Health Assessment

Name_____Date_____

List 3 of your Major Health Issues/Concerns:_____

_____

If you had one wish which would you like to get RID of the most?_____

How long and when was the Very First time you ever noticed and or was diagnosed?_____

How often are you suffering with this condition monthly?_____

How many prescriptions are you currently taking?_____

List of Medication:_____

_____

If you can improve your health without drugs or surgery, would you? Yes / No

Do you feel that your health improves each year, stays the same or worsens? _____

On a Scale of 1-10, 10=great health 1=poor health: Where do you rate yourself? _____/10

Specific Goals – List 3 Health Targets & Goals that you would love to accomplish next year:

_____

_____

_____

On a Scale of 1-10, 10 being your GREATEST DESIRE to improve your health where would you rate your DESIRE? _____

Is there anything you can think of that is preventing you from reaching your Targets & Goals, explain? _____

_____