Elevate Your Wellness

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Energy Enhancement System

Patient Questionnaire #1

Name: _____ Date: _____

Before your first session in the Energy Enhancement System, please answer the following questions based on how you feel right now.

Physical

Please rate the severity of the following symptoms, using the extra space to enter specifics (location or type of pain, etc.).

	None	Mild		Moderate		Severe
Headache	0	1	2	3	4	5
Joint pain	0	1	2	3	4	5
Muscle pain	0	1	2	3	4	5
Back pain	0	1	2	3	4	5
Swelling	0	1	2	3	4	5
Nasal/sinus congestion	0	1	2	3	4	5
Cough	0	1	2	3	4	5
Skin problems	0	1	2	3	4	5
Menstrual problems	0	1	2	3	4	5
Fatigue	0	1	2	3	4	5
Sleep disturbances	0	1	2	3	4	5
Nausea, vomiting	0	1	2	3	4	5
Bowel disturbances (diarrhea, constipation, gas)	0	1	2	3	4	5
Urinary problems	0	1	2	3	4	5
Numbness or tingling	0	1	2	3	4	5
Dizziness/vertigo	0	1	2	3	4	5
Infection	0	1	2	3	4	5
Other: _____	0	1	2	3	4	5
Other: _____	0	1	2	3	4	5

Additional comments: _____

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Worst				Best

Energy/Sleep	0	1	2	3	4	5
How energetic do you usually feel?						
How well do you sleep?	0	1	2	3	4	5
How easily do you fall asleep?	0	1	2	3	4	5
How is your energy level when you wake up?	0	1	2	3	4	5
How much do you rely on coffee or stimulants?	0	1	2	3	4	5

Mental

	None	**Low**		**Moderate**		**High**
Concentration	0	1	2	3	4	5
Mental clarity	0	1	2	3	4	5
Short-term memory	0	1	2	3	4	5
Long-term memory	0	1	2	3	4	5
Other: _____	0	1	2	3	4	5
Other: _____	0	1	2	3	4	5
Other: _____	0	1	2	3	4	5

Additional comments: _____

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Emotional & Spiritual

	None	**Low**		**Moderate**		**High**
Anger	0	1	2	3	4	5
Fear	0	1	2	3	4	5
Anxiety	0	1	2	3	4	5
Sadness/grief	0	1	2	3	4	5
Shame	0	1	2	3	4	5
Guilt	0	1	2	3	4	5
Mood swings	0	1	2	3	4	5
Love	0	1	2	3	4	5
Self-acceptance	0	1	2	3	4	5
Trust	0	1	2	3	4	5
Connection with others/intimacy	0	1	2	3	4	5
Hopefulness/optimism	0	1	2	3	4	5
Joyfulness	0	1	2	3	4	5
Peacefulness/calmness	0	1	2	3	4	5
Contentment	0	1	2	3	4	5
Confidence	0	1	2	3	4	5
Other: _____	0	1	2	3	4	5

Other: _____	0	1	2	3	4	5
Other: _____	0	1	2	3	4	5

Additional comments: _____

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