



Name: \_\_\_\_\_

Date \_\_\_\_\_

Email: \_\_\_\_\_

## Part 1: Physical State

Presence of physical pain (Neck/back ache, sore arms/legs, etc.L)

Circle one:

Never Rarely Occasionally Regularly Constantly

Feeling tension or stiffness or lack of flexibility in your spine.

Circle one:

Never Rarely Occasionally Regularly Constantly

Incidence of Fatigue or low energy.

Circle one:

Never Rarely Occasionally Regularly Constantly

Incidence of cold and flu.

Circle one:

Never Rarely Occasionally Regularly Constantly

Headaches of any kind.

Circle one:

Never Rarely Occasionally Regularly Constantly

Nausea or constipation.

Circle one:

Never Rarely Occasionally Regularly Constantly

Allergies or skin rashes.

Circle one:

Never Rarely Occasionally Regularly Constantly

Accidents or falling or tripping.

Circle one:

Never Rarely Occasionally Regularly Constantly

Menstual discomfort.

Circle one:

Never Rarely Occasionally Regularly Constantly

## **Part 2: Mental/Emotional State**

If pain is present, how distressed are you about it?

Circle one:

Never Rarely Occasionally Regularly Constantly

Presence of negative or critical feelings about yourself.

Circle one:

Never Rarely Occasionally Regularly Constantly

Experience of moodiness or temper or angry outbursts.

Circle one:

Never Rarely Occasionally Regularly Constantly

Experiene of depression or lack of interest.

Circle one:

Never Rarely Occasionally Regularly Constantly

Being overly worried about small things.

Circle one:

Never Rarely Occasionally Regularly Constantly

Difficulty thinking or concentration or indecisiveness.

Circle one:

Never Rarely Occasionally Regularly Constantly

Experience of Vague fears or anxiety.

Circle one:

Never Rarely Occasionally Regularly Constantly

Being fidgety or restless; difficulty sitting still

Circle one:

Never Rarely Occasionally Regularly Constantly

Difficulty falling or staying asleep.

Circle one:

Never Rarely Occasionally Regularly Constantly

Experience of recurring thoughts or dreams.

Circle one:

Never Rarely Occasionally Regularly Constantly

### **Part 3: Stress Evaluation**

Please rate your stress relative to the following:

Family

None Slight Moderate Pronounced Extensive

Significant Relationship

None Slight Moderate Pronounced Extensive

Finances

None Slight Moderate Pronounced Extensive

Sex Life

None Slight Moderate Pronounced Extensive

Work

None Slight Moderate Pronounced Extensive

School

None Slight Moderate Pronounced Extensive

General Well-being

None Slight Moderate Pronounced Extensive

Emotional Well-being

None Slight Moderate Pronounced Extensive

Coping with Daily Problems

None Slight Moderate Pronounced Extensive

## Part 4: Life Enjoyment

Using the following scale, rate the following:

Openness to guidance to your "inner voice/feelings.:

None Slight Moderate Pronounced Extensive

Experience of relaxation, ease, or well-being.

None Slight Moderate Pronounced Extensive

Presence of positive feelings about yourself.

None Slight Moderate Pronounced Extensive

Interest in maintaining a healthy lifestyle (e.g. diet, fitness,etc)

None Slight Moderate Pronounced Extensive

Feeling of being open and aware/connected when relating to others.

None Slight Moderate Pronounced Extensive

Level of confidence in your ability to deal with adversity:

None Slight Moderate Pronounced Extensive

Level of compassion for, and acceptance of, others

None Slight Moderate Pronounced Extensive

Satisfaction with the level of recreation in your life

None Slight Moderate Pronounced Extensive

Incidence of feelings of happiness or joy

None Slight Moderate Pronounced Extensive

Level of satisfaction with your sex life

None Slight Moderate Pronounced Extensive

Time devoted to things you enjoy

None Slight Moderate Pronounced Extensive

## Part 5: Overall Quality of Life

Using the following scale, evaluate your feelings relative to the quality of life.

Your personal life

Terrible Unhappy Mostly Dissatisfied Mixed Mostly Satisfied Pleased Delighted

Your wife/husband or significant other

Terrible Unhappy Mostly Dissatisfied Mixed Mostly Satisfied Pleased Delighted

Your Romantic Life

Terrible Unhappy Mostly Dissatisfied Mixed Mostly Satisfied Pleased Delighted

Your co-workers

Terrible Unhappy Mostly Dissatisfied Mixed Mostly Satisfied Pleased Delighted

The actual work you do

Terrible Unhappy Mostly Dissatisfied Mixed Mostly Satisfied Pleased Delighted

The handling of your problems

Terrible Unhappy Mostly Dissatisfied Mixed Mostly Satisfied Pleased Delighted

What you are accomplishing in your life

Terrible Unhappy Mostly Dissatisfied Mixed Mostly Satisfied Pleased Delighted

Your ability to adjust to change

Terrible   Unhappy   Mostly Dissatisfied   Mixed   Mostly Satisfied   Pleased   Delighted

Your life as a whole

Terrible   Unhappy   Mostly Dissatisfied   Mixed   Mostly Satisfied   Pleased   Delighted

## Consents

### Communication

#### Appointment Reminders and Notifications

##### Email

You can opt to receive emails to keep you informed of new bookings, changes in your bookings, and reminders of appointments.

I would like to received email notifications

##### Text Messages

I would like to receive text messages 24 hours before appointments

I would like to receive text messages 2 hours before appointments (you can choose both)

#### Privacy and Sharing of Information- Required

I authorize A Garden for Wellness and its associated health professional to collect my personal and medical information as documented above. In addition, I authorize the clinic and its associated health professionals to communicate with my family doctor and/or referring doctor as deemed necessary for my beneficial treatment. I also understand that my personal and medical information is confidential and will only be disclosed to third parties with my permission.

I agree

#### Signature- Required

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Date

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