

➔ PRACTICE INFORMATION HERE

Patient Quality Of Life Survey

Name: _____

Date: _____

*Please take several minutes to answer these questions so we can help you get better.
(Please circle as many that apply)*

- 1** How have you taken care of your health in the past?
 - a. Medications
 - b. Emergency Room
 - c. Routine Medical
 - d. Exercise
 - e. Nutrition/Diet
 - f. Holistic Care
 - g. Vitamins
 - h. Chiropractic
 - i. Other (please specify): _____

- 2** How did the previous method(s) work out for you?
 - a. Bad results
 - b. Some results
 - c. Great results
 - d. Nothing changed
 - e. Did not get worse
 - f. Did not work very long
 - g. Still trying
 - h. Confused

- 3** How have others been affected by your health condition?
 - a. No one is affected
 - b. Haven't noticed any problem
 - c. They tell me to do something
 - d. People avoid me

- 4** What are you afraid this might be (or beginning) to affect (or will affect)?
 - a. Job
 - b. Kids
 - c. Future ability
 - d. Marriage
 - e. Self-esteem
 - f. Sleep
 - g. Time
 - h. Finances
 - i. Freedom

5 Are there health conditions you are afraid this might turn into?

- a. Family health problems
- b. Heart disease
- c. Cancer
- d. Diabetes
- e. Arthritis
- f. Fibromyalgia
- g. Depression
- h. Chronic Fatigue
- i. Need surgery

→ How has your health condition affected your job, relationships, finances, family, or other activities? Please give examples:

→ What has that cost you? (time, money, happiness, freedom, sleep, promotion, etc.) Give 3 examples:

→ What are you most concerned with regarding your problem?

→ Where do you picture yourself being in the next 1-3 years if this problem is not taken care of? Please be specific

→ What would be different/better without this problem? Please be specific

→ What do you desire most to get from working with us?

→ What would that mean to you?
