

Feel Awesome Wellness Center LLC
Discover Transform Awaken

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INITIAL QUESTIONNAIRE

Name: _____ Date: _____

List your concerns and then rate their strength from 1 to 10, with 1 being only a mild concern and 10 maximally challenging.

Chief Physical Concerns – list in order of priority

1. _____ (1) (2) (3) (4) (5) (6) (7) (8) (9) (10)

2. _____ (1) (2) (3) (4) (5) (6) (7) (8) (9) (10)

3. _____ (1) (2) (3) (4) (5) (6) (7) (8) (9) (10)

Chief Emotional Concerns

1. _____ (1) (2) (3) (4) (5) (6) (7) (8) (9) (10)

2. _____ (1) (2) (3) (4) (5) (6) (7) (8) (9) (10)

3. _____ (1) (2) (3) (4) (5) (6) (7) (8) (9) (10)

Any other concerns that you would like the doctor to know about?

1. _____

2. _____

3. _____

What would you like to accomplish during your healing process?

1. _____

2. _____

3. _____