PATIENT SURVEY

Name:_____ **Phone #:**_____
Email Address:_____

Would you like to receive emails from our wellness program? ☐ Yes ☐ No
Would you like someone to contact you regarding a personalized wellness programs? ☐ Yes ☐ No

1) **Are you presently taking any type of nutritional supplements? (Check all that apply)**
☐ Vitamins ☐ Amino Acids
☐ Minerals ☐ Fish Oils
☐ Herbs ☐ Other:_____

2) **Who recommended you take these supplements? (Check all that apply)**
☐ Family member ☐ Health Professional
☐ Friend ☐ Personal research
☐ Advertisement ☐ Other_____

3) **Where did you purchase these supplements? (Check all that apply)**
☐ Mail-order ☐ Pharmacy
☐ Nutrition or vitamin shop ☐ Healthcare provider
☐ Other_____

4) **If this office offered advanced, high quality line of supplements, would you consider purchasing them?**
☐ Yes ☐ No

5) **If this office offered a simple genetic test to determine what supplemental regimen is best for you, based on your genetic variations, would you consider doing it?** ☐ Yes ☐ No

6) **If this office offered a comprehensive weight management program, would you consider it?** ☐ Yes ☐ No

7) **If this office offered a nutrition education program to improve your dietary habits, would you consider it?**
☐ Yes ☐ No

8) **If this office offered Wellness Programs that reached beyond your Physical Therapy needs, what products would most interest you?**_____
_____
_____

IWR Therapy Systems

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