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.*

1-I **regularly eat** home-cooked meals with fruit, organic vegetables and meats, poultry or seafood.

100% Disagree ○ ○ ○ ○ ○ ○ ○ ○ ○ ○ ○ 100% Agree

2-I **rarely eat** fast food, processed food, added sugar, desserts, alcohol, caffeine or preservatives.

100% Disagree ○ ○ ○ ○ ○ ○ ○ ○ ○ ○ ○ 100% Agree

3- **Most days**, I walk, jog or run at least 10,000 steps/5 miles per day.

100% Disagree ○ ○ ○ ○ ○ ○ ○ ○ ○ ○ ○ 100% Agree

4- **At least a few times per week**: I move my entire body through its full range of motion and lift, carry, push or pull heavy objects/items/weights in ways that require much of my physical strength.

100% Disagree ○ ○ ○ ○ ○ ○ ○ ○ ○ ○ ○ 100% Agree

5- **Most nights**, I go to bed 'on time' and rarely need an alarm clock to wake me in time to start my day.

100% Disagree ○ ○ ○ ○ ○ ○ ○ ○ ○ ○ ○ 100% Agree

6- I have multiple supportive relationships with family, friends and others. I have one or more supportive social communities/networks (include extended family) and feel a strong sense of belonging.

100% Disagree ○ ○ ○ ○ ○ ○ ○ ○ ○ ○ ○ 100% Agree

7- I **do NOT smoke or use tobacco products**.

100% Disagree ○ ○ ○ ○ ○ ○ ○ ○ ○ ○ ○ 100% Agree

0 1 2 3 4 5 6 7 8 9 10

General Physical Function Questionnaire: Please choose the answer that seems most correct.

"Recently, because of my pain (or other symptoms for which I am seeking treatment) <u>my ability to</u>:

SIT is:
- ❑ Not Limited 0
- ❑ Mildly Limited 2
- ❑ Moderately Limited 3
- ❑ Severely Limited 4

HOLD or CARRY things is:
- ❑ Not Limited
- ❑ Mildly Limited
- ❑ Moderately Limited
- ❑ Severely Limited

CARE FOR MYSELF is:
- ❑ Not Limited
- ❑ Mildly Limited
- ❑ Moderately Limited
- ❑ Severely Limited

STAND or WALK is:
- ❑ Not Limited
- ❑ Mildly Limited
- ❑ Moderately Limited
- ❑ Severely Limited

BEND or REACH is:
- ❑ Not Limited
- ❑ Mildly Limited
- ❑ Moderately Limited
- ❑ Severely Limited

SLEEP is:
- ❑ Not Limited
- ❑ Mildly Limited
- ❑ Moderately Limited
- ❑ Severely Limited

Patient Name/ Signature: _____/_____ Date: ____/___/_____

This form is 2-sided

Staff use only: WBQ Score ____/70 (0-70, 70=Perfect wellness behavior score)
GPFQ Score ___/24_ (0=No functional limitation, 24=Highest possible functional limitation)

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Welcome!

Reason for visit (check one or more):

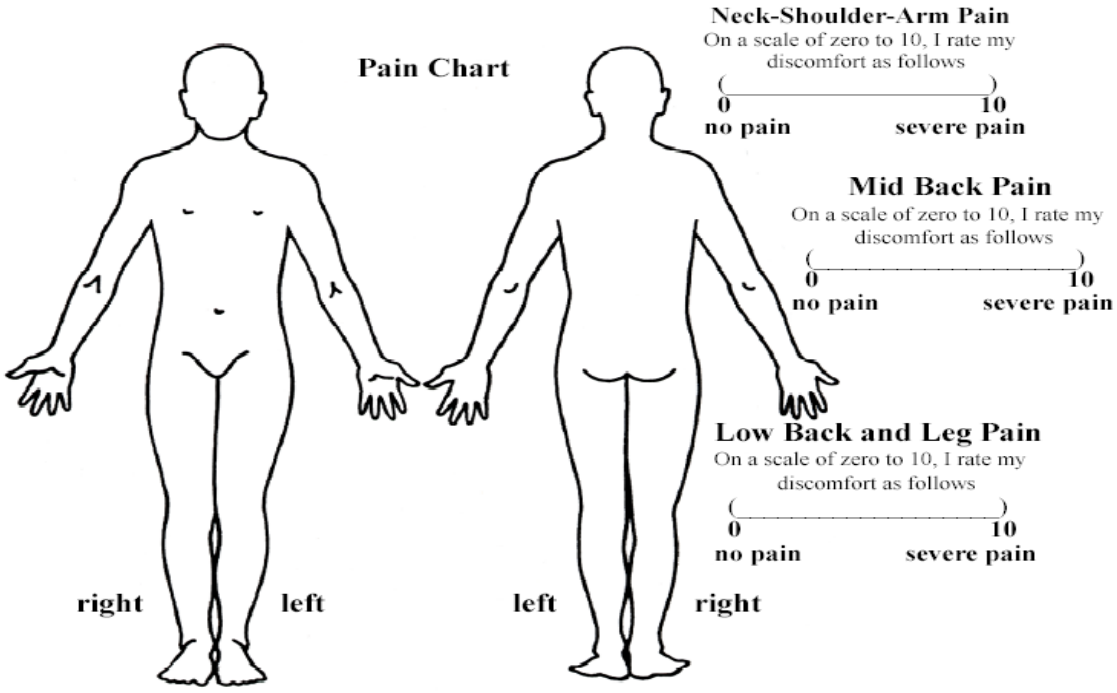
1- __ I am a new patient.
2- __ I am a former patient returning with a new problem (or reoccurrence of an old problem).
3- __ I am a current patient and this is a scheduled re-evaluation.

If you checked #1 or #2 briefly describe your reason for this visit: _____
_____

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

Please mark, draw or fill in areas on the body picture (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
- - - - -	OOOOO	XXXXX	*****	/////
- - - - -	OOOOO	XXXXX	*****	/////
- - - - -	OOOOO	XXXXX	*****	/////



Are you taking medications (prescription or non-prescription) to alleviate your 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-sided