

Patient Health Survey

We want to make sure we're not missing any health issues you may be struggling with and we want to support you the best way we can. Please take a moment to fill out the following survey. Thank you!

Name: _____ Date: _____

Please circle the number between 1 and 7 which you feel best fits the following statements. This refers to your usual way of life within the last week.

1 indicates “strongly disagree” and 7 indicates “strongly agree”

	Strongly Disagree ————> Strongly Agree						
	1	2	3	4	5	6	7
1) I'm struggling with sleep/fatigue issues	1	2	3	4	5	6	7
2) I'm struggling with weight loss issues	1	2	3	4	5	6	7
3) I'm struggling with digestive issues	1	2	3	4	5	6	7
4) I'm struggling with hormone imbalances	1	2	3	4	5	6	7
5) I'm struggling with mood/anxiety issues	1	2	3	4	5	6	7

Are any of the above health issues something you would like help improving? Yes No