



# Wellness Survey



Name \_\_\_\_\_ Age \_\_\_\_\_ E-Mail \_\_\_\_\_  
Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_  
Zip \_\_\_\_\_  
Phone \_\_\_\_\_ Work \_\_\_\_\_ Cell \_\_\_\_\_  
Occupation \_\_\_\_\_ # hours working per week \_\_\_\_\_

## 1) Check off any of the following symptoms you have experience in the last 6 months:

- |  |   |   |
|--|---|---|
| <input type="checkbox"/> Fatigue                                 | <input type="checkbox"/> Insomnia                                   | <input type="checkbox"/> Menstrual Problems |
| <input type="checkbox"/> Headaches/Migraines                     | <input type="checkbox"/> Irritability                               | <input type="checkbox"/> Asthma             |
| <input type="checkbox"/> Pain/Tension/Numbness                   | <input type="checkbox"/> Digestive Trouble                          | <input type="checkbox"/> Bladder Trouble    |
| <input type="checkbox"/> Neck <input type="checkbox"/> Legs      | <input type="checkbox"/> Constipation <input type="checkbox"/> Gas  | <input type="checkbox"/> Ringing in Ears    |
| <input type="checkbox"/> Shoulders <input type="checkbox"/> Arms | <input type="checkbox"/> Diarrhea <input type="checkbox"/> Bloating | <input type="checkbox"/> Nervousness        |
| <input type="checkbox"/> Low Back <input type="checkbox"/> Hands | <input type="checkbox"/> Sinus Problems/Allergies                   | <input type="checkbox"/> Dizziness          |
| <input type="checkbox"/> Weight Trouble                          |   |   |
| <input type="checkbox"/> Other _____                             |   |   |

## 2) Does this cause:                      3) Does this affect your work?                      4) Does this affect your life?

- |  |  |  |
|--|--|--|
| <input type="checkbox"/> Moodiness                   | <input type="checkbox"/> Decision Making             | <input type="checkbox"/> Lose Patience with Spouse and/or Child(ren)         |
| <input type="checkbox"/> Irritability                | <input type="checkbox"/> Poor Attitude               | <input type="checkbox"/> Restrict household duties                           |
| <input type="checkbox"/> Interrupted Sleep           | <input type="checkbox"/> Decreased Productivity      | <input type="checkbox"/> Hinder ability to exercise or Participate in Sports |
| <input type="checkbox"/> Restricted Daily Activities | <input type="checkbox"/> Exhausted at the End of Day | <input type="checkbox"/> Interfere with Ability to Participate in Hobbies    |
|  | <input type="checkbox"/> Unable to Work Long Hours   |  |

## If you could eliminate one health concern, what would it be?

Have you been in an accident in the last 6 months?                      Yes                      No

**There are several alternatives available to you. Please check the item Most appropriate to you.**

- I would like to see Dr. Beneski for a consultation. There is NO CHARGE for this office visit.
- I would like Dr. Beneski to call me to discuss my health problems before making an appointment.
- I would like to come in on: \_\_ Monday \_\_ Tuesday \_\_ Wednesday \_\_ Thursday \_\_ Friday

By Signing this form, I freely provide my permission to participate in a health screening and massage. I understand that this does not create a doctor/patient relationship and is provided for education and relaxation only. I have been informed of the effects massage may have on me, including improved relaxation, and better circulation, but also muscle soreness and release of toxins.

Signature \_\_\_\_\_ Date \_\_\_\_\_