BWellness Health Assessment

Name:____Birthday:____________

Address____ Age:______________

Email Address:____

Phone #:______________________________ Relationship status:____________

Height:___________Weight:_________ Body Measurements:________________

Occupation:____________________Children:_______________ Pets:________

Health Concerns:____

Personal Wellness Goals:____

Past Injuries/Illness/hospitalizations:______________________________________

Ancestry:______________________When did you feel your best:_______________

How many hours do you sleep?_______________Do you wake up at night?________

Do you take Supplements?__________ Vitamins:__________Medications:________

Do you suffer from allergies?_________How many meals do you eat daily?_________

Do you exercise?___________ If yes, what activities do you perform?_____________

How often do you exercise?__________________Do you have any cravings?________

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