******* EFFECTIVE DATE: 03/01/2025 *******

Clients will receive a signed copy of this agreement.

Wellness Consultation Questionnaire

Client Information:

Full Name: _____

Date of Birth: _____ Age: _____

Phone Number: _____

Email Address: _____

Emergency Contact Name & Phone: _____

Health & Wellness History:

1. What are your primary wellness concerns or goals?

_____

2. Do you have any chronic conditions or medical diagnoses?

[ ] Yes [ ] No (If yes, please specify)

_____

3. Are you currently taking any medications or supplements?

[ ] Yes [ ] No (If yes, please list)

_____

4. Do you have any known allergies (food, environmental, etc.)?

[ ] Yes [ ] No (If yes, please list)

_____

5. Have you experienced recent major life changes or stressors?

[ ] Yes [ ] No (If yes, please describe)

_____

Lifestyle & Daily Habits:

6. How would you describe your daily energy levels?

[ ] High [ ] Moderate [ ] Low

7. How many hours of sleep do you typically get per night?

[ ] Less than 5 [ ] 5-7 [ ] 7-9 [ ] More than 9

8. How often do you engage in physical activity?

[ ] Never [ ] Occasionally [ ] 3-5 times per week [ ] Daily

9. How would you describe your current diet and nutrition?

[ ] Balanced [ ] Needs Improvement [ ] Poor

10. Do you consume alcohol, caffeine, or tobacco? (Check all that apply)

[ ] Alcohol [ ] Caffeine [ ] Tobacco [ ] None

Wellness Consultation Questionnaire

Emotional & Mental Well-Being:

11. How would you rate your stress levels?

[ ] Low [ ] Moderate [ ] High

12. What are your main sources of stress?

_____

13. Do you practice mindfulness, meditation, or relaxation techniques?

[ ] Yes [ ] No

14. Do you have a strong support system (friends, family, community)?

[ ] Yes [ ] No

15. What activities bring you joy and relaxation?

_____

Wellness Goals & Expectations:

16. What are your short-term wellness goals?

_____

17. What are your long-term wellness goals?

_____

18. Are there specific areas you would like guidance on? (Check all that apply)

[ ] Nutrition [ ] Stress Management [ ] Sleep Health [ ] Physical Activity

[ ] Emotional Well-being [ ] Other: _____

19. What barriers might prevent you from reaching your goals?

_____

20. How can this consultation best support you in achieving your goals?

_____

Signature: _____

Date: _____

This questionnaire is confidential and for wellness consultation purposes only.