apto
CHIROPRACTIC

Name________________________________ Date___/___/___ Age____ Male / Female

Address__________________________ City_____________ State____ ZIP______________

Phone: Home_______________________ Cell __________________ Provider __________

Email Address _______________________ Date of Birth ______/______/_____________

Occupation _______________________ Employer's Name ________________________

Single / Married / Divorced / Widowed Spouse's Name ______________________

Number of Children ______ Names, Ages & Gender __________________________

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Who may we thank for referring you in? ___________________ EVAL COST _______

PLEASE LIST YOUR HEALTH CONCERNS BELOW

Health Concerns: List Worst First	Rate Severity 1= Mild 10=Unbearable	When did this episode start?	Did you have this condition before? when?	Did the problem begin with an injury?	Constant or Intermittent?

Since your problem started, is it

___ ABOUT THE SAME ___GETTING BETTER ___GETTING WORSE

What makes it worse? ____

What helps make it better? ____

Health, Wellness & Quality of Life Questionnaire

Case Number: ______________

Answer each of the questions below by putting a circle around the number that **best** represents you at this time.

Date: ______________

I. Physical State

Rate the following questions with respect to frequency:

		Never	Rarely	Occasionally	Regularly	Constantly
1.	Presence of physical pain (neck/back ache, sore arms/legs, etc.).	1	2	3	4	5
2.	Feeling of tension or stiffness or lack of flexibility in your spine.	1	2	3	4	5
3.	Incidence of fatigue or low energy.	1	2	3	4	5
4.	Incidence of colds and flu.	1	2	3	4	5
5.	Incidence of headaches (of any kind).	1	2	3	4	5
6.	Incidence of nausea or constipation.	1	2	3	4	5
7.	Incidence of menstrual discomfort.	1	2	3	4	5
8.	Incidence of allergies or skin rashes.	1	2	3	4	5
9.	Incidence of dizziness or light-headedness.	1	2	3	4	5
10.	Incidence of accidents or near accidents or falling or tripping.	1	2	3	4	5

II. Mental/Emotional State

Rate the following questions with respect to frequency:

		Never	Rarely	Occasionally	Regularly	Constantly
1.	If pain is present, how distressed are you about it?	1	2	3	4	5
2.	Presence of negative or critical feelings about your self.	1	2	3	4	5
3.	Experience of moodiness or temper or angry outbursts.	1	2	3	4	5
4.	Experience of depression or lack of interest.	1	2	3	4	5
5.	Being overly worried about small things.	1	2	3	4	5
6.	Difficulty thinking or concentrating or indecisiveness.	1	2	3	4	5
7.	Experience of vague fears or anxiety.	1	2	3	4	5
8.	Being fidgety or restless; difficulty sitting still.	1	2	3	4	5
9.	Difficulty falling or staying asleep.	1	2	3	4	5
10.	Experience of recurring thoughts or dreams.	1	2	3	4	5

III. Stress Evaluation

Evaluate your stress relative to the following:

		None	Slight	Moderate	Pronounced	Extensive
1.	Family.	1	2	3	4	5
2.	Significant Relationship.	1	2	3	4	5
3.	Health.	1	2	3	4	5
4.	Finances.	1	2	3	4	5
5.	Sex Life.	1	2	3	4	5
6.	Work.	1	2	3	4	5
7.	School.	1	2	3	4	5
8.	General well-being.	1	2	3	4	5
9.	Emotional well-being.	1	2	3	4	5
10.	Coping with daily problems.	1	2	3	4	5

IV. Life Enjoyment

Rate the following on a degree scale of 1-5:

	Not at all	Slight	Moderate	Considerable	Extensive
1. Openness to guidance to your "inner voice/feelings."	1	2	3	4	5
2. Experience of relaxation or ease or well-being.	1	2	3	4	5
3. Presence of positive feelings about yourself.	1	2	3	4	5
4. Interest in maintaining a healthy lifestyle (e.g., diet, fitness, etc).	1	2	3	4	5
5. Feeling of being open and aware/connected when relating to others.	1	2	3	4	5
6. Level of confidence in your ability to deal with adversity.	1	2	3	4	5
7. Level of compassion for, and acceptance of, others.	1	2	3	4	5
8. Satisfaction with the level of recreation in your life.	1	2	3	4	5
9. Incidence of feelings of joy or happiness.	1	2	3	4	5
10. Level of satisfaction with your sex life.	1	2	3	4	5
11. Time devoted to things you enjoy.	1	2	3	4	5

V. Overall Quality of Life

Evaluate your feelings relative to the quality of life:

	Terrible	Unhappy	Mostly Dissatisfied	Mixed	Mostly Satisfied	Pleased	Delighted
1. Your personal life.	1	2	3	4	5	6	7
2. Your wife/husband or "significant other".	1	2	3	4	5	6	7
3. Your romantic life.	1	2	3	4	5	6	7
4. Your job.	1	2	3	4	5	6	7
5. Your co-workers.	1	2	3	4	5	6	7
6. The actual work you do.	1	2	3	4	5	6	7
7. The handling of problems in your life.	1	2	3	4	5	6	7
8. What you are actually accomplishing in your life.	1	2	3	4	5	6	7
9. Your physical appearance - the way you look to others.	1	2	3	4	5	6	7
10. Your self.	1	2	3	4	5	6	7
11. Your ability to adjust to change in your life.	1	2	3	4	5	6	7
12. Your life as a whole.	1	2	3	4	5	6	7
13. Overall contentment with your life.	1	2	3	4	5	6	7
14. The extent to which your life has been as you want it.	1	2	3	4	5	6	7

VI. Overall Impressions

Answer each of the questions with respect to when you first came to this office:

	Better	Same	Worse
1. Overall my physical well-being is:	1	2	3
2. Overall my mental/emotional state is:	1	2	3
3. Overall my ability to handle stress is:	1	2	3
4. Overall my enjoyment of life is:	1	2	3
5. Overall my quality of life is:	1	2	3

SCORE:________