

VB Transformations Health Questionnaire

Thank you for taking the time to fill out the following questions. This information will give me a much better idea of how I can help you. All your information will be kept confidential. Send the completed form back to:

- 1. What is your main health or life concern?**

- 2. What have you done in the past to work on this situation? Please include medical and alternative forms of therapy that you have tried.**

- 3. What has proven to be most effective for the above situation?**

- 4. How would you like to be feeling 30 days from now?**

- 5. How would you like to feel in 90 days and what changes would you like to see?**

- 6. What obstacles, challenges, and struggles do you see interfering the upcoming changes?**

- 7. What do you hope to get out of our time together?**

- 8. What are five things that you Love about your life?**