Additional Wellness Questions

Your alcohol use: ☐ None ☐ Rarely ☐ Socially ☐ Daily

Your tobacco use: ☐ None ☐ Rarely ☐ Socially ☐ Daily

How would you rate your stress level? ☐ Low ☐ Medium ☐ High

Do you exercise on a regular basis? ☐ Yes ☐ No

What exercise do you do and how often? ____

____

Are you pre-menopausal? ☐ Yes ☐ No

Are you post-menopausal? ☐ Yes ☐ No

Do you have regular check-ups with your physician? ☐ Yes ☐ No Date of last exam: ________________

Are you under the care of any of the following:

☐ Medical Doctor (MD) ☐ Osteopath (DO) ☐ Dentist ☐ Psychiatrist/Psychologist

☐ Chiropractor ☐ Acupuncturist ☐ Trainer ☐ Physical/Occupational Therapist

May we contact them if needed? ☐ Yes ☐ No

If yes, please complete contact information below for any of the care providers:

Contact Name: ____

Contact Phone: _________________________________ Contact Email: ________________________________

Additional Contact Info: ____

Contact Name: ____

Contact Phone: _________________________________ Contact Email: ________________________________

Additional Contact Info: ____

Contact Name: ____

Contact Phone: _________________________________ Contact Email: ________________________________

Additional Contact Info: ____