Application Form

Welcome to our office! We specialize in assisting people to achieve their best health through Functional Medicine, Chiropractic Neurology, Brain-based Therapy, metabolic corrective programs, massage, and health coaching. Our approach may be considered *very* unique and advanced from other rehabilitative programs. As such, we have strict requirements in accepting new patients, allowing them to achieve far superior results compared to most other systems.

In order to be seen, I agree to:

- ☐ Complete Daily Food Journal for 5-7 days.
- ☐ Fill out all paperwork & mail, email, fax, or drop off at Valeo prior to scheduled exam
- ☐ Wear comfortable clothing to first appointment

☐ I agree to the above terms and understand that if paperwork is not completed and sent to the doctor at least 24hrs before my scheduled exam, my appointment will need to be rescheduled.

☐ I agree and understand that should I receive a Consultation on my case as outlined in this paperwork, that the doctors at Valeo Health and Wellness are assessing my case on the basis of their chiropractic license alone and do not diagnose or treat any disease including cancer. I agree and understand that it is my responsibility to seek appropriate medical care in such cases.

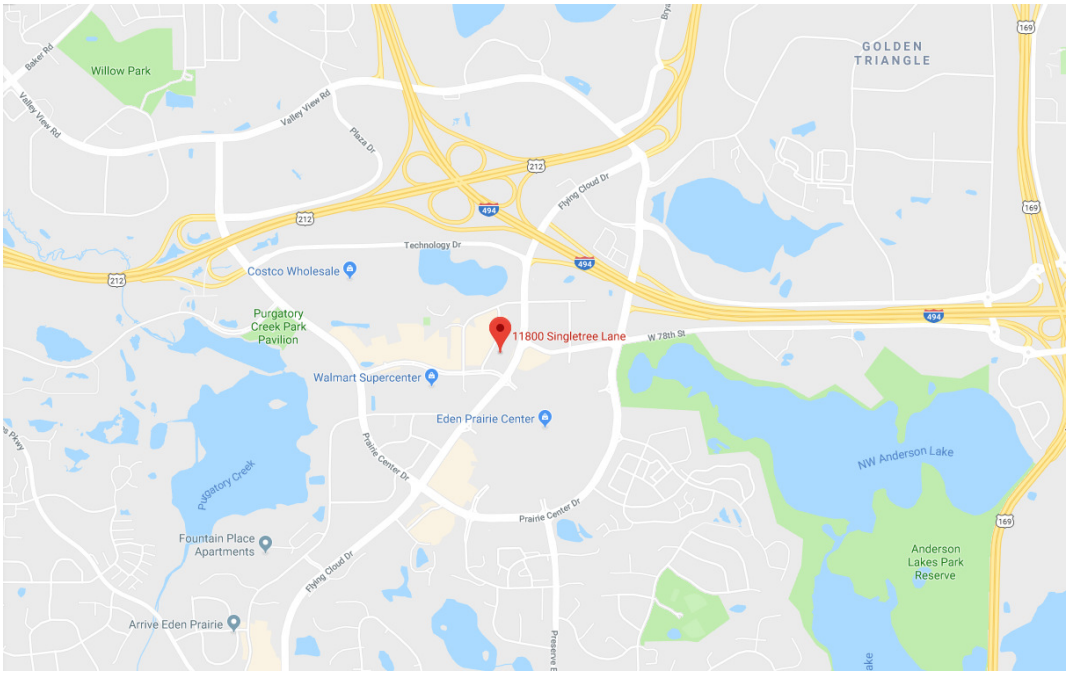
Signature _____

Today's Date _____

PLEASE SUBMIT PAPERWORK PRIOR TO SCHEDULED EXAM.

Email: info@valeowc.com / Fax: 952-949-0868 / Phone: 952-949-0676

Address: 11800 Singletree Lane, Ste 205, Eden Prairie 55344



VALEO
HEALTH AND WELLNESS CENTER

Office Use Only
Practitioner: AM JT RL
Appt Type: CHIRO FUNC
Appt Date _____ ☐ CT ☐ CC ☐ TY

PERSONAL INFORMATION

Name:	**Guardian's Name (if minor):**		
Today's Date:	**Date of Birth:**		**Age:**
Address:	**Height:**	**Weight:**	**Gender:**
City:	**Email Address:**		
State: **Zip:**	**Ph: H/C**		
Preferred Contact: ◯ Phone ◯ Email	**Do you have MEDICARE?** ◯ Yes ◯ No		
Marital Status (Dropdown):	**Would you like to receive our newsletter?** ◯ Yes ◯ No		

EMERGENCY CONTACT INFORMATION

Name of Emergency Contact	Relationship to Patient	Phone Number

REFERRAL INFORMATION

How were you referred to our office? (Dropdown)

Name of referrer or event (so that we can thank them):

GOALS FOR MY CARE

People see health care practitioners for a variety of reasons. Some go for relief of pain, some to correct the cause of pain and others to correct whatever the core malfunction may be. Your practitioner will weigh your needs and desires when recommending your program of care. Please check the type of care desired so that we may be guided by your wishes.

◯ Relief Care: Symptomatic relief of pain or discomfort

◯ Corrective Care: Correcting and relieving the cause of the problem as well as the symptoms

◯ Comprehensive Care: Address the entire system and bring your body to the highest state of health possible.

Any other goals you'd like to share?

THE BEGINNING YEARS

Birth to 17 years of age	NO	YES	EXPLAIN
Did you have any serious childhood illness?			
Did you have any serious falls as a child?			
Was there prolonged use of medicine such as antibiotics or an inhaler?			
Were you vaccinated?			
Adult: 18 YO to Present			
Are you pregnant? If yes, when are you due?			
Do you have a pacemaker?			
Do you have any metal in your body?			
Do you exercise regularly?			
Do you have any scars?			

HEALTH CONCERNS - List according to severity. Rate from 1 (mild) to 10 (unbearable)

Health Concern	Severity	Episode Start Date?	Had this before? When?	Constant or Intermittent?

Since the problem started, is it (Please Check):

◯ Same ◯ Improving ◯ Worse

Does it travel/radiate?

◯ No ◯ Yes, where?

What makes it better?

What makes it worse?

Do you have a family history of this or similar symptoms?

◯ No ◯ Yes/explain:

Have you seen other doctors for this condition? ◯ No ◯ Yes

☐ Medical ☐ Chiropractor ☐ Other:

If yes, what Yes, diagnosis:

What was done?

Do you have allergies/sensitivities to fragrances or oils?

◯ No ◯ Yes, explain:

Do you have any known allergies?

◯ No ◯ Yes, explain:

How have you taken care of your health in the past?

☐ Medications ☐ Emergency Room ☐ Routine Medical
☐ Exercise ☐ Nutrition/Diet ☐ Holistic Care
☐ Vitamins ☐ Chiropractic ☐ Other:

How have the previous method(s) work out for you?

☐ Bad results ☐ Some results ☐ Great Results
☐ No change ☐ Still trying ☐ Other:

Are you concerned that this condition is or will negatively affect any of the following?

☐ Job ☐ Marriage ☐ Kids ☐ Future Ability
☐ Sleep ☐ Self-esteem ☐ Freedom ☐ Finances
☐ Time ☐ Other

Are you concerned that your helath conditions(s) might turn into any of the following?

☐ Family health problems ☐ Heart Disease ☐ Cancer
☐ Fibromyalgia ☐ Depression ☐ Chronic Fatigue
☐ Diabetes ☐ Arthritis ☐ Other

Have your health condition(s) affected your job, finances, relationships, family or other activities?

☐ No
☐ Yes, explain:

If you have health issues, what have they cost you?

☐ Time ☐ Money ☐ Hope ☐ Happiness
☐ Sleep ☐ Freedom ☐ Please explain:

PAST ACCIDENTS/SURGERIES/INJURIES/PROCEDURES: List all (auto/work), x-rays, trauma (physical/emotional)

Type	Date	Doctor/Hospitalization/x-rays/Procedure

List all prescription drugs, over-the-counter drugs, and all supplements you are currently taking

Name of drug or supplement	Taken for how long?	For what purpose?	How much?

HIPAA ACKNOWLEGEMENT OF RECEIPT OF NOTICE

Under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), you have certain rights regarding the use and disclosure of your protected health information. These rights are more fully described in Valeo Health & Wellness Center's Notice of Privacy Practices. Valeo is permitted to revise its Notice of Privacy Practices at any time. We will provide you with a copy of the revised Notice of Privacy Practices upon your request. Signing below acknowledges that you have access to this notice via internet or the copy in our office for your review at any time.

Client Name: _____

Signature of patient (or parent, if minor): _____ Date _____

VALEO PAYMENT POLICY

RETURNED CHECK POLICY - If you pay with a check that is returend due to insufficient funds, we will require immediate payment in another form plus a $35.00 returned check fee and any bank charges. If there is no response from you, we must send this to collections.

SERVICE AGREEMENT - I clearly understand and agree that all services and products rendered me are charged directly to me, and that I am personally responsible for payment. I also understand that if I suspend or terminate my care, any fees for professional services rendered to me will become immediately due and payable. Valeo will work with you regarding payment plans if necessary. There will be an 18% APR charged on balances over 30 days past due. Anything older than 120 days will be sent to collections. Please contact us if you have any questions regarding this policy.

CANCELLATION AND MISSED APPOINTMENT POLICY - I understand and agree that text and/or email reminders are only a courtesy of Valeo and that I am personally responsible for tracking my scheduled appointments. I also understand and agree to pay 50% of the appointment type charge if I miss my appointment or cancel my appointment with less than 24-hours notice (except in cases of emergency).

Signature: _____ Date: _____

INSURANCE PAYMENT AGREEMENT - *FOR PERSONAL INJURY, WORK COMP OR MEDICARE ONLY:*
I understand that insurance will be billed for Valeo services and I hereby authorize assignment of my insurance rights and benefits (if applicable) directly to the provider for services rendered.

Signature: _____ Date: _____

POLICIES AND PROCEDURES

1. The practitioners design and recommend specific health plans in order for you to get better in the shortest amount of time. It is to your benefit to maintain your visit schedule and care plan as explained to you when you start care with the practitioner. The practitioners take your health very seriously and we ask that you do the same.

2. If you need to cancel or reschedule an appointment, please provide the office with at least a 24-hour notice. Our goal is to stay on time; however, occasionally emergencies or unforseen circumstances arise where the practitioner will spend more time with a patient. We will do our best to inform you if the practitioner is running behind schedule. Appointments missed or canceled with fewer than 24-hours notice may be charged in accordance with the cancellation and missed appointment policy above.

Daily Record of Food Intake | *Your diet may be the key to better health.*

Each day, record all the items you eat and drink. Be sure to include the approximate amount of each item. When you have completed this form, return it to your health care professional for evaluation.

Name:

Day 1 - Date:

BREAKFAST *Time:*	***LUNCH*** *Time:*	***DINNER*** *Time:*
Meat & Dairy:		
Vegetables & Fruits:		
Breads, Cereals, & Grains:		
Fats (butter, margarine, oils, etc.):		
Candy, Sweets, & Junk Food:		
Water Intake (fl. oz.):		
Other Drinks:		
MID-MORNING SNACK *Time:*	***MID-DAY SNACK*** *Time:*	***NIGHTTIME SNACK*** *Time:*
Snack:		
Bowel Movements*(# and consistency):*	***Hours of Sleep:***	***Quality of Sleep:*** (good) 1 2 3 4 5 (poor)

Day 2 - Date:

BREAKFAST *Time:*	***LUNCH*** *Time:*	***DINNER*** *Time:*
Meat & Dairy:		
Vegetables & Fruits:		
Breads, Cereals, & Grains:		
Fats (butter, margarine, oils, etc.):		
Candy, Sweets, & Junk Food:		
Water Intake (fl. oz.):		
Other Drinks:		
MID-MORNING SNACK *Time:*	***MID-DAY SNACK*** *Time:*	***NIGHTTIME SNACK*** *Time:*
Snack:		
Bowel Movements*(# and consistency):*	***Hours of Sleep:***	***Quality of Sleep:*** (good) 1 2 3 4 5 (poor)

Day 3 - Date:

BREAKFAST *Time:*	***LUNCH*** *Time:*	***DINNER*** *Time:*
Meat & Dairy:		
Vegetables & Fruits:		
Breads, Cereals, & Grains:		
Fats (butter, margarine, oils, etc.):		
Candy, Sweets, & Junk Food:		
Water Intake (fl. oz.):		
Other Drinks:		
MID-MORNING SNACK *Time:*	***MID-DAY SNACK*** *Time:*	***NIGHTTIME SNACK*** *Time:*
Snack:		
Bowel Movements*(# and consistency):*	***Hours of Sleep:***	***Quality of Sleep:*** (good) 1 2 3 4 5 (poor)

Notes:

Day 4 - Date:

BREAKFAST *Time:*	***LUNCH*** *Time:*	***DINNER*** *Time:*
Meat & Dairy:		
Vegetables & Fruits:		
Breads, Cereals, & Grains:		
Fats (butter, margarine, oils, etc.):		
Candy, Sweets, & Junk Food:		
Water Intake (fl. oz.):		
Other Drinks:		
MID-MORNING SNACK *Time:*	***MID-DAY SNACK*** *Time:*	***NIGHTTIME SNACK*** *Time:*
Snack:		
Bowel Movements*(# and consistency):*	***Hours of Sleep:***	***Quality of Sleep:*** (good) 1 2 3 4 5 (poor)

Day 5 - Date:

BREAKFAST *Time:*	***LUNCH*** *Time:*	***DINNER*** *Time:*
Meat & Dairy:		
Vegetables & Fruits:		
Breads, Cereals, & Grains:		
Fats (butter, margarine, oils, etc.):		
Candy, Sweets, & Junk Food:		
Water Intake (fl. oz.):		
Other Drinks:		
MID-MORNING SNACK *Time:*	***MID-DAY SNACK*** *Time:*	***NIGHTTIME SNACK*** *Time:*
Snack:		
Bowel Movements*(# and consistency):*	***Hours of Sleep:***	***Quality of Sleep:*** (good) 1 2 3 4 5 (poor)

Day 6 - Date:

BREAKFAST *Time:*	***LUNCH*** *Time:*	***DINNER*** *Time:*
Meat & Dairy:		
Vegetables & Fruits:		
Breads, Cereals, & Grains:		
Fats (butter, margarine, oils, etc.):		
Candy, Sweets, & Junk Food:		
Water Intake (fl. oz.):		
Other Drinks:		
MID-MORNING SNACK *Time:*	***MID-DAY SNACK*** *Time:*	***NIGHTTIME SNACK*** *Time:*
Snack:		
Bowel Movements*(# and consistency):*	***Hours of Sleep:***	***Quality of Sleep:*** (good) 1 2 3 4 5 (poor)

Day 7 - Date:

BREAKFAST *Time:*	***LUNCH*** *Time:*	***DINNER*** *Time:*
Meat & Dairy:		
Vegetables & Fruits:		
Breads, Cereals, & Grains:		
Fats (butter, margarine, oils, etc.):		
Candy, Sweets, & Junk Food:		
Water Intake (fl. oz.):		
Other Drinks:		
MID-MORNING SNACK *Time:*	***MID-DAY SNACK*** *Time:*	***NIGHTTIME SNACK*** *Time:*
Snack:		
Bowel Movements*(# and consistency):*	***Hours of Sleep:***	***Quality of Sleep:*** (good) 1 2 3 4 5 (poor)

Metabolic Assessment Form™

Name: _____ **Age:** _____ **Sex:** _____ **Date:** _____

PART I

Please list your 5 major health concerns in order of importance:

1. _____ **4.** _____

2. _____ **5.** _____

3. _____

PART II **Please circle the appropriate number on all questions below. 0 as the least/never to 3 as the most/always.**

Category I

Feeling that bowels do not empty completely	0	1	2	3
Lower abdominal pain relieved by passing stool or gas	0	1	2	3
Alternating constipation and diarrhea	0	1	2	3
Diarrhea	0	1	2	3
Constipation	0	1	2	3
Hard, dry, or small stool	0	1	2	3
Coated tongue or "fuzzy" debris on tongue	0	1	2	3
Pass large amount of foul-smelling gas	0	1	2	3
More than 3 bowel movements daily	0	1	2	3
Use laxatives frequently	0	1	2	3

Category II

Increasing frequency of food reactions	0	1	2	3
Unpredictable food reactions	0	1	2	3
Aches, pains, and swelling throughout the body	0	1	2	3
Unpredictable abdominal swelling	0	1	2	3
Frequent bloating and distention after eating	0	1	2	3

Category III

Intolerance to smells	0	1	2	3
Intolerance to jewelry	0	1	2	3
Intolerance to shampoo, lotion, detergents, etc	0	1	2	3
Multiple smell and chemical sensitivities	0	1	2	3
Constant skin outbreaks	0	1	2	3

Category IV

Excessive belching, burping, or bloating	0	1	2	3
Gas immediately following a meal	0	1	2	3
Offensive breath	0	1	2	3
Difficult bowel movements	0	1	2	3
Sense of fullness during and after meals	0	1	2	3
Difficulty digesting proteins and meats; undigested food found in stools	0	1	2	3

Category V

Stomach pain, burning, or aching 1-4 hours after eating	0	1	2	3
Use of antacids	0	1	2	3
Feel hungry an hour or two after eating	0	1	2	3
Heartburn when lying down or bending forward	0	1	2	3
Temporary relief by using antacids, food, milk, or carbonated beverages	0	1	2	3
Digestive problems subside with rest and relaxation	0	1	2	3
Heartburn due to spicy foods, chocolate, citrus, peppers, alcohol, and caffeine	0	1	2	3

Category VI

Difficulty digesting roughage and fiber	0	1	2	3
Indigestion and fullness last 2-4 hours after eating	0	1	2	3
Pain, tenderness, soreness on left side under rib cage	0	1	2	3
Excessive passage of gas	0	1	2	3
Nausea and/or vomiting	0	1	2	3
Stool undigested, foul smelling, mucus like, greasy, or poorly formed	0	1	2	3
Frequent loss of appetite	0	1	2	3

Category VII

Abdominal distention after consumption of fiber, starches, and sugar	0	1	2	3
Abdominal distention after certain probiotic or natural supplements	0	1	2	3
Decreased gastrointestinal motility, constipation	0	1	2	3
Increased gastrointestinal motility, diarrhea	0	1	2	3
Alternating constipation and diarrhea	0	1	2	3
Suspicion of nutritional malabsorption	0	1	2	3
Frequent use of antacid medication	0	1	2	3
Have you been diagnosed with Celiac Disease, Irritable Bowel Syndrome, Diverticulosis/ Diverticulitis, or Leaky Gut Syndrome?	Yes		No	

Category VIII

Greasy or high-fat foods cause distress	0	1	2	3
Lower bowel gas and/or bloating several hours after eating	0	1	2	3
Bitter metallic taste in mouth, especially in the morning	0	1	2	3
Burpy, fishy taste after consuming fish oils	0	1	2	3
Unexplained itchy skin	0	1	2	3
Yellowish cast to eyes	0	1	2	3
Stool color alternates from clay colored to normal brown	0	1	2	3
Reddened skin, especially palms	0	1	2	3
Dry or flaky skin and/or hair	0	1	2	3
History of gallbladder attacks or stones	0	1	2	3
Have you had your gallbladder removed?	Yes		No	

Category IX

Acne and unhealthy skin	0	1	2	3
Excessive hair loss	0	1	2	3
Overall sense of bloating	0	1	2	3
Bodily swelling for no reason	0	1	2	3
Hormone imbalances	0	1	2	3
Weight gain	0	1	2	3
Poor bowel function	0	1	2	3
Excessively foul-smelling sweat	0	1	2	3

Category X

Crave sweets during the day	0	1	2	3
Irritable if meals are missed	0	1	2	3
Depend on coffee to keep going/get started	0	1	2	3
Get light-headed if meals are missed	0	1	2	3
Eating relieves fatigue	0	1	2	3
Feel shaky, jittery, or have tremors	0	1	2	3
Agitated, easily upset, nervous	0	1	2	3
Poor memory, forgetful between meals	0	1	2	3
Blurred vision	0	1	2	3

Category XI

Fatigue after meals	0	1	2	3
Crave sweets during the day	0	1	2	3
Eating sweets does not relieve cravings for sugar	0	1	2	3
Must have sweets after meals	0	1	2	3
Waist girth is equal or larger than hip girth	0	1	2	3
Frequent urination	0	1	2	3
Increased thirst and appetite	0	1	2	3
Difficulty losing weight	0	1	2	3

Symptom groups listed on this form are not intended to be used as a diagnosis of any disease or condition.

Category XII

Cannot stay asleep	0	1	2	3
Crave salt	0	1	2	3
Slow starter in the morning	0	1	2	3
Afternoon fatigue	0	1	2	3
Dizziness when standing up quickly	0	1	2	3
Afternoon headaches	0	1	2	3
Headaches with exertion or stress	0	1	2	3
Weak nails	0	1	2	3

Category XIII

Cannot fall asleep	0	1	2	3
Perspire easily	0	1	2	3
Under a high amount of stress	0	1	2	3
Weight gain when under stress	0	1	2	3
Wake up tired even after 6 or more hours of sleep	0	1	2	3
Excessive perspiration or perspiration with little or no activity	0	1	2	3

Category XIV

Edema and swelling in ankles and wrists	0	1	2	3
Muscle cramping	0	1	2	3
Poor muscle endurance	0	1	2	3
Frequent urination	0	1	2	3
Frequent thirst	0	1	2	3
Crave salt	0	1	2	3
Abnormal sweating from minimal activity	0	1	2	3
Alteration in bowel regularity	0	1	2	3
Inability to hold breath for long periods	0	1	2	3
Shallow, rapid breathing	0	1	2	3

Category XV

Tired/sluggish	0	1	2	3
Feel cold—hands, feet, all over	0	1	2	3
Require excessive amounts of sleep to function properly	0	1	2	3
Increase in weight even with low-calorie diet	0	1	2	3
Gain weight easily	0	1	2	3
Difficult, infrequent bowel movements	0	1	2	3
Depression/lack of motivation	0	1	2	3
Morning headaches that wear off as the day progresses	0	1	2	3
Outer third of eyebrow thins	0	1	2	3
Thinning of hair on scalp, face, or genitals, or excessive hair loss	0	1	2	3
Dryness of skin and/or scalp	0	1	2	3
Mental sluggishness	0	1	2	3

Category XVI

Heart palpitations	0	1	2	3
Inward trembling	0	1	2	3
Increased pulse even at rest	0	1	2	3
Nervous and emotional	0	1	2	3
Insomnia	0	1	2	3

Category XVI *(Cont.)*

Night sweats	0	1	2	3
Difficulty gaining weight	0	1	2	3

Category XVII *(Males Only)*

Urination difficulty or dribbling	0	1	2	3
Frequent urination	0	1	2	3
Pain inside of legs or heels	0	1	2	3
Feeling of incomplete bowel emptying	0	1	2	3
Leg twitching at night	0	1	2	3

Category XVIII *(Males Only)*

Decreased libido	0	1	2	3
Decreased number of spontaneous morning erections	0	1	2	3
Decreased fullness of erections	0	1	2	3
Difficulty maintaining morning erections	0	1	2	3
Spells of mental fatigue	0	1	2	3
Inability to concentrate	0	1	2	3
Episodes of depression	0	1	2	3
Muscle soreness	0	1	2	3
Decreased physical stamina	0	1	2	3
Unexplained weight gain	0	1	2	3
Increase in fat distribution around chest and hips	0	1	2	3
Sweating attacks	0	1	2	3
More emotional than in the past	0	1	2	3

Category XIX *(Menstruating Females Only)*

Perimenopausal	Yes	No		
Alternating menstrual cycle lengths	Yes	No		
Extended menstrual cycle (greater than 32 days)	Yes	No		
Shortened menstrual cycle (less than 24 days)	Yes	No		
Pain and cramping during periods	0	1	2	3
Scanty blood flow	0	1	2	3
Heavy blood flow	0	1	2	3
Breast pain and swelling during menses	0	1	2	3
Pelvic pain during menses	0	1	2	3
Irritable and depressed during menses	0	1	2	3
Acne	0	1	2	3
Facial hair growth	0	1	2	3
Hair loss/thinning	0	1	2	3

Category XX *(Menopausal Females Only)*

How many years have you been menopausal?	_____ years			
Since menopause, do you ever have uterine bleeding?	Yes	No		
Hot flashes	0	1	2	3
Mental fogginess	0	1	2	3
Disinterest in sex	0	1	2	3
Mood swings	0	1	2	3
Depression	0	1	2	3
Painful intercourse	0	1	2	3
Shrinking breasts	0	1	2	3
Facial hair growth	0	1	2	3
Acne	0	1	2	3
Increased vaginal pain, dryness, or itching	0	1	2	3

PART III

How many alcoholic beverages do you consume per week? _____

How many caffeinated beverages do you consume per day? _____

How many times do you eat out per week? _____

How many times do you eat raw nuts or seeds per week? _____

Rate your stress level on a scale of 1-10 during the average week: _____

How many times do you eat fish per week? _____

How many times do you work out per week? _____

List the three worst foods you eat during the average week: _____ _____ _____

List the three healthiest foods you eat during the average week: _____ _____ _____

PART IV

Please list any medications you currently take and for what conditions:

Please list any natural supplements you currently take and for what conditions:

DIRECTIONS: On a scale from 1-10, where (10) is the highest and (1) is the lowest, please rate your current "health level" in each significant area of your life.

Relationship / Family Life

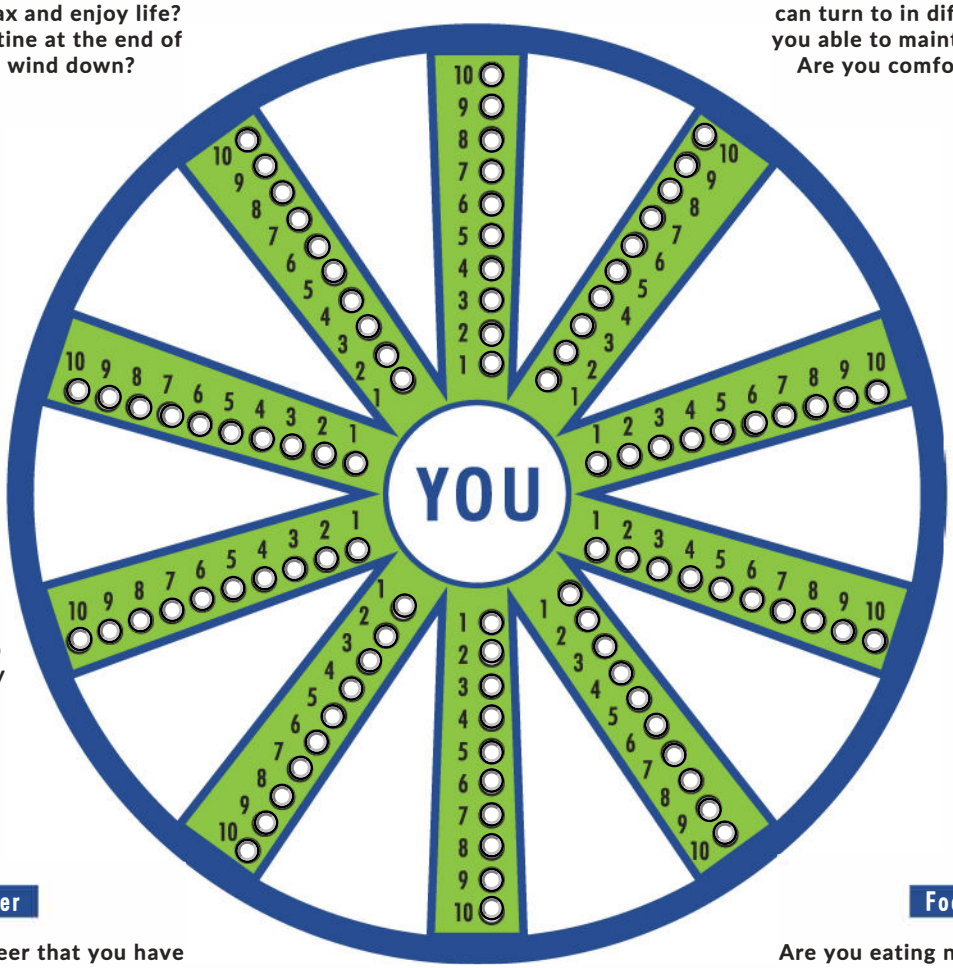
Are you in a loving relationship? Do you feel like you spend enough quality time with your family? Do you have a close connection with your children, parents, and relatives? Do you have poor family relationships from the past or present that negatively impact your health?

Leisure

Are you taking regular vacations without bringing work with you? Do you have time set aside each week to relax and enjoy life? Do you have a healthy routine at the end of the day that helps you wind down?

Social Health

Do you have a connection with at least one other person, outside your family, who you can turn to in difficult and good times? Are you able to maintain long-term friendships? Are you comfortable in social settings?



Environmental

Do you regularly enjoy time out in nature? Do you spend time doing outdoor activities such as sports, camping, fishing, hiking, etc.? Are you aware of toxins in your environment? If you are aware of certain environmental toxins, do you limit your exposure to them?

Intellectual

Are you open to new ideas? What is the quality of the information and entertainment that you allow into your mind? Do you challenge yourself to learn new things and hobbies?

Spiritual

Do you feel that you have a close/strong relationship with God? Do you regularly study, meditate, pray or worship? Do you regularly attend fellowship with others whom share the same beliefs as yourself?

Physical

Do you have plenty of energy? Do you exercise, eat healthy and drink plenty of water on a regular basis? Are you limited in what you can do because of physical ailments?

Job / Career

Are you working in the career that you have always wanted to be working in? Does your job stimulate you, give you energy or drain your energy? Does your career allow you to live the lifestyle you desire? Are you working in a position or towards a career that you feel God has planned for you?

Food / Nutrition

Are you eating natural/organic foods? Are you skipping meals? Do you plan out your meals ahead of time? Do you take whole-food supplements?

Psychological / Emotional / Stress

Do you have a positive attitude even during stressful times? Does your stress level overwhelm you? Do you have peace in your life?

Name:

Date:

SCORE:

Your Well Score

1. Copy your score from the front and write it here _____ / 100.

2. Knowing the score you wrote down, what would you like your total score to be?_____

3. What do you think the time frame will be to achieve that number? _____

4. Of the ten categories on the front, what area of your life would you like to change the most?

_____

5. What changes in your life do you think will need to be made in order for you to achieve your goal(s)? Please check all that apply below.

☐ Exercise ☐ Diet Changes ☐ Supplements ☐ Body Cleanse ☐ Chiropractic Care

☐ Massage Therapy ☐ Medical Treatment ☐ Counseling ☐ Spiritual Healing

☐ Other _____

6. How will your life improve as a result of making these changes?

_____

_____

_____

_____

11800 Singletree Lane / Suite #205 / Eden Prairie / MN 55344
Phone: (952) 949-0676 / Fax: (952) 949-0868 / Web: www.valeowc.com