



Wellness Program

CHIROPRACTIC & FAMILY WELLNESS PC
GUIDING YOUR FAMILY TO WELLNESS

Name: _____ Date: _____

Instructions: Please circle the number that best describes the question being asked.

1 – Exercise Lifestyle

1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	6 <input type="checkbox"/>	7 <input type="checkbox"/>	8 <input type="checkbox"/>	9 <input type="checkbox"/>	10 <input type="checkbox"/>
normal daily activity	1time per week	2x/week	3x/week	2 x cardio 1 x weights	3 x cardio 1 x weights	4 x cardio 1 x weights	4 x cardio 2 x weights	5 x cardio 2 x weights	5 x cardio 3 x weights

2 – Nutritional Habits

Vegetable servings Per DAY: **1** **2** **3** **4** **5** **6** **7** **8** **9** **10**

(Do not include potatoes, fries, ketchup and grains)

Fruit servings per day: **1** **2** **3**

Check which of the following applies: Positive

- | | | |
|---|---|--|
| <input type="checkbox"/> lean, grass fed, Organic Meats | <input type="checkbox"/> Organic Veg. | <input type="checkbox"/> Organic Fruits |
| <input type="checkbox"/> At least 32 oz of water | <input type="checkbox"/> Grasses: wheat grass, barley grass, oat grass, kamut grass, and lemongrass | |
| <input type="checkbox"/> Nuts/Seeds 2 tbl spoons / day: (almonds-walnuts-Brazil nuts-sunflower seeds-pumpkin seeds and flax seeds.) | | |
| <input type="checkbox"/> Omega 3 Supplements | <input type="checkbox"/> Probiotics | <input type="checkbox"/> Whole Food Multivitamin |

Check which of the following applies: Negative

- | | | |
|---|---|---|
| <input type="checkbox"/> More than 1 serving of grains per day: Wheat, flour, bread, rice, corn, chips (If you are going to eat them then whole grain-wild) | <input type="checkbox"/> Fried foods | <input type="checkbox"/> Juices / Sodas |
| <input type="checkbox"/> Crave Breads / sweets / salty things | <input type="checkbox"/> Hydrogenated fat (Trans. Fats) | <input type="checkbox"/> MSG-Hydrolyzed protein |
| <input type="checkbox"/> Caffeine | <input type="checkbox"/> Partially hydrogenated fat | <input type="checkbox"/> Corn syrup |
| <input type="checkbox"/> Aspartame and artificial sweeteners | <input type="checkbox"/> Smoking | <input type="checkbox"/> _____ |
| <input type="checkbox"/> Alcohol | | |

Eating Habits:

- | | | |
|--|---|---|
| <input type="checkbox"/> You shop when full (not hungry) | <input type="checkbox"/> Eat Breakfast | <input type="checkbox"/> Eat Protein in Breakfast |
| <input type="checkbox"/> Eat vegetables with every meal | <input type="checkbox"/> Eat vegetables first | <input type="checkbox"/> Eat Slow and enjoy meals |

3 – Stress: Rate your over all stress level:

- | | | |
|--|--|---|
| High Stress | Moderate Stress | Light Stress |
| <input type="checkbox"/> High stress everyday | <input type="checkbox"/> Moderate stress everyday | <input type="checkbox"/> Light stress everyday |
| <input type="checkbox"/> High stress most days of week | <input type="checkbox"/> Moderate stress most days of week | <input type="checkbox"/> Light stress most days of week |
| <input type="checkbox"/> High stress 2-3 days of week | <input type="checkbox"/> Moderate stress 2-3 days of week | <input type="checkbox"/> Light stress 2-3 days of week |
| <input type="checkbox"/> High stress 1 day of week | <input type="checkbox"/> Moderate stress 1 day of week | <input type="checkbox"/> Light stress 1 day of week |

Types of stress:

- | | | |
|---|--|--|
| <input type="checkbox"/> Work | <input type="checkbox"/> Kids | <input type="checkbox"/> Your Personality |
| <input type="checkbox"/> Financial | <input type="checkbox"/> Marital | <input type="checkbox"/> Your House of worship |
| <input type="checkbox"/> Death of loved one | <input type="checkbox"/> Unknown / no Reason | Other: _____ |