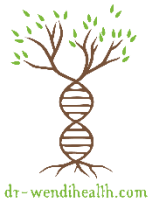
Assessment Form



Name _____ Date_____

Email _____

Phone _____

Please answer each of the following questions using the space provided.

1. How did you find out about Dr. Wendi? _____
2. What is your Height? _____ Weight? _____ Age _____ Gender _____
3. What are your primary health concerns? Please list them in order of priority.

   _____

   _____
4. What level of stress would you say you have been feeling currently in the past 1-2 weeks on a scale of 1 (low stress) to 10 (high stress)? _____
5. Do you have any unhealthy coping mechanisms such as drinking excess alcohol, smoking, eating junk food etc.? _____

   _____
6. Do you have healthy coping mechanisms like meditation, exercise, talking to a friend?

   _____

   _____
7. How would you describe your energy level on a scale of 1 (low) to 10 (high)? Does it change at various times of the day? _____

   _____

8. How would you rate your level of daily physical activity on average from 1 (low) to 10 (high). Physical activity includes walking, housework, yard work, physical job, as well as intentional exercise like going to a gym, playing sports etc. _____

9. Do you do intentional exercise? How often, what type of exercise, duration, and intensity. _____

   _____

   _____

10. Do you wish to gain weight? _____ If yes, how much? _____

11. Do you wish to lose weight? _____ If yes, how much? _____

12. How would you rate your quality and amount of sleep from 1 (poor) to 10 (great) _____

13. Do you take any prescription medications? _____ If yes, please list the drugs and the dosages. _____

    _____

14. Have you had any vaccines in the last 5 years? If so, which ones _____

    _____

15. Do you take any supplements? _____ If yes, please list them, the dosage, and the brand.

    _____

    _____

    _____

16. Do you have any allergies? _____ If yes, please describe _____

    _____

17. Do you have any food sensitivities? _____ If yes, please describe _____

    _____

18. Do you have any diagnosed chronic diseases? _____ If yes, please describe _____

    _____

19. Have you had any major surgery? _____ If yes, please describe _____
    _____

20. Have you taken antibiotics in the last year? _____

Females

21. Are you currently pregnant? _____

22. Are you in menopause? _____

Dietary habits

23. Are you currently on any kind of diet, such as keto, vegan, carnivore etc _____ If yes, please describe _____

24. Do you practice any time-restricted eating or intermittent fasting? _____

25. Are there any foods you avoid? _____

26. Are there any foods you crave? _____

27. How often do you cook meals at home? _____

28. How often do you eat take out, in a restaurant, or fast food? _____

29. How often do you eat processed food or packaged food, such as noodles with sauces, frozen dinners, cereal, snack foods like chips, store cookies or granola bars etc. _____

Food Log

For a typical 3-day period, list all foods and snacks you consume. Please make it as close to your normal diet as possible.

Time of day	Day 1	Day 2	Day 3