FREEFORM CHIROPRACTIC

QUALITY OF LIFE SURVEY

Name: _____ Date: _____

How have you taken care of your health in the past?

- ☐ Medications
- ☐ Emergency Room
- ☐ Routine Medical
- ☐ Exercise
- ☐ Diet / Nutrition
- ☐ Vitamins
- ☐ Holistic Care
- ☐ Chiropractic
- ☐ Other (Please specify)

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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 Anything
- ☐ People Avoid Me
- ☐ They Tell Me Directly

What are you afraid this might be (or beginning) to affect (or will affect)?

- ☐ Job
- ☐ Family/Kids
- ☐ Future Ability
- ☐ Marriage
- ☐ Self- Esteem
- ☐ Sleep
- ☐ Time
- ☐ Finances
- ☐ Freedom

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

- ☐ Arthritis
- ☐ Diabetes
- ☐ Cancer
- ☐ Fibromyalgia
- ☐ Depression
- ☐ Chronic Fatigue
- ☐ Need Surgery
- ☐ Heart Disease
- ☐ Family Health Disease

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.). Please give 3 Examples:

1. _____
2. _____
3. _____

What are you most concerned about regarding your problem?

_____

_____

_____

_____

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

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_____

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Patient Signature: _____ **Date:** _____

*****Doctors Use Only*****

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