OptimumHealth
AN INTEGRATIVE APPROACH TO HEALING

WELLNESS SURVEY

PATIENT NAME _____ **DATE**_____

EXERCISE: ☐ None ☐ Moderate ☐ Daily ☐ Heavy **HABITS:**

WORK ACTIVITY: ☐ Sitting ☐ Standing ☐ Light ☐ Heavy ☐ Tobacco Use Packs/Day _____

Do you have high stress in your life? ☐ Yes ☐ No ☐ Alcohol Use Drinks/Week _____

Reason_____ ☐ Caffeine Use Cups/ Day _____

Please complete the following questionnaire. Describe each symptom based upon your experiences over the last 60 days.

Symptom Scoring System (please circle the appropriate number below):

0 = No Symptoms (zero points)

1 = Experience Mild Symptoms (one point)

2 = Experience Moderate Symptoms (two points)

3 = Severe Symptoms (three points)

Head/Ears

0 1 2 3 Migraines
0 1 2 3 Headaches
0 1 2 3 Earaches
0 1 2 3 Ear Infection
0 1 2 3 Ringing in Ears

Respiratory/Sinus

0 1 2 3 Stuffy or Runny Nose
0 1 2 3 Chest Congestion
0 1 2 3 Chronic Cough
0 1 2 3 Wheezing
0 1 2 3 Frequent Sneezing

Energy

0 1 2 3 Fatigue
0 1 2 3 Hyperactivity
0 1 2 3 Lethargy
0 1 2 3 Restlessness
0 1 2 3 Difficulty Sleeping

Digestive

0 1 2 3 Stomach Pains / Cramping
0 1 2 3 Constipation / Diarrhea
0 1 2 3 Reflux / Heartburn
0 1 2 3 Bloating / Gas
0 1 2 3 Nausea / Vomiting
0 1 2 3 GI Upset from Specific Foods

Skin Disorders

0 1 2 3 Eczema / Psoriasis
0 1 2 3 Dermatitis
0 1 2 3 Excessive Sweating
0 1 2 3 Rashes / Hives
0 1 2 3 Dry Skin
0 1 2 3 Acne

Emotional/Mental

0 1 2 3 Depression
0 1 2 3 Anxiety
0 1 2 3 Mood Swings
0 1 2 3 Irritability
0 1 2 3 Poor Concentration
0 1 2 3 Poor Memory

Musculo-Skeletal

0 1 2 3 Joint Pain
0 1 2 3 Arthritis
0 1 2 3 Tendonitis
0 1 2 3 Muscle Aches

Eyes/Throat

0 1 2 3 Itchy / Dry Eyes
0 1 2 3 Watery Eyes
0 1 2 3 Sore Throat
0 1 2 3 Persistent Canker Sores

Weight

0 1 2 3 Inability to Lose Weight
0 1 2 3 Food Cravings
0 1 2 3 Binge Eating
0 1 2 3 Water Retention

Genito-Urinary

0 1 2 3 Bladder Irritation / Pain
0 1 2 3 Frequent UTIs
0 1 2 3 Yeast Infections

Cardio-Vascular

0 1 2 3 Irregular Heartbeat
0 1 2 3 Heart Palpitations
0 1 2 3 Chest Pains

Other Symptoms

0 1 2 3 Thyroid Issues
0 1 2 3 High Blood Pressure
0 1 2 3 Blood Sugar Control
0 1 2 3 Libido Issues

Please list any symptoms not mentioned above: _____

FOR OFFICE USE ONLY

☐ Musculo-Skeletal ☐ hc3 ☐ Prometheus ☐ ION ☐ CoQ10 ☐ Other _____

☐ ALCAT ☐ GI Effects ☐ Organix ☐ Fat Soluble Vitamins ☐ Male Hormone Panel ☐ Other _____

☐ ASI ☐ Cyrex Array3 / Array4 ☐ Elements ☐ Vit D ☐ Vit K ☐ Female Hormone Panel ☐ Other _____

Comments: _____