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___ ☐ Alcohol Use: Drinks/Week ____

Do you have high stress in your life? ☐ Yes ☐ No ☐ Caffeine Use: Cups/Day ___

Reason_____

Each symptom based upon your experiences over last 60 days. (Please circle the appropriate number below):

0 = No Symptoms **1 = Mild Symptoms** **2 = Moderate Symptoms** **3 = Severe Symptoms**

Head

0 1 2 3 Migraines
0 1 2 3 Headaches

Ears

0 1 2 3 Earaches
0 1 2 3 Ear Infection
0 1 2 3 Ringing in Ears
0 1 2 3 Itching
0 1 2 3 Fullness/popping
0 1 2 3 Hearing problems

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

Musculo-Skeletal

0 1 2 3 Joint Pain
0 1 2 3 Arthritis
0 1 2 3 Tendonitis
0 1 2 3 Muscle Aches
0 1 2 3 Loss of Height

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 Abdominal Fat

Respiratory/Sinus

0 1 2 3 Stuffy or Runny Nose
0 1 2 3 Chest/Sinus Congestion
0 1 2 3 Chronic Cough
0 1 2 3 Wheezing/Shortness of Breath
0 1 2 3 Itching/Sneezing
0 1 2 3 Drainage. Color:
0 1 2 3 Frequent sinus infections
0 1 2 3 Change in sense of smell

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

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
0 1 2 3 Redness/Swelling
0 1 2 3 Post nasal drip
0 1 2 3 Throat clearing

Cardio-Vascular

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

Genito-Urinary

0 1 2 3 Bladder Irritation / Pain
0 1 2 3 Frequent UTIs
0 1 2 3 Yeast Infections
0 1 2 3 Increase Frequency Urination
0 1 2 3 Blood in Urine

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 Memory

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
0 1 2 3 Low strength / Endurance

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
0 1 2 3 Declined Intimacy

Please list any symptoms not mentioned above: _____

FOR OFFICE USE ONLY

☐ Musculo-Skeletal ☐ GI Profile ☐ Fatigue Panel ☐ Wellness Panel ☐ Weight Loss ☐ hCG
☐ Food Sensitivity ☐ Cyrex Array3 ☐ Thyroid Panel ☐ Allergy Testing Weight _____
☐ ASI ☐ Genetic Celiac Panel ☐ Hormone Panel **F** **M** ☐ Other _____ Body Fat % _____

Comments:_____