Advanced Wellness Survey

Today's Date: _____ / _____ / _____ **Date of Birth:** _____ / _____ / _____ **Gender:** M F

First + Last Name:

Parent Name (If Minor):

Contact Email:

Contact Phone:

Check "Yes" if the condition or disease applies to you, then indicate its relative Severity

	Yes	Severity	
		Low	High
Acne	☐	☐	☐
Addiction	☐	☐	☐
ADHD	☐	☐	☐
Aging Skin	☐	☐	☐
Alzheimer's	☐	☐	☐
Anxiety	☐	☐	☐
Arthritis	☐	☐	☐
Asthma	☐	☐	☐
Autism	☐	☐	☐
Bipolar	☐	☐	☐
Bloating	☐	☐	☐
Brain Fog	☐	☐	☐
Cancer	☐	☐	☐
Cataract	☐	☐	☐
Cholesterol	☐	☐	☐
Concentration	☐	☐	☐
Constipation	☐	☐	☐
Crohn's	☐	☐	☐
Depression	☐	☐	☐
Diabetes	☐	☐	☐
Diabetic Eye Disease	☐	☐	☐
Diarrhea	☐	☐	☐
Eczema	☐	☐	☐
Endometriosis	☐	☐	☐
Erectile Disfunction	☐	☐	☐
Fatigue	☐	☐	☐
Fibromyalgia	☐	☐	☐
Glaucoma	☐	☐	☐
Graves	☐	☐	☐
Heart Disease	☐	☐	☐

	Yes	Severity	
		Low	High
Hypothyroid	☐	☐	☐
IBS	☐	☐	☐
Insomnia	☐	☐	☐
Joint Pain	☐	☐	☐
Libido	☐	☐	☐
Lupus	☐	☐	☐
Macular Degeneration	☐	☐	☐
Memory Loss	☐	☐	☐
Migraine	☐	☐	☐
Multiple Sclerosis	☐	☐	☐
Obesity	☐	☐	☐
Osteoporosis	☐	☐	☐
Parkinson's	☐	☐	☐
Prostate Enlargement	☐	☐	☐
Psoriasis	☐	☐	☐
Retinitis Pigmentosa	☐	☐	☐
Rheumatoid Arthritis	☐	☐	☐
Seizure	☐	☐	☐
Stress	☐	☐	☐
Tinnitus	☐	☐	☐
Ulcerative Colitis	☐	☐	☐
Uveitis	☐	☐	☐
Weight Management	☐	☐	☐
Wrinkles	☐	☐	☐

WOMEN ONLY

Hot Flashes	☐	☐	☐
Impending Pregnancy	☐	☐	☐
Infertility	☐	☐	☐
Menopause	☐	☐	☐

PROVIDER NOTES