Please Fill in this document prior to the course:

Please list any current symptoms that are bothering you. Please list by number (most important to least) using short phrases or words. Place a number by each on a scale of 1-10 with one being the least bothersome to 10 being the worst.

Ex. as follows

1. *Sleep issues - 10*
2. *Joint pain and soreness - 5*
3. *Bowel issues/constipation - 3*
4. *Acne - 2*
5. *Moodiness - 1*

Please rate the following health activities on how you are doing at this point in time.
Use 1 as doing great (able to complete almost all the time and it is a steady habit) to 5 (not doing it at all).

Sleeping 7-9 hours well:
Having a good bedtime and routine (bed by 10-11pm):
Exercising:
Quiet/relaxation time:
Hobbies:
Social time/support:
Faith life:
Stress reduction techniques:
Feeling like you have goals and purpose:
Eating healthy:
Relationships (positive vs negative relationships):
Self Talk:
Daily detox strategies:
Fun/laughter:

Please list the barriers you feel you have or may have to sustaining health goals:

Please list the people in your life and put a + or - after (to show if they support your health changes or not):

Ex.

1. *Spouse +*
2. *Kids -*
3. *Co-workers - (except xxxx)*
4. *Parents +*
5. *In-laws -*

Please answer the following with Y/N in relation to if you consume the following:
Gluten:
Dairy:
Eggs:
Sugary foods/desserts:
Processed foods:
Fast food:
Foods with artificial colors:
Foods with artificial flavors:
Foods with artificial sweeteners like aspartame:
Pop (if so what kind and how many/day):
Alcohol (if so what kind and how many/day or week):
Coffee:
Do you add anything to your coffee?
Fruit juice:

Do you eat late at night?
Do you practice any intermittent fasting:
Do you eat while doing other tasks (working, tv, etc..)?
Do you chew 20-30 times with each bite?
Do you think about and enjoy your food?