Welcome to WELLNESS
Your best health starts here.

Adult Health Survey

Circle any of the following symptoms you have experienced in the past 6 months:

Shoulder pain	Tension/migraine headaches	Inability to concentrate
Leg or arm pain	Inconsistent bowel movements	Heart issues
Low back pain	Neck pain	Allergies/asthma
Tired or fatigued	Chronic illness	Digestive issues
Menstrual issues	Carpal tunnel	Sinus issues
Dizziness	Poor sleep	Foot/knee/hip pain

Which of the above is the worst? _____

How long have you had this symptom? _____

When it is at its worst, how does it feel? _____

Do these symptoms cause you to feel any of the following?

- ☐ Moody
- ☐ Irritable
- ☐ Interrupted during sleep
- ☐ Restricted on daily activities
- ☐ Unable to work long hours
- ☐ Restricted on household duties

How does this affect your work/life?

- ☐ Decision making
- ☐ Poor attitude
- ☐ Decreased production
- ☐ Exhausted at the end of the day
- ☐ Lose patience with others
- ☐ Hinders exercise/sports

Take the next step in transforming your health. Check one of the following:

- ☐ I would like to schedule an appointment for a complete exam. This will allow me to find out how I can be helped by chiropractic.
- ☐ I would like to come to a class on nutrition, stress management, or weight management and exercise.
- ☐ I would like a chiropractic doctor to call me and discuss my health before making an appointment.

Name _____ **Age** _____ **Phone** _____

Work _____ **Address** _____

Occupation _____ **# Of Hours Working Per Week** _____

Email: Sign up for Welcome to Wellness newsletter _____