ Loss of Bladder Control

◯ Heavy Bleeding ◯ Joint Pains ◯ Headaches ◯ Weight Gain ◯ Vaginal Dryness ◯ Low Sex Drive

◯ Palpitations ◯ Use of Hormone Replacement Therapy *If so, for how long?:* _____

MEN'S HISTORY (for men only)

Have you had a PSA done?: ◯ Yes ◯ No Level: ◯ 0-2 ◯ 2-4 ◯ 4-10 ◯ >10

◯ Prostate Enlargement ◯ Prostate Infection ◯ Change in Libido ◯ Impotence ◯ Difficulty Obtaining Erection

◯ Difficulty Maintaining Erection ◯ Nocturia (urination at night) *If so, how many times a night?:* _____

◯ Urgency/Hesitancy/Change in Urinary Stream ◯ Loss of Bladder Control

Last Prostate Exam: YYYY / MM / DD Last Self-Testicular Exam: YYYY / MM / DD

GASTROINTESTINAL HISTORY

Foreign Travel?: ◯ Yes ◯ No *If so, where?:* _____

Wilderness Camping?: ◯ Yes ◯ No *If so, where?:* _____

Have you ever had severe: ◯ Gastroenteritis ◯ Diarrhea

Do you feel like you digest all your food well?: ◯ Yes ◯ No Do you feel bloated after meals?: ◯ Yes ◯ No

PATIENT BIRTH HISTORY

◯ Term ◯ Premature Pregnancy Complications: _____

Birth Complications: _____

Did you eat a lot of candy or sugar as a child?: ◯ Yes ◯ No

DENTAL HISTORY

DENTAL SURGERY

◯ Silver/Mercury Fillings *If so, how many?:* _____ ◯ Gold Fillings ◯ Root Canals ◯ Implants

◯ Tooth Pain ◯ Bleeding Gums ◯ Gingivitis ◯ Problems Chewing

Do you floss regularly?: ◯ Yes ◯ No *How many days per week?:* _____

MEDICATIONS

CURRENT MEDICATIONS *(or attach pharmacist print out)*

MEDICATION	DOSE	FREQUENCY	START DATE	REASON FOR USE

PAST MEDICATIONS *(last 10 years, fill in to the best of your ability)*

MEDICATION	DOSE	FREQUENCY	START DATE	REASON FOR USE

NUTRITIONAL SUPPLEMENTS *(vitamins, minerals, herbs, homeopathy)*

SUPPLEMENT OR BRAND	DOSE	FREQUENCY	START DATE	REASON FOR USE

Have medications or supplements ever caused you unusual side effects or problems?: ◯ Yes ◯ No

If so, please describe: _____

Have you had prolonged or regular use of NSAIDS (Advil, Aleve, etc.) Motrin, or Aspirin?: ◯ Yes ◯ No

Have you had prolonged or regular use of Tylenol?: ◯ Yes ◯ No

Have you had prolonged or regular use of Acid Blocking Drugs (Tagamet, Zantac, Prilosec, etc.)?: ◯ Yes ◯ No

Frequent antibiotic use *(>3 times/year)*?: ◯ Yes ◯ No Long-term antibiotic use?: ◯ Yes ◯ No

Use of steroids (prednisone, nasal allergy inhalers) in the past?: ◯ Yes ◯ No

Use of oral contraceptives?: ◯ Yes ◯ No

FAMILY HISTORY

Check family members that apply

	Father	Mother	Brother(s)	Sister(s)	Children	Maternal Grandmother	Maternal Grandfather	Paternal Grandmother	Paternal Grandfather	Aunts/Uncles	Details
Age *(if alive)*											
Age at death *(if deceased)*											
Cancer *(breast, colon, leukemia, etc.)*											
Heart Disease											
Obesity											
Diabetes											
Stroke											
Arthritis											
Inflammatory Bowel Disease											
Autoimmune Disease *(Lupus, MS, etc.)*											
Gastrointestinal Issues *(IBS, celiac, Crohn's, etc.)*											
Allergy/Skin Issues *(Eczema, Asthma, Environmental Sensitivities, etc.)*											
Parkinson's											
ALS or Motor Neuron Diseases											
Genetic Disorders											
Mental Health Issues *(substance abuse, psychiatric disorders, depression, schizophrenia, ADHD, Autism, Bipolar, Dementia, etc.)*											

SOCIAL HISTORY

NUTRITION HISTORY *(Describe your typical daily diet)*

Breakfast _____ **Dinner** _____

_____ _____

_____ _____

Lunch _____ **Snacks** _____

_____ _____

_____ _____

Have you ever had a nutrition consultation?: ◯ **Yes** ◯ **No**

Have you made any changes to your eating habits because of your health?: ◯ **Yes** ◯ **No** *describe:* _____

Do you currently follow a special diet or nutritional program?: ◯ **Yes** ◯ **No** *describe:* _____

Do you have cravings for a specific item(s)?: ◯ **Yes** ◯ **No** *to what?* _____

Height: Weight: Usual Weight Range (+/- 5lbs): _____

Desired Weight Range (+/- 5lbs): Highest Adult Weight: Lowest Adult Weight: _____

Weight Fluctuations (>10lbs): ◯ **Yes** ◯ **No** Body Fat %: _____

How often do you weigh yourself?: ◯ **Daily** ◯ **Weekly** ◯ **Monthly** ◯ **Rarely** ◯ **Never**

Do you grocery shop?: ◯ **Yes** ◯ **No** *if no, who does the shopping?* _____

Do you read food labels?: ◯ **Yes** ◯ **No** *if yes, what are you looking for?* _____

Do you cook?: ◯ **Yes** ◯ **No** *if no, who does the cooking?* _____

How many meals do you eat out per week?: ◯ **0-1** ◯ **1-3** ◯ **3-5** ◯ **>5 meals per week**

Check all the factors that apply to your current lifestyle and eating habits:

◯ **Fast eater** ◯ **Erratic eating pattern** ◯ **Eat too much** ◯ **Late night eating** ◯ **Dislike healthy food**

◯ **Time constraints** ◯ **Eat more than 50% of meals away from home** ◯ **Travel frequently**

◯ **Non-availability of healthy food** ◯ **Do not plan meals or menus** ◯ **Reliance on convenience items**

◯ **Poor snack choices** ◯ **Significant other or family members do not like healthy foods**

◯ **Significant other or family members have special dietary needs or preferences** ◯ **Eat in the middle of the night**

◯ **Struggle with eating issues** ◯ **Emotional eater** *(eat when sad, lonely depress or bored)* ◯ **Eat too much under stress**

◯ **Eat too little under stress** ◯ **Don't care to cook** ◯ **Confused about nutrition advice**

◯ **Love to eat** ◯ **Eat because I have to** ◯ **Have a negative relationship with food**

SMOKING

Currently Smoking?: ◯ Yes ◯ No *if so, for how many years* _____ *how many packs per day* _____

# of Attempts to Quit: Previous Smoking?: *for how many years* _____ *how many packs per day* _____

Second Hand Smoke Exposure?: _____

ALCOHOL INTAKE

How many drinks do you currently have per week? *1 drink= 5 ounces of wine, 12 ounces of beer, 1.5 ounces of spirits*

◯ None ◯ 1-3 ◯ 4-6 ◯ 7-10 ◯ >10

OTHER SUBSTANCES

Caffeine?: ◯ Yes ◯ No *Coffee cups/day:* ◯ 1 ◯ 2-4 ◯ >4 *Black Tea cups/day:* ◯ 1 ◯ 2-4 ◯ >4

Caffeinated Soda or Diet Soda?: ◯ Yes ◯ No *12 ounce can or bottle/day:* ◯ 1 ◯ 2-4 ◯ >4

Are you currently using any recreational drugs?: ◯ Yes ◯ No *if so, what type?* _____

EXERCISE

Current Exercise Program: *(Describe your weekly exercise regime, including sports, leisure activities, stretching, etc.)*

_____

_____

_____

_____

Rate your level of motivation for including exercise in your life: ◯ Low ◯ Medium ◯ High

Do you have any problems that limit activity?: ◯ Yes ◯ No *if so, describe:* _____

Do you feel unusually fatigued after exercise?: ◯ Yes ◯ No Do you usually sweat when exercising?: ◯ Yes ◯ No

PSYCHOSOCIAL

Do you feel significantly less vital than you did a year ago?: ◯ Yes ◯ No Are you happy?: ◯ Yes ◯ No

Do you believe stress is presently reducing your quality of life?: ◯ Yes ◯ No

Do you like the work you do?: ◯ Yes ◯ No Have you ever experienced major losses in your life?: ◯ Yes ◯ No

Do you spend the majority of your time and money to fulfill responsibilities and obligations?: ◯ Yes ◯ No

Would you describe your experience as a child in your family as happy and secure?: ◯ Yes ◯ No

STRESS/COPING

Have you ever sought counseling?: ◯ Yes ◯ No

Are you currently in therapy?: ◯ Yes ◯ No *if so, describe:* _____

Do you have an excessive amount of stress in your life?: ◯ Yes ◯ No

Do you feel you can easily handle the stress in your life?: ◯ Yes ◯ No

Daily Stressors: *(rate on a scale of 1-10, 10 being the worst)*

Work _____ **Family** _____ **Social** _____ **Finances** _____ **Health** _____ **Other** _____

Do you practice meditation or relaxation techniques?: ◯ Yes ◯ No *if yes, check all that apply*

◯ Yoga ◯ Meditation ◯ Imagery ◯ Breathing ◯ Tai Chi ◯ Prayer ◯ Other _____

Have you ever been the victim of a crime, experienced significant trauma, or been physically, sexually or emotionally abused?:

◯ Yes ◯ No

SLEEP/REST

Average number of hours you sleep per night: ◯ >10 ◯ 8-10 ◯ 6-8 ◯ <6

Do you have trouble falling asleep?: ◯ 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

ROLES/RELATIONSHIPS

Children: *(if applicable)*

Age	Gender	Age	Gender

Who is living in the household?: *Number of people:* _____ *Names:* _____

Resources for emotional support?: *check all that apply*

◯ Spouse ◯ Family ◯ Friends ◯ Religious/Spiritual ◯ Pet(s) ◯ Other _____

Are you satisfied with your sex life?: ◯ Yes ◯ No

ENVIRONMENTAL AND DETOXIFICATION ASSESSMENT

Do you have known adverse food reactions, sensitivities, or allergies?: ◯ Yes ◯ No

If yes, describe symptoms: _____

List all known: _____

When you drink caffeine, do you feel: ◯ Irritable or Wired ◯ Aches & Pains

Which of these significantly affect you?: *check all that apply*

◯ Cigarette Smoke ◯ Perfumes/Colognes ◯ Auto Exhaust Fumes ◯ Other _____

In your work or home environment, are you exposed to: ◯ Chemicals ◯ Electromagnetic Radiation ◯ Mold

Do you have a known history of significant exposure to any harmful chemicals such as the following:

◯ Herbicides ◯ Insecticides *(frequent visits by exterminator)* ◯ Pesticides ◯ Organic Solvents

◯ Heavy Metals ◯ Other _____

Chemical Name, Date & Length of Exposure: _____

Do you dry clean your clothes frequently?: ◯ Yes ◯ No Do you have any pets or farm animals?: ◯ Yes ◯ No

Do you or have you lived or worked in a damp or moldy environment or had other mold exposure?: ◯ Yes ◯ No

SYMPTOM REVIEW

Please check all current symptoms occurring or present

GENERAL

◯ Poor appetite ◯ Poor sleep ◯ Fatigue ◯ Fevers ◯ Chills ◯ Night sweats ◯ Sweat easily

◯ Tremors ◯ Cravings ◯ Localized weakness ◯ Poor balance ◯ Change in appetite

◯ Bleed or bruise easily ◯ Peculiar tastes or smells ◯ Strong thirst *(cold or hot drinks)*

◯ Chronic infections ◯ Sudden energy drop *what time of day?:* _____

SKIN AND HAIR

◯ Rashes ◯ Ulcerations ◯ Hives ◯ Itching ◯ Pimples ◯ Dandruff ◯ Loss of hair

◯ Recent moles ◯ Change in hair or skin texture

◯ Any other hair or skin problems? *describe:* _____

HEAD, EYES, EARS, NOSE AND THROAT

◯ Dizziness ◯ Concussions ◯ Migraines ◯ Glasses ◯ Eye strain ◯ Eye pain

◯ Poor vision ◯ Night blindness ◯ Color blindness ◯ Cataracts ◯ Blurry vision ◯ Earaches

◯ Ringing in ears ◯ Poor hearing ◯ Ear infections ◯ Sinus problems ◯ Nosebleeds

◯ Spots in front of eyes ◯ Grinding teeth ◯ Facial pain ◯ Sores on lips or tongue

◯ Canker sores ◯ Recurrent sore throats ◯ Tonsillitis ◯ Chronic swollen glands

◯ Teeth/gum problems *# of Mercury(silver amalgams):* _____

CARDIOVASCULAR

◯ Low blood pressure ◯ Chest pain ◯ Irregular heartbeat ◯ Dizziness ◯ Fainting

◯ Cold hands or feet ◯ Swelling of hands ◯ Swelling of feet ◯ Phlebitis ◯ Blood clots

◯ Difficulty breathing ◯ Any other heart or blood vessel problems? *describe:* _____

RESPIRATORY

◯ Cough ◯ Coughing Blood ◯ Pain with a deep breath ◯ Difficulty breathing when lying down

◯ Production of phlegm *colour?* _____ ◯ Any other lung problems? *describe:* _____

GASTROINTESTINAL

◯ Nausea ◯ Vomiting ◯ Constipation ◯ Diarrhea ◯ Chronic laxative use ◯ Indigestion

◯ Belching ◯ Gas ◯ Bad breath ◯ Black stools ◯ Blood in stools ◯ Rectal pain

◯ Abdominal pain or cramps

◯ Any other problems with your stomach or intestines? *describe:* _____

GENITO-URINARY

◯ Pain on urination ◯ Frequent urination ◯ Blood in urine ◯ Urgency to urinate

◯ Unable to hold urine ◯ Decrease in flow ◯ Impotency ◯ Sores on genitals

◯ Do you wake to urinate? *how often?:* _____

◯ Any particular colour to your urine? *describe:* _____

◯ Any other problems with your genitals or urinary system? *describe:* _____

NEUROPSYCHOLOGICAL

◯ Dizziness ◯ Loss of balance ◯ Areas of numbness ◯ Lack of coordination ◯ Poor memory

◯ Concussion ◯ Quick temper/irritable ◯ Easily susceptible to stress ◯ Panic attacks

◯ Have you ever received treatment for emotional problems?

◯ Have you ever considered or attempted suicide?

◯ Any other neurological or psychological problems? *describe:* _____

MUSCULO-SKELETAL

◯ Joint pain ◯ Stiffness ◯ Lack of flexibility ◯ Radiating pain ◯ Headaches/Migraines

◯ Low back pain ◯ Foot pain ◯ Neck pain ◯ Trauma *(ie. MVA, slip, fall)* ◯ Joint pain

◯ Jaw clicks ◯ Any other head or neck problems? *describe:* _____

READINESS ASSESSMENT

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

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

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 *(e.g., work demands, sleep habits)*	◯ 5	◯ 4	◯ 3	◯ 2	◯ 1
Practice a relaxation technique	◯ 5	◯ 4	◯ 3	◯ 2	◯ 1
Engage in regular exercise	◯ 5	◯ 4	◯ 3	◯ 2	◯ 1
Have periodic lab tests to assess your progress	◯ 5	◯ 4	◯ 3	◯ 2	◯ 1

Comments

_____

_____

_____

Rate on a scale of 5 (very confident) to 1 (not confident 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 on-going support and contact (e.g. telephone consults, e-mail correspondence) from our professional staff would be helpful to you as you implement your personal health program?

○5 ○4 ○3 ○2 ○1

Comments