Dr. John J. Collins Springbrook Chiropractic 420 Villa Rd. Newberg, Oregon 97132 (503) 538-0618 fax: (503) 537-2539 www.liferealigned.com

Wellness Behaviors Questionnaire: Select the answer that seems most correct.

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100% Disagree	0	O	C	0	0	0	C	C		0	100% A	gree
2-I rarely eat fast	food, pro	cessed	food,	added	sugar,	desse	rts, alc	ohol, d	caffein	e or pr	eservativ	es.
100% Disagree C	0	0	0	0	0	C	0	C		0	100% A	gree
3- Most days , I wa	alk, jog o	r run a	t least 1	0,000	steps/	5 mile	s per c	lay.				
100% Disagree (0	0	0	0	0	0	0	0	0	0	100% A	gree
4- At least a few t heavy objects/item											otion and	lift, carry, push or pull
100% Disagree (0	0	0	0	0	0	0	0	0	0	100% A	gree
5- Most nights , I g	go to bed	on tin	ne' and	l rarely	need	an ala	rm clo	ck to v	vake n	ne in ti	me to sta	rt my day.
100% Disagree	0	O	C	0	0	0	C	C	C	0	100% A	gree
6- I have multiple communities/netwo					•							supportive social
100% Disagree 🤇	0	0	0	0	0		0	0		0	100% A	gree
7- I do NOT smok	ke or use	tobaco	co prod	ducts.								
1000/ B:		_	_							_		A
100% Disagree 🤇	J U	0	0		0	0		0	0	0	100%	Agree
100% Disagree 0	1	2	3	C 4	5	6	© 7	8	9	10	100%	Agree
0	1		3	4	5	6	7	8	9	10		
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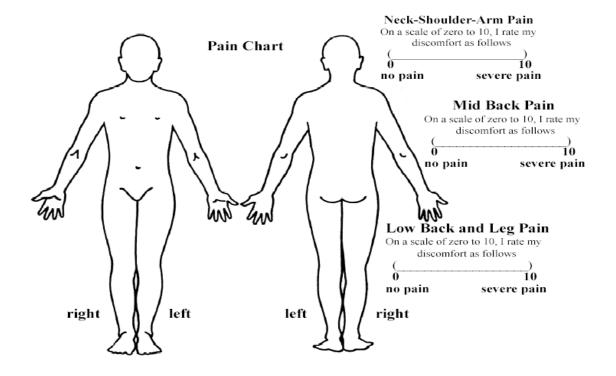
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Reason for visit (check one or more):	
1 I am a new patient.	
2 I am a former patient returning with a new problem (or reoccurrence of an old problem).	
3 I am a current patient and this is a scheduled re-evaluation.	
If you checked #1 or #2 briefly describe your reason for this visit:	
<u></u>	

If you checked #3, has your condition improved since your last exam? __Yes; __No; __ Don't know

Please mark, draw or fill in areas <u>on the body picture</u> (below) **where** you feel any PAIN OR OTHER SYMPTOMS. Mark areas of shooting pain too. Include headaches and any other symptoms that you might have. You can also write words and use arrows to describe your symptoms.

Numbness	Pins & Needles	Burning	Aching	Stabbing
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	00000	XXXXX	2012 2012 2012 2012	/////
	00000	XXXXX	शंद शंद शंद शंद शंद	/////



Are you taking medications (prescription or n	on-prescription) t	o alleviate you	r symptoms?	No. Yes.
If yes, what are you taking and how much? _				·
In general, your MAIN symptoms are (circle	one): Infrequent	Occasional	Frequent	Constant
Print Patient Name:	_ Signature:		Date:	//
	This form is 2-sic	ded		