

Chronic Pain and Metabolic Conditions

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Patient Quality Of Life Survey

Name: _____

Date: _____

Address: _____

Phone: _____

Zip _____

Please take several minutes to answer these questions so we can help you get better faster. **(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:

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

What are you most concerned with regarding your problem? _____

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

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

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

What would that mean to you? _____
