Exceptional Wellness Plan

Name ______________________________ Date __________________

Wellness Assessment

Occupation _______________________ How long? __________________________

In a scale from 1-10, with 10 being the most severe and most important .

Area of Health	Severe	Most important
Allergy Symptoms (i.e. runny nose, itching, congestion, etc.)	______	__________
Immune System (i.e. prone to diseases, auto-immune issues, etc.)	______	__________
Digestion (i.e. acid reflux, indigestion, constipation, etc.)	______	__________
Sleep (i.e. insomnia, sleep apnea, etc.)	______	__________
Mental Acuity (i.e. concentration, memory, etc.)	______	__________
Energy (i.e. tired, lethargy, chronic fatigue, listlessness, etc.)	______	__________
Physical Pain (i.e. back pain, neck pain, headaches, migraines, etc.)	______	__________
Physical Mobility (i.e. injury, range of motion limitation, etc.)	______	__________
Emotional Mood (i.e. anxiety, depression, anger, etc.)	______	__________
Emotional Stress (i.e. worry, overwhelm, irritability, etc.)	______	__________
Other ______________________________	______	__________

How much time do you spend in a week

1. At work____ 2. W/Family_______ 3.Exercise/sport_____

Wellness Goals

If you could make major improvements in up to three of these areas, which would they be?

1. ____ By When?______
2. ____ By When?______
3. ____ By When?______