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

Wellness Behavior 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% False ○ ○ ○ ○ ○ ○ ○ ○ ○ ○ ○ 100% True

2-I **rarely or never** eat fast food, processed foods, added sugars, desserts, alcohol, caffeine or preservatives.

100% False ○ ○ ○ ○ ○ ○ ○ ○ ○ ○ ○ 100% True

3- I am certain that I walk, jog or run at least 10,000 steps/5 miles per day on **most days**.

100% False ○ ○ ○ ○ ○ ○ ○ ○ ○ ○ ○ 100% True

4- **Several times per week**: I stretch or 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% False ○ ○ ○ ○ ○ ○ ○ ○ ○ ○ ○ 100% True

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

100% False ○ ○ ○ ○ ○ ○ ○ ○ ○ ○ ○ 100% True

6- I regularly cultivate caring, 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% False ○ ○ ○ ○ ○ ○ ○ ○ ○ ○ ○ 100% True

7- I do not smoke, or use tobacco products.

100% False ○ ○ ○ ○ ○ ○ ○ ○ ○ ○ ○ 100% True

Collins Physical Function Questionnaire (Copyright John J. Collins, DC)

My Ability To SIT is:
- ❑ Not Limited
- ❑ Mildly Limited
- ❑ Moderately Limited
- ❑ Severely Limited
- ❑ Completely Limited

My Ability To LIFT/ CARRY is:
- ❑ Not Limited
- ❑ Mildly Limited
- ❑ Moderately Limited
- ❑ Severely Limited
- ❑ Completely Limited

My Ability To WALK is:
- ❑ Not Limited
- ❑ Mildly Limited
- ❑ Moderately Limited
- ❑ Severely Limited
- ❑ Completely Limited

My Ability To STAND is:
- ❑ Not Limited
- ❑ Mildly Limited
- ❑ Moderately Limited
- ❑ Severely Limited
- ❑ Completely Limited

My Ability To BEND is:
- ❑ Not Limited
- ❑ Mildly Limited
- ❑ Moderately Limited
- ❑ Severely Limited
- ❑ Completely Limited

My Ability To SLEEP is:
- ❑ Not Limited
- ❑ Mildly Limited
- ❑ Moderately Limited
- ❑ Severely Limited
- ❑ Completely Limited

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

Staff use only: WBQ Score _____/70____ (0-70, 70=perfect score)
CPFQ Score _____/24_____ (0= No disability, 24= Total subjective disability)

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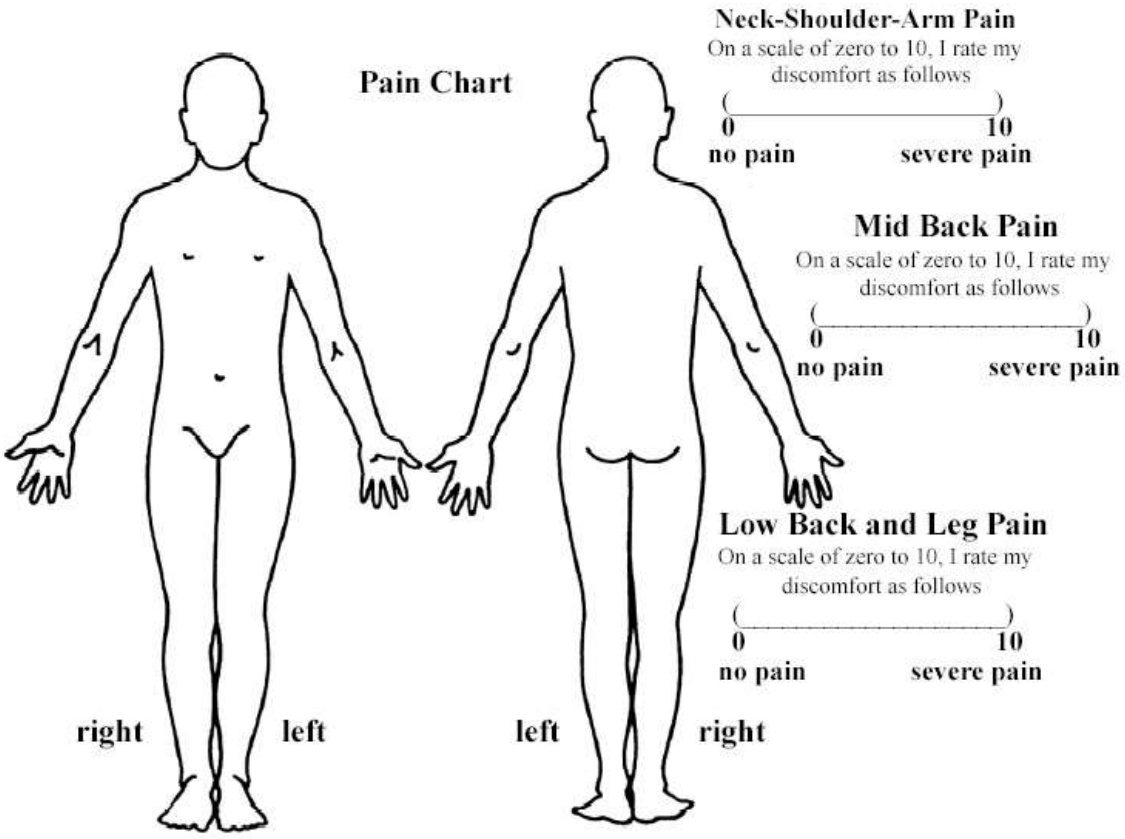
SHOW AREA(S) OF PAIN OR OTHER SYMPTOMS.

Mark the areas on this body where you feel the described sensations. Make up your own if these do not accurately describe them. Mark areas of radiating/shooting pain. Include all affected areas. Include headaches and any other symptoms that you might have. (i.e. Muscle spasms, stiffness, weakness)

0= No symptoms. 10= worst symptoms you can imagine.

Numbness	Pins & Needles	Burning	Aching	Stabbing
- - - - -	OOOOO	xxxxx	*****	/////
- - - - -	OOOOO	xxxxx	*****	/////
- - - - -	OOOOO	xxxxx	*****	/////



Are you taking medications (prescription or non-prescription) in order to minimize 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: __/__/___