**Reason Seeking Care: Pain/Injury Related YES NO**

**Wellness/Health Maintenance YES NO**

**Have you been to a chiropractor before? YES NO**

**Briefly describe that experience:**

**Did the last chiropractor adjust your spine? YES NO**

**If yes, was there a "popping" sound when they adjusted you? YES NO**

**If yes please explain to the best of your ability what causes that "popping" sound:**

**Expectations of care.**

**How many visits to our office do you anticipate?**

**In our chiropractic office we provide many services for your health. To get an idea of what you want and expect please take the following survey.**

**Do you want to live a long & healthy life? Yes No**

**If you answered yes above, how much time per day outside our office are you willing to commit to this goal? _____hours _____minutes**

**Please score yourself from 1 to 10 below in each health category and then indicate if you are interested in receiving help in these areas. You can select as many or as few as you like.**

**Neck pain: 1 2 3 4 5 6 7 8 9 10 (1 no pain at all, 10 extreme pain)**

**I would like help and/or info on decreasing my neck pain: Yes No**

**Mid-back/rib cage pain: 1 2 3 4 5 6 7 8 9 10 (1 no pain at all, 10 extreme pain)**

**I would like help and/or info on decreasing my mid-back/rib cage pain: Yes No**

**Low back pain: 1 2 3 4 5 6 7 8 9 10 (1 no pain at all, 10 extreme pain)**

**I would like help and/or info on decreasing my low back pain: Yes No**

**Shoulder pain: 1 2 3 4 5 6 7 8 9 10 (1 no pain at all, 10 extreme pain)**

**I would like help and/or info on decreasing my shoulder pain: Yes No**

**Elbow pain: 1 2 3 4 5 6 7 8 9 10 (1 no pain at all, 10 extreme pain)**

**I would like help and/or info on decreasing my elbow pain: Yes No**

**Wrist/hand pain: 1 2 3 4 5 6 7 8 9 10 (1 no pain at all, 10 extreme pain)**

**I would like help and/or info on decreasing my wrist/hand pain: Yes No**

**SI joint pain: 1 2 3 4 5 6 7 8 9 10 (1 no pain at all, 10 extreme pain)**

**I would like help and/or info on decreasing my SI joint pain: Yes No**

**Hip joint pain: 1 2 3 4 5 6 7 8 9 10 (1 no pain at all, 10 extreme pain)**

**I would like help and/or info on decreasing my hip joint pain: Yes No**

**Knee pain: 1 2 3 4 5 6 7 8 9 10 (1 no pain at all, 10 extreme pain)**

**I would like help and/or info on decreasing my knee pain: Yes No**

**Ankle/foot pain: 1 2 3 4 5 6 7 8 9 10 (1 no pain at all, 10 extreme pain)**

**I would like help and/or info on decreasing my ankle/foot pain: Yes No**

**Energy level: 1 2 3 4 5 6 7 8 9 10 (1 low energy, 10 high energy)**

**I would like help and/or info on increasing my energy level: Yes No**

**Diet and nutrition: 1 2 3 4 5 6 7 8 9 10 (1 horrible diet, 10 excellent diet)**

**I would like help and/or info on improving my diet and nutrition: Yes No**

**Exercise program: 1 2 3 4 5 6 7 8 9 10 (1 horrible exercise habits, 10 excellent exercise habits)**

**I would like help and/or info on exercise: Yes No**

**Ability to sleep well: 1 2 3 4 5 6 7 8 9 10 (1 horrible sleeper, 10 excellent sleeper)**

**I would like help and/or info on getting a good night's sleep: Yes No**

**Stress level: 1 2 3 4 5 6 7 8 9 10 (1 no stress at all, 10 extreme stress)**

**I would like help and/or info on decreasing my stress: Yes No**

**Headache frequency: 1 2 3 4 5 6 7 8 9 10 (1 constant headaches, 10 never)**

**I would like help and/or info on decreasing my headaches: Yes No**

**Posture: 1 2 3 4 5 6 7 8 9 10 (1 poor posture, 10 perfect posture)**

**I would like help and/or info on improving my posture: Yes No**

**Breathing: 1 2 3 4 5 6 7 8 9 10 (1 poor breather, 10 good breather)**

**I would like help and/or info on improving my breathing: Yes No**

**Blood pressure: 1 2 3 4 5 6 7 8 9 10 (1 poor blood pressure, 10 normal blood pressure)**

**I would like help and/or info on improving blood pressure: Yes No**

**Daily Activities: 1 2 3 4 5 6 7 8 9 10 (1 unable to perform, 10 able to perform)**

**(ex: house chores, driving distance, sitting extended period, etc)**

**I would like help and/or info on improving my ability to perform daily activities: Yes No**

**Enjoyable Activities: 1 2 3 4 5 6 7 8 9 10 (1 unable to perform, 10 able to perform)**

**(ex: golf, gardening, play with kids)**

**I would like help and/or info on improving my ability to perform enjoyable activities: Yes No**

**Please list 5 activities of daily living you can't perform at 100% (ex: house chores, driving distance, sitting extended period, etc)**

**1.**

**2.**

**3.**

**4.**

**5.**

**Please list 5 activities that you really enjoy that you can't perform at 100% (ex: golf, gardening, play with kids)**

**1.**

**2.**

**3.**

**4.**

**5.**