Personal Improvement Support Exploratory

Date ____/_____/____

Name _____ Age _____ D.O.B. ____/_____/____

Address _____ City _____ State_____ Zip _____

Phone _____ Email _____ Website _____

Height _____ Weight _____ Occupation _____

What main challenges are you facing? _____

_____

_____

How is it affecting your life?_____

_____

How did you first become aware of this? _____

Have you experienced this challenge before? _____ If so when? _____

Details _____

_____

How are you handling the situation so far?_____

_____

Are you getting any results? _____

Do you have a support network? _____

Are you receiving guidance in this matter?_____

_____

How did you get directed to us? _____

What kind of help are you seeking from us? _____

What kind of diet are you on? _____

Are you experiencing any emotional trauma? _____

Are you experiencing any spiritual trauma? _____

Are you being antagnized or harassed by any individuals or groups? _____

_____

Are you experiencing any self esteem issues? _____

_____

Have you been subjected to Racial, Status or Gender persecution? _____

_____

Do you have hobbies? _____

Do you sing or play a musical instrument? _____

Do you perform before audiances? _____

Do you participate in group activities? _____

Do you participate in outdoor activities? _____

Are you reclusive? _____ If so why? _____

Do you walk regularly? _____ Do you run sometimes? _____

Does your energy last throughout the day? _____

Do you get tired easily? _____

Do you get cold easily? _____if so how long do you remember this happening? _____

Do you like the way you look? _____

Do you take naps? _____

Do you sleep soundly through the night?_____

When you awaken are you tired or rested? _____

Do you get angry easily? _____

Any particular people that get on your nerves? _____

Do you watch the news a lot? _____

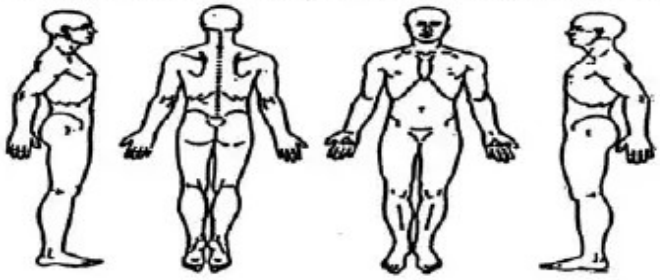
Do world events affect you emotionally? _____

Is your family close? _____

Do you love yourself? _____

1. Is today's problem caused by:_____

2. Indicate on the drawings below where you have pain/symptoms



3. How often do you experience your symptoms?

□ Constantly (76-100% of the time) □ Occasionally (26-50% of the time)
□ Frequently (51-75% of the time) □ Intermittently (1-25% of the time)

4. How would you describe the type of pain?

□ Sharp □ Numb
□ Dull □ Tingly
□ Diffuse □ Sharp with motion
□ Achy □ Shooting with motion
□ Burning □ Stabbing with motion
□ Shooting □ Electric like with motion
□ Stiff □ Other:_____

5. How are your symptoms changing with time?

□ Getting Worse □ Staying the Same □ Getting Better

6. Using a scale from 0-10 (10 being the worst), how would you rate your problem?

0 1 2 3 4 5 6 7 8 9 10 (*Please circle*)

7. How much has the problem interfered with your work?

□ Not at all □ A little bit □ Moderately □ Quite a bit □ Extremely

8. How much has the problem interfered with your social activities?

□ Not at all □ A little bit □ Moderately Quite a bit □ Extremely

9. Who else have you seen for your problem?

□ Chiropractor □ Neurologist □ Primary Care Physician
□ ER physician □ Orthopedist □ Other:_____
□ Massage Therapist □ Physical Therapist □ No one

10. How long have you had this problem? _____

11. How do you think your problem began?

_____

12. Do you consider this problem to be severe?

□ Yes □ Yes, at times □ No

13. What aggravates your problem?

_____

14. What concerns you the most about your problem; what does it prevent you from doing?

_____

15.

16. How would you rate your overall Health?

□ Excellent □ Very Good □ Good □ Fair □ Poor

17. What type of exercise do you do?

□ Stenuous □ Moderate □ Light □ None