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THE CENTER FOR ENERGY MEDICINE

HEALTH & WELLNESS PLAN

Name _____ Date _____

Wellness Assessment

Occupation _____ How Long _____

On scale of 1 to 10, 10 being the highest priority of overall wellness, please rate each of the following areas.

Area of Health	Where You Are Now	Where You Want To Be	Importance
Allergy Symptoms (i.e. runny nose, itching, congestion, etc.)			
Immune System (i.e. prone to diseases, auto-immune issues, etc.)			
Digestions (i.e. acid reflux, indigestion, constipation, etc.)			
Sleep (i.e. insomnia, sleep apnea, etc.)			
Mental Acuity (i.e. concentration, memory, etc.)			
Energy (i.e. tired, lethargy, chronic fatigue, listlessness, etc.)			
Physical Mobility (i.e. injury, range of motion limitation, etc.)			
Emotional Mood (i.e. anxiety, depression, anger, etc.)			
Emotional Stress (i.e. worry, overwhelm, irritability, etc.)			
Other			

How much time do you spend in a week:

1. At Work? _____ 2. W/Family? _____ 3. Exercise/Sports? _____

Wellness Goals

If you could make major improvements in up to three of these areas, which would they be?

1. _____ By When? _____
2. _____ By When? _____
3. _____ By When? _____

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