

**Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**ACTIVITIES OF DAILY LIVING**

List **activities of daily living** you can’t perform at 100% due to your current condition (ex: house chores, driving distance, exercising, golfing, gardening, hiking, playing w/ kids, sitting extended period, etc)

**1.**

**2.**

**3.**

**4.**

**5.**

**HEALTH SURVEY (Optional) :**

**This chiropractic office provides many services for improving your health and lifestyle.**

**To get an idea of what you want and expect or didn’t expect please take the following health survey.**

* How would you rate your current state of health? Poor- Fair- Average- Good- Excellent
* Do you want to focus more attention towards living a healthier lifestyle? **Yes No**
* Musculoskeletal pain: 1 2 3 4 5 6 7 8 9 10 (1 none at all, 10 extreme)

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

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

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

* Detoxing (water fasting) 1 2 3 4 5 6 7 8 9 10 (1 none at all, 10 high priority)

I would like help and/or info on doctor supervised water fasting: **Yes No**

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

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

* Weight Gain/Loss: 1 2 3 4 5 6 7 8 9 10 (1 horrible, 10 excellent)

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

* Ability to get a good night sleep: 1 2 3 4 5 6 7 8 9 10 (1 horrible, 10 excellent)

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

* Stress level: 1 2 3 4 5 6 7 8 9 10 (1 extreme, 10 none at all)

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

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

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

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

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

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

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

* Pharmaceutical drug intake: 1 2 3 4 5 6 7 8 9 10 (1 (daily), 10 never)

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