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 healthy coping mechanisms like meditation, exercise, talking to a friend?

   ____

   ____

6. Do you have any unhealthy coping mechanisms such as drinking excess alcohol, smoking, eating junk food etc.?

   ____

   ____

7. How would you describe your energy level on a scale of 1 (low) to 10 (high)? _____________
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 wish to gain weight? ____________ If yes, how much? _______________
10. Do you wish to lose weight? ____________ If yes, how much? _______________

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

12. Do you take any prescription medications? __________ If yes, please list the drugs and the dosages. ____
____

13. Have you had any vaccines in the last 5 years? If so, which ones __________________________
____

14. Do you take any supplements? ___________ If yes, please list them, the dosage, and the brand.
____
____
____

15. Do you have any allergies? ____________ If yes, please describe _________________________
____

16. Do you have any food sensitivities? ______________ If yes, please describe ________________
____

17. Do you have any diagnosed chronic conditions? __________ If yes, please describe
____

18. Have you taken antibiotics in the last year? _______________

Females

19. Are you currently pregnant? ______________

20. Are you in menopause? _____________

Dietary habits

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

22. Do you practice any time-restricted eating or intermittent fasting? ______________

23. Are there any foods you avoid? ____

24. Are there any foods you crave? ____

25. How often do you cook meals at home? ____________________

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

27. 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**