

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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