Planet Wellness Questionnaire

Full Name: _____Today's Date:_____
Preferred Name: _____ Marital Status: Single, Married, Divorced, Widowed, Other
Address: _____ City: _____ State:_____ Zip: _____
Home ( ) _____ Work ( ) _____ Cell ( ) _____
Email Address: _____ Male _____ Female _____
Birth Date: _____ Height: _____
Occupation: _____ Employer Name: _____
Spouse: _____ Your Activity Level: ( ) Low ( ) Moderate ( ) High ( ) Intense
Would you like appointment reminders? Yes No
If yes, ( ) Email ( ) Text to cell (service provider: _____)

YOUR HEALTH SUMMARY

Please ☑ check all symptoms YOU have ever had [self=S], even if they do not seem related to your current problem, & mark [family=F] if you have a FAMILY history of any of them, like this ✓

S	F		S	F		S	F		S	F	
❑	○	Stroke	❑	○	**Epilepsy**	❑	○	Headaches	❑	○	Mood Swings
❑	○	Heart Attack	❑	○	**Hypoglycemia**	❑	○	Neck Pain	❑	○	Loss of balance
❑	○	Diabetes	❑	○	**Pacemaker**	❑	○	Poor Sleep	❑	○	Nervousness
❑	○	Thyroid Disease	❑	○	**Organ Transplant**	❑	○	Dizziness	❑	○	Stomach upset
❑	○	Gallbladder Disease	❑	○	High Blood Pressure	❑	○	Arthritis	❑	○	Tension
❑	○	Kidney Disease	❑	○	Intestine Problems	❑	○	Mid Back Pain	❑	○	Cold feet
❑	○	Depression	❑	○	Shortness of Breath	❑	○	Lower Back Pain	❑	○	Hot flashes
❑	○	Gout	❑	○	High Cholesterol	❑	○	Cancer (Type: _____)	❑	○	Heartburn

List any medications you are taking & what for: _____
_____

In addition to weight loss, if there was one other health condition or struggle that you would love to see your body heal and/or overcome, what would that be? _____

Have you been treated by a physician in the last 12 months? ( ) Yes ( ) No
If "Yes", please describe: _____

Are you under regular chiropractic care? ( ) Yes ( ) No

How long have you been overweight? _____Have you tried to lose weight in the past? ( )Yes ( )No

What are your top 2 reasons why you want to lose weight?

1. _____ 2. _____

Has your doctor recommended you to lose weight? ( ) Yes ( ) No

What is your "Goal Weight"? _____ When is the last time you weighed that? _____

On a scale of 1-10, with 10 meaning "I'm serious about losing weight and fully committed" what is your current level of commitment? 1 2 3 4 5 6 7 8 9 10

Females: Are you pregnant? ( ) Yes ( ) No Are you breast feeding? ( ) Yes ( ) No
Are you on birth control? ( ) Yes ( ) No Do you have an estrogen patch or implant? ( ) Yes ( ) No