## 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.

| ~ ·   | ome-coo  |                          |           |                    | _  |  |  |  |                | _           |            |   |
|---|--|--------------------------|-----------|--------------------|--|--|--|--|----------------|-------------|------------|---|
| 100% Disagree   | 0  | O                        | C         | 0                  | 0  | 0  | C  | C  |                | 0           | 100% A     | gree  |
| 2-I <b>rarely eat</b> 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- <b>Most days</b> , 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- <b>At least a few t</b><br>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- <b>Most nights</b> , 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:  |  | _                        | _         |                    |  |  |  |  |                | _           |            | <b>A</b>  |
| 100% Disagree 🤇   | J U  | 0                        | 0         |                    | 0  | 0  |  | 0  | 0              | 0           | 100%       | Agree   |
| 100% Disagree 0   | 1  | 2                        | 3         | C<br>4             | 5  | 6  | <b>©</b><br>7  | 8  | 9              | 10          | 100%       | Agree   |
| 0   | 1  |                          | 3         | 4                  | 5  | 6  | 7  | 8  | 9              | 10          |            |   |
| 0   | 1<br>Physica   | ıl Fun                   | 3 ction ( | 4<br>Quest         | 5<br>ionna   | 6<br>nire: I   | 7<br>Please  | 8 choos  | 9<br>se the    | 10<br>answe | r that se  | ems most correct.   |
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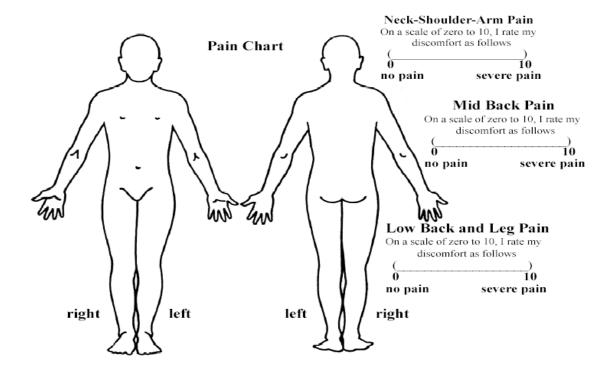
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|----|---------------|---|-----|
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| Reason for visit (check one or more):   |  |
|---|--|
| 1 I am a new patient.   |  |
| 2 I am a former patient returning with a new problem (or reoccurrence of 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 |
|----------|----------------|---------|---------------------|----------|
|          | 00000          | XXXXX   | मेर मेर मेर मेर मेर | /////    |
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| 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             |             |          |