Mind Body Connection
Wellness Questionnaire

Name ________________________________ **Date**___________

Please rate your overall physical health (0 = Poor to 5 = Excellent):
Please rate your overall emotional health (0 = Poor to 5 = Excellent):
Please rate your overall spiritual health (0 = Poor to 5 = Excellent):

Blood Type _______

The Essentials of Life

1) Oxygen/Air
   a. Have you ever been told you have emphysema, COPD, or asthma?
   b. Do you participate in any activities that focus on proper breathing (such as yoga)?
   c. Do you perform controlled breathing exercises?
   d. Do you use a point of use air filtration in your home?

2) Water
   a. How much water do you drink per day?
   b. What type of water do you drink (bottled, filtered, tap)?
   c. If you don't drink water, what types of fluids do you drink?
   d. Do you use shower filtration?

3) Nutrition:
   a. Are you currently trying to lose weight through diet?
   b. What type of diet do you follow (if any)?
   c. How many servings per day do you eat per day of the following?
      i. Calcium rich foods/beverages (milk, cheese, calcium fortified beverages):
      ii. Fruits/Vegetables:
      iii. Whole grains:
   d. How many servings per week do you have the following:
      i. Meals at a restaurant
      ii. Fast Food
      iii. Fish
      iv. Red Meat
   e. What types of fats do you eat/cook with (butter, margarine, type of oil)?
   f. How many meals do you usually eat per day?
   g. How many snacks do you usually eat per day?
   h. What is your largest meal of the day?
   i. Do you eat breakfast every day?
   j. Do you take any vitamins or supplements (if yes, please provide list with brand, name of vitamin/supplement, and dosage)

4) Sleep
   a. On average, how many hours do you sleep?
   b. Do you feel rested during the day?
   c. How many times do you wake at night?
   d. What type of mattress do you sleep on and how old is the mattress?

Avoiding Environmental Toxins

1) Smoking
   Do you smoke?
   If yes, packs per day ______   since what year______

2) "Anti-Nutrients"
   a. Do you read food labels before you buy/eat?
   b. Do you know how to identify whether foods have trans-fats?
   c. Do you know how to identify whole grain products?
   d. Do you know what foods contain High Fructose Corn Syrup?
   e. Do you eat organic foods? If yes, which of the following do you buy organic?
      i. Produce
      ii. Meats
      iii. Dairy
      iv. Coffee/tea

Fitness

How often do you participate in the following:
Cardio/aerobic exercise:
Strength training:
Flexibility (stretching, yoga, etc…):
Sports:
Other:

Avoiding Damage from Stress

Do you drink alcohol?   Type: Drinks per week:

Do you experience physical pain on a daily basis?

If yes, does it limit your activity or cause you emotional stress?

Please rate your overall stress level (0 Very little to 5 Severe):

Please list any major/traumatic events in your life (divorce, death of close friend/family, abuse, major illness, etc…)

Current/Recent:

Past:

Do you still have unresolved anger, resentment, or sadness from any of these events?

Do you "self medicate" your stress or negative emotions with alcohol, over-the counter or prescription medications, tobacco, drugs, or food?

Do you think that stress or emotional issues are affecting your physical health?

What relaxation techniques do you use to relieve stress in your life (controlled breathing, yoga, Tai Chi, meditation, prayer, etc…)?

Alternative Modalities:

Do you or have you used alternative health practitioners?

Chiropractic- Massage- Acupuncture- Nutritionist- Microscopy- ?

Other ____

Consent and Release

I, the undersigned, hereby consent to the taking of a blood sample for viewing under a Dark Field Microscope. I understand and acknowledge that this blood sample is for Nutritional viewing and education only and will not be used for diagnostic purpose.

I further understand and acknowledge that no claims of any kind are being made as to the efficiency of any of the supplements or enzymes.

Signature____Date____________________

Person name if under 18 years of age____

Notes: