WAY TO WELLNESS QUESTIONAIRRE

FULL NAME_____NICKNAME_____

DATE OF BIRTH _____BIRTHPLACE _____ TIME_____

EMAIL _____CELL _____

Body (Circle answers where indicated)

1. When you were a child was your body type Thin, wiry? Slim, athletic? Leaned toward plump? _____
2. When you were a child, were you in constant motion, anxious, ADD? Active, determined? Slow, steady? _____
3. What is your body type like now? _____
4. What is your physical energy overall? _____
5. What is your favorite style of exercise? _____
6. How often do you exercise a week? _____
7. Would you describe yourself as healthy? _____
8. Are you currently undergoing medical treatment for an illness/injury? _____
9. Do you have any chronic pain in your body? _____ Where? _____
10. Do you have any food allergies? _____ List: _____

Mind

1. Have you ever meditated? _____ If so, how? _____
2. Do you tend to worry a lot? _____ If so, why? _____
3. Would you say you overthink things in your life? _____
4. Would you say you are focused and determined? Or scattered and forgetful? Quick witted? Slow deep thinker? _____
5. Do you have trouble letting go of thoughts and issues? _____
6. When do you tend to lose track of time and thoughts? _____
7. Are you good at visualization? _____
8. Have you ever used mantra as meditation? _____
9. Do you have trouble sleeping or nightmares? _____

WAY TO WELLNESS QUESTIONAIRRE (continued)

Spirit

1. Did you have a religious practice as a child? _____Now? _____
2. Do you have a spiritual practice? _____
3. Are you empathic? (able to feel others pain and emotions) _____
4. Have you been described as overly sensitive? _____
5. Do you believe in angels or spirit guides? _____
6. Have you had visions of spirits? _____
7. Do you believe in God/Divine Spirit/Source? _____
8. Do you believe in reincarnation? _____

Support

1. Are you married? _____ How Long? _____Happily? _____
2. Are you divorced? _____Widowed? _____Separated? _____ How Long Ago? _____
3. Do you have children? _____ Ages?_____Live at home?_____
4. Are you parents still alive? _____
5. If so, do you provide care for them? _____
6. Have you recently experienced the loss of a loved one? _____ Who? _____
7. Would you say you have supportive friends? _____
8. Are you the strong nurturer in your social circle? _____
9. When you need help, do you have people to call on? _____
10. What are you hoping to achieve through this program? _____

Please circle all healing modalities you have tried:

Reiki Crystals Sound Healing Tarot Reading Quantum

Astrology Numerology Acupuncture Shiatsu Massage

Other: _____

Please feel free to answer as many questions as you feel comfortable with to help us best assess your needs. It's okay to skip any you are not comfortable with. Please use the back for extra information that you feel will be helpful. Your answers are completely confidential.