

## Health, Wellness and Quality of Life Questionnaire

Name: \_\_\_\_\_

Date: \_\_\_\_\_

*The categories below are actual changes people have had in the past who receive Gentle Network Chiropractic. Please fill out the following questions below based how you feel at this time. You will be given this questionnaire again during your re-evaluation to see the changes you have made. It is very exciting when you can see how much you have changed in such a short period of time.*

### 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. How often do you observe yourself with poor posture	1	2	3	4	5
4. Incidence of fatigue or low energy	1	2	3	4	5
5. Incidence of colds or flu	1	2	3	4	5
6. Incidence of headaches (of any kind)	1	2	3	4	5
7. Incidents of nausea, constipation or diarrhea (please circle)	1	2	3	4	5
8. Incident of menstrual discomfort	1	2	3	4	5
9. Incidents of allergies or skin rashes	1	2	3	4	5
10. Incidents of dizziness or light-headedness	1	2	3	4	5
11. Incidents of accidents, 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 yourself	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 falling or staying asleep	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 thinking, concentrating, or indecisiveness	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. Work	1	2	3	4	5
5. School	1	2	3	4	5
6. General well-being	1	2	3	4	5
7. Emotional well-being	1	2	3	4	5
8. Coping with daily problems	1	2	3	4	5

#### IV. LIFE ENJOYMENT

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

	none	slight	moderate	considerable	extensive
1. Ability to listen to your "gut feelings"	1	2	3	4	5
2. Experience of relaxation or ease of well-being	1	2	3	4	5
3. 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. Level of confidence in your ability to deal with adversity	1	2	3	4	5
6. Level of compassion for, and acceptance of, others	1	2	3	4	5
7. Satisfaction with the level of recreation in your life	1	2	3	4	5
8. Incidents of feelings of joy or happiness	1	2	3	4	5
9. Time devoted to things you enjoy	1	2	3	4	5

#### V. OVERALL QUALITY OF LIFE

Evaluate your feelings relative to each 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/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. Extent to which your life has been the way you want it	1	2	3	4	5	6	7