Patient Survey

the WELLNESS prescRiption

Over the last 6 months how healthy have you felt?

1	2	3	4	5	6	7	8	9	10
Awful									Wonderful

How valuable is your health to you?

1	2	3	4	5	6	7	8	9	10
No Value									Very Valuable

Do you take any vitamins or nutritional supplements?

Yes _____ No _____

If Yes, what supplements do you currently take?

Where do you purchase your supplements?

How do you decide which supplements to take?

Do you think your supplements are effective?

Yes _____ No _____ Unsure _____

If this office offered a test that would measure your personal wellness, and guide your wellness program, how interested would you be?

Very Interested _____ Somewhat Interested _____ Not interested _____

Which of the following is of interest to you?

Customized Nutrition _____ Weight Management _____ DNA Analysis _____

Would you like guidance from your healthcare professional in these matters?

Yes _____ No _____

If there is a natural alternative to what you are currently taking, would you be interested?

Yes _____ No _____

(Please Print) Your Name _____ Phone # _____

Sincerely, Dr. _____