Quality of Life Survey

Name: ____ Date: _____ /______ / ______

Please take several minutes to answer these questions so we can assist you in your wellness journey more effectively.
(Please circle all that may apply)

- **How have you taken care of your health in the past?**
  - Medications
  - Emergency Room
  - Routine Medical
  - Exercise
  - Nutrition/Diet
  - Holistic care
  - Vitamins
  - Chiropractic
  - Other (Please specify): ______________________________________

- **How did the previous method(s) work out for you?**
  - Bad results
  - Some results
  - Great results
  - Nothing changed
  - Did not get worse
  - Did not work very long
  - Still trying
  - Confused

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

- **What are you afraid this might be (or beginning) to affect (or will affect)?**
  - Job
  - Kids
  - Future ability
  - Marriage
  - Self-esteem
  - Sleep
  - Time
  - Finances
  - Freedom

- **Are there any health conditions you are afraid this might turn into?**
  - Family health problems
  - Heart disease
  - Cancer
  - Diabetes
  - Arthritis
  - Fibromyalgia
  - Depression
  - Chronic fatigue
  - 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 most desire to achieve from working with us? What would it mean to you to achieve that desire?**

___

___

___