

Columbus Innovative Wellness

Dr. Ardie Singh, D.C., D.PSc

NEW CLIENT HISTORY AND LIFESTYLE INTAKE

Name: _____ DOB: _____ Date: _____

Address _____ City _____

State _____ Zip _____ Phone # _____

In order for us to completely evaluate your health status, please fill out the following pages. Be as *thorough* as possible. Fill out all sections, even ones that you don't think apply to you (except male/female, of course!). This allows us to assess your metabolic, neurological, immune, and structural imbalances.

HEALTH HISTORY

Allergies

Are you allergic to any medications or drugs? Y N

If yes, list names and type of reaction. (Example: penicillin – rash)

_____ 1 _____

Have you ever been tested for food allergies? Y N

Do you have any food allergies (i.e., lactose, gluten, nuts)? Y N

If yes, what foods? _____

Do any foods bother you? Y N (Example: tomatoes – reflux). If yes, what foods? _____

Do you have any environmental allergies? (Example: Dust, ragweed, animals)? Y N

Do you have any seasonal allergies? Y N Please list all you can think of _____

Diagnoses

List any diagnosis you have had (Example: high blood pressure, hypothyroid, high cholesterol, diabetes, sleep apnea, etc.)

1. _____

4. _____

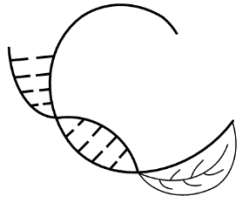
2. _____

5. _____

3. _____

6. _____

Blood Sugar Readings (if applicable)



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What was your lowest reading in the past 3 months? _____

What was your highest reading in the past 3 months? _____

What was your blood sugar level today? _____

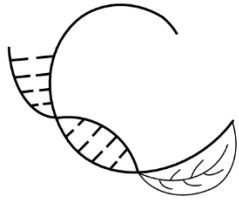
What was your last Hemoglobin A1C level? _____ Date Checked: _____

Current Medications (prescribed and over-the-counter) – please complete separate sheet.

Do you think medications are helping? Y N

Are you having any side effects? Y N Explain: _____

Current Supplements (Vitamins) – please complete separate sheet.



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Surgery

Type of Surgery	Date	Reason
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Hospitalizations

Date	Hospital	How long?	Reason
Example: 1/1/13	Cleve. Clinic	2 days	Gall Bladder
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Family History (If unknown, write "unknown").

Family member	Living?	How old?	List health conditions they had in their life (i.e. cancer, thyroid, heart attack, stroke, etc.)
Mom	Y <input type="checkbox"/> N <input type="checkbox"/>	_____	_____
Dad	Y <input type="checkbox"/> N <input type="checkbox"/>	_____	_____
Mat. Grandmother	Y <input type="checkbox"/> N <input type="checkbox"/>	_____	_____
Pat. Grandmother	Y <input type="checkbox"/> N <input type="checkbox"/>	_____	_____
Mat. Grandfather	Y <input type="checkbox"/> N <input type="checkbox"/>	_____	_____
Pat. Grandfather	Y <input type="checkbox"/> N <input type="checkbox"/>	_____	_____
Sibling	Y <input type="checkbox"/> N <input type="checkbox"/>	_____	_____
Sibling	Y <input type="checkbox"/> N <input type="checkbox"/>	_____	_____
Sibling	Y <input type="checkbox"/> N <input type="checkbox"/>	_____	_____

Kids

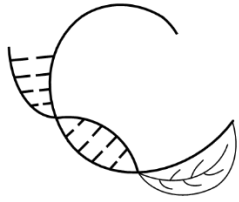
Name	Age	Health Status	Living with you?
_____	_____	_____	Y <input type="checkbox"/> N <input type="checkbox"/>
_____	_____	_____	Y <input type="checkbox"/> N <input type="checkbox"/>
_____	_____	_____	Y <input type="checkbox"/> N <input type="checkbox"/>
_____	_____	_____	Y <input type="checkbox"/> N <input type="checkbox"/>
_____	_____	_____	Y <input type="checkbox"/> N <input type="checkbox"/>

General Constitution

On a scale of 1 – 10 (with 10 being the highest/best):

What is your present energy level (without pushing yourself)? 1 2 3 4 5 6 7 8 9 10 High

What was your energy level 1 year ago? Low 1 2 3 4 5 6 7 8 9 10 High



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What was your energy level 5 years ago? Low 1 2 3 4 5 6 7 8 9 10 High
What time of day do you have the most energy? _____ am/pm to _____ am/pm
What time of day do you have the least energy? _____ am/pm to _____ am/pm
On a scale of 1 – 10 (with 10 being the best):
How would you rate your endurance? Poor 1 2 3 4 5 6 7 8 9 10 Best
How is your short term memory? Poor 1 2 3 4 5 6 7 8 9 10 Best
Are you forgetful? Y N How big of a problem is it? Mild Moderate Severe
Do you get brain fog? Y N How bad does it get? Good 1 2 3 4 5 6 7 8 9 10 Bad
Do you suffer from fevers? Y N Chills? Y N
Do you feel any generalized weakness? Y N

Weight/Height History

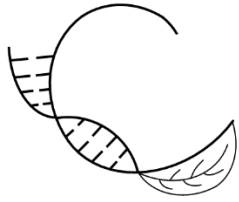
Current Height: _____ feet _____ inches
Current Weight _____ lbs. Weight 1 year ago _____ lbs. Weight 5 years ago _____ lbs.
Is your weight going up or down or is it stabilized? Up Down Stabilized
What is the most you ever weighed as an adult? _____ lbs. Was this during pregnancy? Y N
Can you explain your weight changes? _____
How much weight would you like to lose in 6 months? Be realistic. _____

Eyes/Vision

Do you ever get blurred vision? Y N When (Ex: computer, high blood sugars, etc.)? _____
Do you wear glasses? Y N Contacts? Y N Reading glasses? Y N
Do you ever get double vision? Y N When? _____
How is your night vision? Great Average Poor
Do you have an eye disease (i.e., glaucoma, cataracts, retinopathy)? Y N
What type? _____
Have you had any eye injuries? Y N Type and date: _____

Ears/Nose/Mouth/Throat

Did you or do you suffer from chronic sinus problems Y N
Do you have swollen glands in the neck? Y N Was any testing performed? Y N
Do you have any difficult swallowing? Y N
Does food get stuck in your throat? Y N
Do you have any hearing loss? Y N Hearing aids? Y N
Did you or do you suffer from any ringing in the ears? Y N
Do you get ear aches or drainage? Y N How often? _____
Do you get a stuffy or runny nose? Y N
Do you get frequent nose bleeds? Y N
Do you have mouth sores? Y N
Do you have bleeding gums? Y N
Do you have bad breath? Y N



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Does your voice change? Y N
Do you get frequent hoarseness? Y N How often? _____
Do you get sore throats? Y N How often? _____

Hematologic/Lymphatic/Other

Have you ever been told you were anemic? Y N If so, which type? _____
Do you bleed easily? Y N
Have you ever had any blood clots? Y N Where? _____
Have you ever been told you have phlebitis? Y N
Have you ever had a blood transfusion? Y N Date(s) _____
Have you ever been diagnosed with a bleeding disorder? Y N

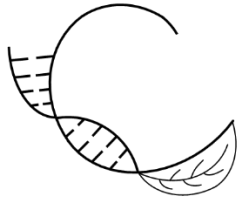
Cardiovascular System

Do you have high blood pressure? Y N
Do you have low blood pressure? Y N
Have you ever been diagnosed with heart disease? Y N
Have you ever had chest pains? Y N Date(s) _____ EKG performed? Y N
Do you ever get heart palpitations? Y N
Have you ever been told you have mitral valve prolapse (MVP)? Y N
Do your feet or ankles swell? Y N
Do you bruise easily? Y N
Do you get shortness of breath? Y N When? (i.e., exertion, stairs, laying down) _____

Do you have varicose veins? Y N
Do you have spider veins? Y N
Have you ever been diagnosed with an aortic aneurysm? Y N
Do you have plaque build-up in your carotid arteries? Y N
Have you ever spit up blood? Y N When? _____
Does your heart rate get really high? Y N
Does your heart rate get really low? Y N
Have you ever been told you have atrial fibrillation? Y N
Have you ever been told you have poor circulation? Y N

Sleep Patterns

If you work, what shift do you work? Day Afternoon Nights Start time: ____ End Time: ____
How many hours of sleep do you get each night? _____ How many do you think you need? _____
Describe how you fall asleep: Watch TV Read a book Go to Bed Other: _____
Do you have trouble falling asleep? Y N
If yes, how long does it take you to fall asleep (give me a range: i.e., 15 -30 min.)? _____
If you awaken at night, do you have trouble falling back asleep? Y N How often? _____
If yes, how long until you to fall back to sleep (give me a range: i.e., 15 -30 min.)? _____
If you dream how often? _____ Do you remember your dreams? Y N



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What time do you go to bed? _____ What time do you get up? _____
Are your sleep habits routine? Y N If not, why? _____
Do you have trouble waking up in the morning? Y N Sometimes
Do you feel well rested upon awakening? Y N Sometimes
When are you most awake and alert? From _____ am/pm to _____ am/pm
Do you get tired during the day? Y N Sometimes What times? _____
Do you get a second wind late at night when you want to stay up later? Y N Sometimes
If so, how many days per week? _____
Rate your sleep on a scale of 1-10 (with 10 being the best) 1 2 3 4 5 6 7 8 9 10 Best

Brain

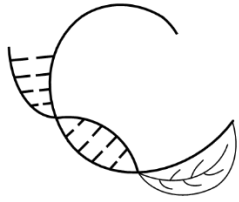
Do you get anxiety attacks? Y N How often? _____
Do you feel depressed? Y N Sometimes
Have you ever been diagnosed with depression? Y N
Do you have a hard time turning your mind off? Y N
Do you have nervousness? Y N
Have you ever been bulimic or anorexic? Y N
Have you ever been told you are bipolar? Y N
Have you ever been diagnosed a schizophrenic? Y N

Genitourinary

Any increase of urinary urgency? Y N If yes, for how long? _____
How many times do you urinate during the night? 1 2 3 4 5 6 Hourly
Do you have burning or painful urination? Y N
Do you have any urinary incontinence? Y N If yes, how long? _____
(i.e., get urinary leakage when you cough, laugh, etc.)
Do you wear urinary protection? Y N
Do you have blood in your urine? Y N
Do you strain to empty your bladder? Y N
What color is your urine? _____
Is there dribbling at the end of urination? Y N
Is your urine stream weaker than it used to be? Y N
Have you ever had kidney stones? Y N # of times: _____
Have you ever had hemorrhoids? Y N Did they bleed? Y N

Males Only

Do you have a decrease in morning erections? Y N
Do you have any difficulty in achieving erections or maintaining an erection? Y N
How long have you had difficulty with erections? _____
Have you ever been diagnosed with erectile dysfunction (ED)? Y N
Are you on medications for ED? Y N Type: _____ Dosage: _____
Is it helping? Y N



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Do you avoid sexual activity because of physical problems? Y N
 Do you have prostate trouble? Y N Enlarged? Y N
 Have you had your PSA checked? Y N If yes, date: ___/___/___ Results: _____
 Have you had a prostate digital exam? Y N If yes, date: ___/___/___
 Results: Normal Enlarged
 Have you ever had a sexually transmitted disease? Y N If yes, explain: _____
 Do you have AIDS or HIV? Y N
 What is the frequency of your present sexual activity? _____
 Does your partner use hormone replacement therapy? Y N

Females Only (Please fill out completely)

Age and year periods began (Onset of menarche) _____
 Date of LMP (Last Menstrual Period) _____
 How many days from start of one period to start of the next?
 Early years _____ 20-30 _____ 30-40 _____ 40-50 _____ >50 _____
 How many days does(did) your period last? _____ Is/has this been the norm? Y N
 Is (was) your cycle regular? Y N Not Always
 Do (did) you pass any clots? Y N If yes, was it? mild moderate or severe
 Is (was) the flow: Heavy Medium Light
 How many pads _____ tampons _____ are/were used on heavy days?
 Do you have cramps BEFORE your period? Y N If yes, how many days? _____
 Do you have cramps DURING period? Y N If yes, how many days? _____
 Do you have spotting (bleeding between periods)? Y N
 Have you ever had (circle all that apply)

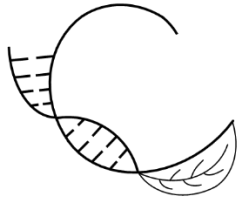
Fibrocystic breasts Uterine Fibroids Endometriosis Genital Warts HPV
 Pelvic Inflammatory Disease Herpes Venereal disease

Are you pregnant now? Y N
 Any change in breast size during period? Y N
 Do you experience tender breasts? Y N If yes, when? _____
 Do you have any nipple discharge? Y N If so, what color? _____
 Do you do breast self-exams? Y N
 Approximate age and year of menopause (if applicable) _____
 Do you have hot flashes? Y N #times during day _____ Mild Moderate Severe
 Do you have night sweats? Y N # during night _____ Mild Moderate Severe
 # per week: Hot flashes _____ Night sweats _____

Have you ever taken estrogen or hormone replacement therapy (HRT)? Y N

Name of hormone	Dosage	Pill or Cream
_____	_____	_____
_____	_____	_____
_____	_____	_____

Approximate age and year of estrogen/HRT _____ For how many years? _____
 Are you still on HRT? Y N Does your partner use HRT? Y N



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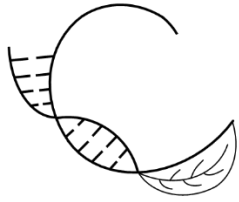
Date of last mammogram and findings: Negative Positive For what? _____
How many mammograms have you had in your life? _____
Date of last pelvic/gynecological exam and result: Negative Positive For what? _____
Date of last pap test and result: Negative Positive For what? _____
Do you experience itching or burning of the vaginal area? Y N
Do you experience vaginal discharge? Y N
If yes: Amount _____ Color _____ When did this begin? _____
Do you get yeast infections? Y N If yes, how often? _____ Date of last one: _____
Do you have pain/discomfort with sexual intercourse? Y N If yes, explain: _____
Have you ever had a sexually transmitted disease? Y N If yes, explain: _____
Do you have AIDS or HIV? Y N

Birth Control Methods & Pregnancy History (females only):

Have you used an IUD? Y N If yes, what type? _____
Describe any problems with IUD: _____
Have you used any form of Birth Control Pill, Patch or Shot? Please indicate which type & how long:
Pill How long? _____ Shot How long? _____ Patch How long?: _____
How old were you when you started birth control? _____ How many total years on birth control? _____
Describe any problems while on Birth Control (i.e., weight gain)? _____
Do you find your present birth control method satisfactory for your health? Y N
Have you ever been pregnant? Y N
Number of Pregnancies: 1 2 3 4 5 6 7+
How old were you during pregnancies? _____
Describe any complications with pregnancies/deliveries? _____
Did you breastfeed? Y N If yes, how long? _____
What is the frequency of your present sexual activity? _____

GastroIntestinal

Do you get belly aches or stomach pain? Y N
If yes, how many times? per week: _____ per month: _____ Mild Moderate Severe
Do you get bloated after you eat? Y N
If yes, when do you notice? 15 min. after meal 1 hour after meal 2+ hours after meal
How long does it take to go away? _____
When did this start? _____
Do you pass gas? Y N Foul smelling? Y N Burping/belching? Y N
Do you get heartburn/gastric reflux? Y N
Have you ever been told you have a hiatal hernia? Y N
Have you ever had ulcers? Y N
Do you get nausea? Y N If so, when? _____
Do you have any vomiting? Y N
If so, is there ever any blood in your vomit? Y N



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Have you ever had a liver problem? Y N Type: _____
Have you ever had hepatitis? Y N If yes, type: Hep. A Hep. B Hep. C
Have you ever had gallbladder problems? Y N
Have you ever had your gallbladder removed? Y N Date(year): _____
Have you ever had any colon problems (i.e., Crohns, colitis, diverticulitis, IBS, etc.)? Y N
Have you ever had appendicitis? Y N Did you have it removed? Y N
Have you ever had pancreatitis? Y N
Have you ever noticed a loss in your appetite? Y N When? _____
Have you ever noticed an increase in your appetite? Y N When? _____
Do you feel hungry all of the time? Y N

Bowel Movements

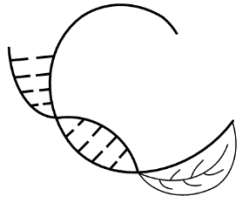
How many bowel movements do you have per day? _____ If not daily, how many per week? _____
Well formed? Y N Hard? Y N Small marble size? Y N Runny? Y N
How many times per week for solid stools? _____ Runny or loose stools? _____
What is the color? Clay Lt. Brown Med. Brown Dark Brown Black Tan Red
Do they sink? Y N Sometimes Unknown
Do they float? Y N Sometimes Unknown
Did you ever get ribbon-shaped stools? Y N How often? _____
Did you ever get "pencil" looking stools? Y N How often? _____
Have you ever had blood in your stool? Y N If yes, how long? _____
If yes, what was the color of the blood? Bright red Darker color
Are bowel movements painful? Y N How often? _____ per week _____ per month

Respiratory

Do you have a chronic cough? Y N
Do you spit up blood? Y N
Have you had pneumonia? Y N # of times: _____ Last episode: _____
Do you have wheezing attacks? Y N
Have you had pleurisy (inflammation of the lung lining)? Y N When? _____
Do you have difficulty breathing? Y N
Do you have asthma? Y N Are you on medication for it now? Y N
Have you ever been diagnosed with emphysema or COPD? Y N

Endocrine

Do you have any parathyroid gland problems? Y N
Have you ever been told you have a goiter or nodule on your thyroid? Y N When? _____
Do you have excessive thirst? Y N
Does the heat bother you? Y N
Does cold weather bother you? Y N
Do your hands and feet get cold? Y N



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Do you startle easily or do loud noises make you jump? Y N
Do you have dry skin? Y N Mild Moderate Severe
Do you have any swollen glands? Y N Where? _____

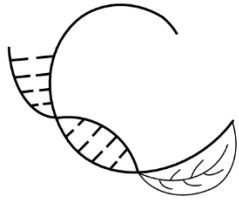
Musculoskeletal

Do you have a spinal curvature or scoliosis? Y N
Do you have arthritis? Y N If yes, where? _____
What is your pain level? Best 1 2 3 4 5 6 7 8 9 10 Worst
Do you have joint pain? Y N What joints? _____
What is your pain level? Best 1 2 3 4 5 6 7 8 9 10 Worst
Does your joint pain move around (i.e., from knees to shoulder)? Y N
Do you have muscle pain? Y N Where? _____
Do you get muscle cramps? Y N Where? _____
Do you cramp when active? Y N What activity? _____
Do you cramp when resting (i.e., in bed)? Y N
Do you have any muscle/joint weakness? Y N
Do you have difficulty walking? Y N If yes, why? _____

Neurologic

Do you have headaches? Y N If yes, how many per week? _____ Per month? _____
Do you get migraine headaches? Y N If yes, how many per week? _____ Per month? _____
Do you get morning headaches? Y N
Do you get afternoon headaches? Y N
Have you ever had a seizure? Y N
Do you feel you have lost coordination? Y N
Do you experience numbness or tingling? Y N If so, where? _____
Do you feel you have tremors? Y N
Have you ever had a head injury? Y N Concussion? Y N If so, when? _____
Do you get dizzy? Y N
Do you get lightheaded? Y N Does it happen if you stand up too quickly? Y N
Do you have fainting spells? Y N
Have you ever had a stroke or TIA? Y N
Are you slow to heal after cuts? Y N
Have you ever had cancer? Y N Type(s): _____
Have you ever had infectious MONO? Y N
Have you ever had any of these diseases? (Circle all that apply)
Chicken Pox Mumps Measles
Were you vaccinated? Y N
Have you ever had shingles? Y N

Integumentary (Skin/Breast)



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Do you have any rashes? Y N Where? _____

Do you have an itching or crawling sensation? Y N Where? _____

Do you have any of the following on your body? (Circle all that apply)

Hives Eczema Psoriasis Open Wounds

Do you have any changes in skin color? Y N

Is your hair thinning? Y N If so, how severe is the problem? Mild Moderate Severe

Do you have fungus on your toenails? Y N Finger nails? Y N

Do you have brittle nails (nails that break easy)? Y N

LIFESTYLE HISTORY

Tobacco

Do you currently use tobacco? Y N Type:

cigars # per day _____ How many years? _____

cigarettes # packs per day _____ # per week _____ How many years? _____

chewing tobacco how many times in a day? _____ How many years? _____

Have you ever tried to quit the use of tobacco? Y N How many times? _____

Did you ever use tobacco? Y N When? _____ How long? _____ How much? _____

Were you (or are you) exposed to second-hand smoke? Y N

Do you use recreational drugs (i.e, marijuana, cocaine, etc.)? Y N

Beverages – Liquids:

Water: How many ounces of water (by itself) do you drink per day? _____

What type of water? Filtered City / Well Spring Distilled

Milk: Do you drink milk? Y N Type: Skim 1% 2% Whole Soy Almond

How many glasses per day? _____ Per week? _____

Decaffeinated Beverages: Do you drink any caffeine-free beverages? Y N

Type: Decaf Coffee Y N How many cups? _____ Day _____ Week

Decaf – Herbal Tea Y N How many cups? _____ Day _____ Week

No-Caffeine Sodas Y N How many cups? _____ Day _____ Week

Caffeinated Beverages: Do you drink any caffeinated beverages? Y N

Type: Coffee: How many cups? _____ Day _____ Week

Tea: How many cups? _____ Day _____ Week

Soda/Diet Soda: How many cups? _____ Day _____ Week

Name of soda: _____

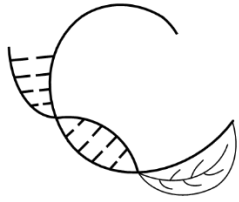
Alcohol: Do you consume any alcoholic beverages? Y N

Type	# per Day	# Per Week	# Per Month	# Per Year
------	-----------	------------	-------------	------------

Beer <input type="checkbox"/>	_____	_____	_____	_____
-------------------------------	-------	-------	-------	-------

Wine <input type="checkbox"/>	_____	_____	_____	_____
-------------------------------	-------	-------	-------	-------

Mixed Drinks <input type="checkbox"/>	_____	_____	_____	_____
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Dietary Patterns:

Infant Diet: Breast Fed? Y N Bottle Fed? Y N

Childhood Diet: American? Y N Vegetarian? Y N Other? explain) _____

Adult Diet: American? Y N Vegetarian Y N Other? (explain) _____

Present Diet: American? Y N Vegetarian Y N Other? (explain) _____

Do you follow a low-fat diet? Y N Not sure

How many meals do you eat per day? _____

What % of your meals are eaten at home? _____% What % are eaten out? _____%

What % of the food you eat is cooked? _____% What % is raw? _____%

Do you eat/consume any: Soy/tofu products? Y N If yes, how often? _____

Do you use any soy nutritional supplements? Y N

What foods or mixtures do you avoid and why do you avoid them? _____

Do you have food cravings? Y N . If so, which foods or type of foods do you usually crave?

What food do you sometimes crave (if any)? _____

Exercise Habits

Are you doing any type of exercise? Y N Consistently? Y N

What type (ex. swimming, walking, aerobic, weights)? _____

Type	# times per week	Length of time
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Please list all doctors you currently see:

Primary doctor: _____

For what condition(s) are you seeing him/her? _____

Doctor #2: _____

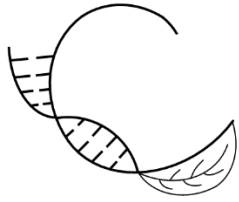
For what condition(s) are you seeing him/her? _____

Doctor #3: _____

For what condition(s) are you seeing him/her? _____

Have you ever had any of the following tests?

CAT Scan Date(s) _____ Area(s) _____ Reason _____



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- MRI Date(s) _____ Area(s) _____ Reason _____
- Bone scan Date(s) _____ Area(s) _____ Reason _____
- X-Rays Date(s) _____ Area(s) _____ Reason _____
- Ultrasound Date(s) _____ Area(s) _____ Reason _____
- Bone density Date(s) _____ Area(s) _____ Reason _____
- EKG Date(s) _____ Area(s) _____ Reason _____
- Stress EKG Date(s) _____ Area(s) _____ Reason _____
- Other Test Type: _____ Date(s) _____ Area(s) _____ Reason _____
- Other Test Type: _____ Date(s) _____ Area(s) _____ Reason _____
- Other Test Type: _____ Date(s) _____ Area(s) _____ Reason _____

What was the date of your last blood work? _____

How willing are you to get your health back? On a scale of 1 to 10 with 10 being the most willing mark the number that best describes your motivation to:

Significantly modify your diet? Least 1 2 3 4 5 6 7 8 9 10 Most

Take several nutritional vitamins each day? Least 1 2 3 4 5 6 7 8 9 10 Most

Keep a record of everything that you eat? Least 1 2 3 4 5 6 7 8 9 10 Most

Modify your lifestyle (diet,sleep,habits)? Least 1 2 3 4 5 6 7 8 9 10 Most

Practice relaxation techniques? Least 1 2 3 4 5 6 7 8 9 10 Most

Engage in regular exercise? Least 1 2 3 4 5 6 7 8 9 10 Most

Have periodic lab tests to assess progress? Least 1 2 3 4 5 6 7 8 9 10 Most

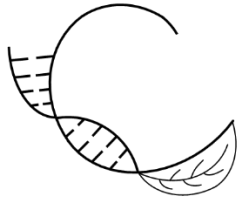
At the present time, how supportive do you think people in your household will be to your implementing the above changes? Least 1 2 3 4 5 6 7 8 9 10 Most

Where do you think you will be health-wise in 1 year if you DO NOT get help now? _____

Where do you think you will be health-wise in 5 years if you DO NOT get help now? _____

On a scale of 1-10 (10 being the most motivated), how motivated are you to getting your health back? Least 1 2 3 4 5 6 7 8 9 10 Most

Is health your top priority? Y N If no, why not? _____



Columbus Innovative Wellness

Dr. Ardie Singh, D.C., D.PSc

Additional Information: Is there anything you would like to add that I did not ask you?

Health Goals

What are your health goals if we accept you into care? Be specific and realistic!

Examples: more energy, better sleep, reduced medications, weight loss, improved digestion

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____