CORNERSTONE WELLNESS.MD
Available Through Physicians Only

Health Survey

Today's date _____

Name _____ Birthdate _____

Address _____ City _____ ST _____ Zip _____

Cell phone _____ Home phone _____ Email _____

Which are you interested in? ❑ Losing weight ❑ Gaining weight ❑ Wellness ❑ Other _____

Current weight _____ Goal weight _____ Height _____

Are you serious about losing/gaining weight now? ❑ Yes ❑ No ❑ Unsure

What have you tried before? (list other programs or approaches)

Why did other programs not work for you?

Do you eat three meals a day? ❑ Yes ❑ No List examples of what you normally eat:

Breakfast

Lunch

Dinner

Do you eat between meals? ❑ Yes ❑ No List examples of snacks:

What time of day do you usually snack? Morning _____ Afternoon _____ Evening _____

Are you currently taking any prescription drugs? ❑ Yes ❑ No If yes, for what condition?

Do you have any of these health problems? (Check all that apply)

❑ Alcoholism	❑ Colitis	❑ Heart burn	❑ PMS
❑ Allergies	❑ Constipation	❑ Hypoglycemia	❑ Sexual Intimacy
❑ Anemia	❑ Depression	❑ High blood pressure	❑ Skin trouble/acne
❑ Anxiety	❑ Diabetes	❑ High cholesterol	❑ Sleep apnea
❑ Asthma	❑ Digestive disorder	❑ High triglycerides	❑ SmokingStress
❑ Back Pain	❑ Fatigue	❑ Joint pain	❑ Thyroid condition
❑ Bloating/gas	❑ Fibromyalgia or Lupus	❑ Lactose intolerance	❑ Trouble sleeping
❑ Chronic infections	❑ Food allergy	❑ Migraines	❑ Ulcers
❑ Circulation problems	❑ Headaches	❑ Osteoporosis	❑ Water retention

❑ Other:

How much water do you drink each day? _____ (# 8-oz glasses)

How much caffeine (coffee, tea, soda) do you drink each day? ❑ None ❑ 1-2 servings ❑ 3 or more

Are you currently taking vitamins or supplements? If yes, please list what you take:

How much money do you spend each day on food, including meals at home, restaurants, fast food, snacks, coffees, sodas, etc.?

Are you currently exercising regularly? ❑ Yes ❑ No If yes, for how long?

	Type	**# days/week**	**# minutes/workout**	**Intensity**
Aerobic Exercise				
Strength Resistance				
Stretching/Yoga				

How would you describe your daily activity level?

❑ Light (office work) ❑ Moderate (standing, walking) ❑ Heavy (construction)