Name: ______________________________ Date: ____________________

1. Do you consider yourself to be healthy? ______________________________

2. On a scale from 1 – 10 (10 being the highest) rate your overall health and well-being?

   (Not Healthy) 0 1 2 3 4 5 6 7 8 9 10 (Healthy)

3. Your current lifestyle habits:

Exercise	X per week	Tobacco use	X per day
Fast Food	X per week	Medications	
Meditate	X per week	Daily vitamins	

4. What are your health goals?

   ____

   ____

5. What do you feel needs to change to meet your goals? ____________________

   ____

6. Which one of your health goals presents the biggest challenge? ____________________

   ____

7. What would your health be like if you continued what you are doing now?

   ____

8. How committed are you to obtaining your health?

   (Not) 0 1 2 3 4 5 6 7 8 9 10 (100%)

Here are the services we offer: Please circle your interest

Chiropractic Care	Upper Cervical Specific Technique
Detox / Purification Programs	Therapeutic Massage
Pediatrics	Smart Fit Personalized Exercise Program
Pre & Post Natal Specific Techniques	Personalized Nutrition Program