For use with <u>Neck and/or Back Problems</u> only.

In order to properly assess your condition, we must understand how much your neck and/or back problems have affected your ability to manage everyday activities. For each item below, please circle the number which most closely describes your condition right now.

1. Pain Intensi	ty				6. Recreation				
0	1	2	3	4	0	1	2	3	4
l No	l Mild	l Moderate	Severe	l Worst	Can do	Can do	Can do	Can do	Cannot
pain	pain	pain	pain	possible	all	most	some	a few	do any
pam	pani	pani	pani	pain	activities	activities	activities	activities	activities
2. Sleeping				puili	7 T				
0	1	2	3	4	7. Frequency of	pain			1.4
	Ι	I		1	0	1	2	3	4
Perfect	Mildly	Moderately	Greatly	Totally	No	Occasional	Intermittent	Frequent	Constant
sleep	disturbed	disturbed	disturbed	disturbed	pain	pain;	pain;	pain;	pain;
	sleep	sleep	sleep	sleep		25%	50%	75%	100%
3. Personal Ca	are (washing, o	dressing, etc.)			0 7 10.1	of the day	of the day	of the day	of the day
0	1	2	3	4	8. Lifting	L.			1.4
 N-		Madamata) Madamta	[0	1	2	3	4
No	Mild	Moderate	Moderate	Severe	No	Increased	Increased	Increased	Increased
pain; no	pain;	pain; need	pain; need	pain; need	pain with	pain with	pain with	pain with	pain with
	no	to go slowly	some assistance	100% assistance	heavy	heavy	moderate	light	any
restrictions	restrictions		assistance	assistance	weight	weight	weight	weight	weight
4. Travel (driv	ring, etc.)				9. Walking				
0	1	2	3	4	0	1	2	3	4
No	Mild	Moderate	Moderate	Severe	No pain;	Increased	Increased	Increased	Increased
pain on	pain on	pain on	pain on	pain on	any	pain after	pain after	pain after	pain with
long trips	long trips	long trips	short trips	short trips	distance	1 mile	1/2 mile	1/4 mile	all
5. Work					10 0/ 1				walking
	11	12	3	4	10. Standing				
0	1		5		0	1	2	3	4
Can do	Can do	Can do	Can do	Cannot	No pain	Increased	Increased	Increased	Increased
usual work	usual work;	50% of	25% of	work	after	pain	pain	pain	pain with
plus unlimited	no extra	usual	usual		several	after several	after	after	any
extra work	work	work	work		hours	hours	1 hour	1/2 hour	standing
Name								Total Score	9
		PRINTED							
		Signature			Date		© 1999-2001 1	Institute of Evidence-H	Based Chiropractic

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The Wellness Score™

Health Satisfaction Score (HSS)

Name: _____ Date: _____

Email Address: _____

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.

[1 - Absolutely Disagree] [2] [3] [4] [5] [6] [7] [8] [9] [10 - Absolutely Agree]

Section 1 - Physical Health

- 1. I am a physically fit person and formally exercise on a regular basis. [1] [2] [3] [4] [5] [6] [7] [8] [9] [10]
- 2. 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]
- 3. 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]
- 4. I get at least 7 hours of sleep, 7 days at week [1] [2] [3] [4] [5] [6] [7] [8] [9] [10]
- 5. I have gotten regular Chiropractic care within the past 5 years. [1] [2] [3] [4] [5] [6] [7] [8] [9] [10]

Section 1 total ____

Section 2 - Emotional/Mental Health

- 6. 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]
- 7. 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]
- 9. I have healthy relationships and a rich social network of friends and activities.[1] [2] [3] [4] [5] [6] [7] [8] [9] [10]
- 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]

Section 2 total _____

Section 3 - Chemical/Nutritional Health

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

[1] [2] [3] [4] [5] [6] [7] [8] [9] [10]

- 12. 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]
- 13. 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]
- 14. I do not smoke cigarettes.
- [1] [2] [3] [4] [5] [6] [7] [8] [9] [10]
- 15. 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]

Section 3 total____

Grand total of all three sections: ____

The Wellness Score™

	Medical Symptoms Questionnaire (MSQ)	
Name:	Date:	
Email Address:		
Rate each of the	e following symptoms based upon your typical health profile for the past 30) days.
Point Scale	 0 - Never or almost never have the 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-sighted)	Total
Ears	 Itchy Ears Earaches, Ear Infections Drainage from Ear 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 	
Skin	Acne Hives, Rashes, Dry Skin Hair Loss Flushing, Hot Flashes Excessive Sweating	Total
		Total
Heart	Irregular or Skipped Heartbeat Rapid or Pounding Heartbeat Chest Pain	
		Total

The Wellness Score™

Lungs	Chest Congestion	
	Asthma, Bronchitis Shortness of Breath	
	Difficulty Breathing	
		Total
Direction	Nousse Versiting	
Digestion	Nausea, Vomiting Diarrhea	
	Constipation Bloated Feeling	
	Belching, Passing Gas	
	Heartburn	
	Intestinal/Stomach Pain	
		Total
		10tur
Joints/	Pain or Aches in Joints	
Muscles	Arthritis	
	Stiffness or Limitation of Movement	
	Pain or Aches in Muscles	
	Feeling of Weakness or Tiredness	
		Total
Weight	Binge Eating/Drinking	
	Craving Certain Foods	
	Excessive Weight	
	Compulsive Eating Water Retention	
	Underweight	Total
Energy/	Fatigue, Sluggishness	
Activity	Apathy, Lethargy	
	Hyperactivity	
	Restlessness	
		Total
Mind	Poor Memory	
	Confusion, Poor Comprehension	
	Poor Concentration	
	Poor Physical Condition	
	Difficulty in Making Decisions	
	Stuttering or Stammering	
	Slurred Speech	
	Learning Disabilities	
		Total
F4		
Emotions	Mood Swings	
	Anxiety, Fear, Nervousness	
	Anger, Irritability, Aggressiveness Depression	
	Depression	Total
		10(41
Other	Frequent Illness	
	Frequent or Urgent Urination	
	Genital Itch or Discharge	
	-	Total
		Grand Total