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?**

  ____
  ____