QUALITY OF LIFE SURVEY

Name: _____ Date: _____

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

7. How has your health condition affected your job, relationship, finances, family or other activities? Please give examples:

_____

_____

_____

8. What has that cost you? (time, money, happiness, freedom, sleep, promotion, etc.) Give 3 examples:

1. _____
2. _____
3. _____

9. What are you most concerned about regarding your problem?

_____

_____

10. Where do you picture yourself being in the next 1-3 years if this problem is not taken care of? Please be specific

_____

_____

11. What would be different /better without this problem? Please be specific

_____

_____

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

_____

_____

13. What would that mean to you?

_____

_____

_____