Health Satisfaction Survey

Please answer the questions on a scale of 1 to 10 , 1 representing that you don't agree with the statement and 10 representing that there is no doubt in your mind or heart that you agree with the statement.

Physical Health

I am a physically fit person and formally exercise on a regular basis.

1 2 3 4 5 6 7 8 9 10

I have a physically attractive body that I am proud to look at in the mirror.

1 2 3 4 5 6 7 8 9 10

I have not had many traumas in my life (auto accident, broken bones, bad falls).

1 2 3 4 5 6 7 8 9 10

I get at least 7 hours of sleep, 7 days at week

1 2 3 4 5 6 7 8 9 10

I have gotten regular Chiropractic care within the past 5 years.

1 2 3 4 5 6 7 8 9 10

TOTAL _____

Emotional/Mental Health

I am a calm, peaceful person. I can shut my mind off and focus my mind at will.

1 2 3 4 5 6 7 8 9 10

I practice some form of mental relaxation (meditation, yoga, breathing exercises, prayer, etc.) on a regular basis.

1 2 3 4 5 6 7 8 9 10

Most of the time, I am truly happy and feel a sense of purpose in my life.

1 2 3 4 5 6 7 8 9 10

I have healthy relationships and a rich social network of friends and activities.

1 2 3 4 5 6 7 8 9 10

I am organized, have time for myself, and can prioritize the important tasks in my life.

1 2 3 4 5 6 7 8 9 10

TOTAL _____

Chemical/Nutritional Health

I eat 4-6 small meals daily and properly combine my protein, carbohydrates and fats.

1 2 3 4 5 6 7 8 9 10

I supplement everyday with good supplements such as a vitamin/mineral complex, antioxidants, and good fatty acids (fish oil, flax seeds).

1 2 3 4 5 6 7 8 9 10

I do not take medications for chronic medical problems such as digestive disorders; cardiovascular problems; headaches; chronic pain; blood sugar problems; chronic fatigue; immune problems or chronic infections; or any other chronic conditions.

1 2 3 4 5 6 7 8 9 10

I do not smoke cigarettes.

1 2 3 4 5 6 7 8 9 10

I drink water as my primary beverage and consume at least 30 ounces per day.

1 2 3 4 5 6 7 8 9 10

TOTAL_____

Total of all 3 sections (physical, emotional, chemical) _____

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Medical Symptoms Questionnaire

PATIENT NAME: **DATE:**

Rate each of the following symptoms based upon your typical health profile for the past 30 days

POINT SCALE

0 - Never or almost never have this symptom
1 - Occasionally have it, effect is not severe
2 - Occasionally have it, effect is severe
3 - Frequently have it, effect is not severe
4 - Frequently have it, effect is severe

HEAD
_____ Headaches
_____ Faintness
_____ Dizziness
_____ Insomnia
TOTAL_____

EYES
_____ Watery or Itchy Eyes
_____ Swollen, Reddened or Sticky Eyelids
_____ Bags or Dark Circles Under Eyes
_____ Blurred or Tunnel Vision
(does not include near or far-sightedness)
TOTAL_____

EARS
_____ Itchy Ears
_____ Earaches, Ear Infections
_____ Drainage from Ear(s)
_____ Ringing in Ears, Hearing Loss
TOTAL_____

NOSE
_____ Stuffy Nose
_____ Sinus Problems
_____ Hay Fever
_____ Sneezing Attacks
_____ Excessive Mucus Formation
TOTAL_____

MOUTH/THROAT
_____ Chronic Coughing
_____ Gagging, Frequent Need to Clear Throat
_____ Sore Throat, Hoarseness, Loss of Voice
_____ Swollen or Discolored Tongue, Gums or Lips
_____ Canker Sores
TOTAL_____

ENERGY/ACTIVITY
_____ Fatigue, Sluggishness
_____ Apathy, Lethargy
_____ Hyperactivity
_____ Restlessness
TOTAL_____

WEIGHT
_____ Binge Eating/Drinking
_____ Craving Certain Foods
_____ Excessive Weight
_____ Compulsive Eating
_____ Water Retention
_____ Underweight
TOTAL_____

EMOTIONS
_____ Mood Swings
_____ Anxiety, Fear, Nervousness
_____ Anger, Irritability, Aggressiveness
_____ Depression
TOTAL_____

MIND
_____ Poor Memory
_____ Confusion, Poor Comprehension
_____ Poor Concentration
_____ Difficulty in Making Decisions
_____ Stuttering or Stammering
_____ Slurred Speech
_____ Learning Disabilities
TOTAL_____

SKIN
_____ Acne
_____ Hives, Rashes or Dry Skin
_____ Hair Loss
_____ Flushing, Hot Flashes
_____ Excessive Sweating
TOTAL_____

LUNGS
_____ Chest Congestion
_____ Asthma, Bronchitis
_____ Shortness of Breath
_____ Difficulty Breathing
TOTAL_____

HEART
_____ Irregular or Skipped Heartbeats
_____ Rapid or Pounding Heartbeat
_____ Chest Pain
TOTAL_____

DIGESTIVE TRACT
_____ Nausea, Vomiting
_____ Diarrhea
_____ Constipation
_____ Bloated Feeling
_____ Belching, Passing Gas
_____ Heartburn
_____ Intestinal/Stomach Pain
TOTAL_____

OTHER
_____ Frequent Illness
_____ Frequent or Urgent Urination
_____ Genital Itch or Discharge
TOTAL_____

JOINTS/MUSCLES
_____ Pain or Aches in Joints
_____ Arthritis
_____ Stiffness or Limited Movement
_____ Pain or Aches in Muscles
_____ Feeling of Weakness or Tiredness
TOTAL_____

GRAND TOTAL_____