



Wellness Survey

Name _____

Address _____

City _____ State _____

Zip _____ Phone Number(s) _____

E-mail Address _____

Children's Names _____

Ages _____

• On a scale from 1 to 10 (with 10 being very important), how important is your health?

- Do you eat 7-13 fruits and vegetables daily? Yes No
- Do you exercise regularly? Yes No
- Do you drink at least 64 ounces of water a day? Yes No
- Do you experience frequent colds or flu-like symptoms often? Yes No
- Do you take over-the-counter or prescription medications? Yes No
- Do you experience low energy or have difficulty sleeping? Yes No
- Do you experience irregularity? Yes No
- Do you eat fast food and/or soft drinks frequently? Yes No

➤ What is the most important concern about your family's health?

Comments: