

## ➔ 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:

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

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**→** What are you most concerned with regarding your problem?

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

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

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

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**→** What would that mean to you?

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