

Get Living Questionnaire

Client name _____ Date _____

Primary phone number _____ Cell, Work, or Home?

Email _____

Marital status _____ Occupation _____

Birth date _____ Time _____

Location _____

Height _____ Weight _____

Age _____

Activity Level (circle one)

Sedentary = office job, sitting all day, or less than 3000 steps per day

Lightly Active = Exercise 1-3x/week or 3-10k steps daily

Moderately Active = Exercise 3-5x/week or 10-15K steps daily

Highly Active = Hard exercise 6-7x/week or 15-20k steps daily

Extremely Active = Intense daily exercise, hard physical labor 7 days a week or 25K steps or more daily

Goals and Desires for the next YEAR of your life _____

Goals and Desires for the next 5 years of your life _____

Goals and Desires for the next 10 years of your life _____

What are you hoping to get from working with Get Living? _____

Health information.

Please circle any health conditions you have.

Aids Allergies Anemia Arthritis Artificial joints Asthma Auto Accident Back
pain Broken Bones Cancer Diabetes Divorce Dizziness Epilepsy Excessive
Bleeding Fainting Glaucoma Growths Hay Fever Head Injuries Heart Disease High
Blood Pressure Jaundice Kidney Disease Liver Disease Mental Disorder Nervous
Disorder Physical Trauma Pregnant Now Respiratory Problems Rheumatic Fever
Rheumatism Sinus Problems Stomach Problems Stroke Thyroid Ulcers Tuberculous
Tumors Ulcers Venereal Disease Other Present Pains

Any other conditions not listed above??

Have you had a diagnosis ? Does it feel right to you? What are your symptoms?

What is your belief system? Do you feel comfortable with the word God, Universe, Creator, Divine?

Is God a loving God?

Have you seen a Chiropractor, Nephrology? D.O.M. ? Ayurvedic Practitioner? Homeopathic? `

`Do you have an insurance plan?

Do you have a regular Doctor? What kind?

For the Following Questions, please answer YES OR NO. If the answer is yes, add a brief explanation 1 sentence to 1 paragraph. You may use the back of the paper or another sheet if you need more room.

Do you remember a significant turning point in your life that may have contributed to this condition?

How old were you?

How many siblings do you have?

Do you have any pets?

Do you have Children?

Can you think of any Childhood Traumas?

Any mid life Traumas or Crisis?

Loss of Family or Friends?

Workplace stress?

Intimate Relationship stress or crisis,

Breakups or Betrayal?

Homeless experiences?

Heart Breaks?

Healing Crisis?

Financial Hardships or unexpected debts?

Child Support?

Court Orders?

Evictions?

Loss of Pets?

Loss of Possessions and or Property?

Mental Breakdowns?

Emotional Breakdowns?

Disclaimer!

Get Living and or its affiliates or not responsible for any Medical Diagnosis or Medical Treatment please consult your Primary Doctor.