CMC Healthy Living Questionnaire

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Name ______________________ **Phone Number** ____________________

Email ___________________________ **Age** _____ **M/F** ______

I have concerns about:

- ☐ Weight Loss
- ☐ Arthritis
- ☐ Alzheimer's
- ☐ Indigestion
- ☐ Menopause/PMS
- ☐ Gout
- ☐ Lack Energy
- ☐ Heart Disease
- ☐ Pain/Describe _________
- ☐ Acid Reflux
- ☐ Fibromyalgia
- ☐ Memory
- ☐ Blood Sugar Regulation
- ☐ High Cholesterol
- ☐ Head Aches
- ☐ Cataracts
- ☐ Sweet Tooth
- ☐ Cancer/Type_________
- ☐ Diabetes
- ☐ Osteoporosis
- ☐ Irregularity
- ☐ High Blood Pressure
- ☐ Fatigue
- ☐ Dehydration
- ☐ Stroke
- ☐ Muscle & Joint Pain
- ☐ Injury/Type__________

Addiction to:

- ☐ Soda / Diet Soda – Number per day ______
- ☐ Coffee / Tea – Cups per day ______

My diet includes:

- ☐ Milk - Glasses __________
- ☐ Bread ________________
- ☐ Alcohol
- ☐ Chips/Dips - Snacks ____________
- ☐ Ice Cream - Dairy ____________
- ☐ Vegetables
- ☐ Breakfast ______________________
- ☐ Sugar/Sweetener Artificial
- ☐ Pastas __________________
- ☐ Drugs
- ☐ Pies - Cakes - Cookies
- ☐ Fish
- ☐ Meat - Types ___________________
- ☐ Lunch __________ Dinner _________

Prescription Drugs: ____

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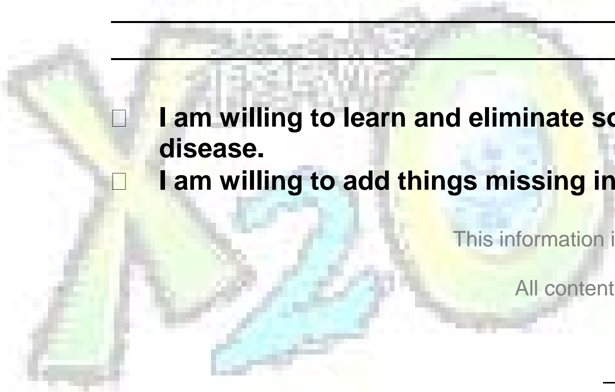

- ☐ **I am willing to learn and eliminate some things to get healthier and prevent disease.**
- ☐ **I am willing to add things missing in my diet to prevent disease.**

This information is not intended to diagnose, treat, cure, or prevent disease.
Consult your health practitioner for any medical advice.
All content of this page is for informational purposes only and has not been evaluated by the Food and Drug Administration.

____________________________**Signed**

______________________**Date**