LIFEPOWER WELLNESS PROGRAM

***Your Wellness is our* FOCUS!**

Full Name: _____
Date: _____ **DOB:** _____
Address: _____
City, State, Zip _____
Phone: _____ **Email:** _____
Occupation: _____

How did you discover the professional services we offer?

_____

What health/life situation/concern(s) would you like attention to right now?

_____

When did you first notice this situation or concern?

_____

Do you have a belief/ guess/ knowledge of how this happened?

_____

What else may be involved?

_____

What actions have you taken prior to this visit to address your concern?

_____

Did it seem to work?

_____

Are you doing anything differently because of this situation/concern?

_____

How do you feel about these changes?

_____

Is there any activity during which you totally forget about this concern?

_____

Please list names of significant relationships (including children)

_____

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Please circle the activities that are affected by your concern and please rate your distress about it.

(1) Slight distress (2) Moderate distress (3) Significant distress

Work	**1** ☐	**2** ☐	**3** ☐
Social Life	**1** ☐	**2** ☐	**3** ☐
Exercise/work	**1** ☐	**2** ☐	**3** ☐
Recreation/play	**1** ☐	**2** ☐	**3** ☐
Walking	**1** ☐	**2** ☐	**3** ☐
Eating/digestion	**1** ☐	**2** ☐	**3** ☐
Rest/Sleep	**1** ☐	**2** ☐	**3** ☐
Sitting	**1** ☐	**2** ☐	**3** ☐
Love/Sex life	**1** ☐	**2** ☐	**3** ☐

Are you on any medications? **yes** ☐ **no** ☐

If so, do you feel the medication is adding to your quality of life?

_____

Please list herbs, nutritional supplements or natural remedies you take regularly:

_____

Please describe what your main diet includes:

_____

Do you drink alcohol?	**yes** ☐ **no** ☐	**How often?**	_____
Sleep well?	**yes** ☐ **no** ☐	**comments:**	_____
Awaken rested?	**yes** ☐ **no** ☐	**comments:**	_____
Spend time outside?	**yes** ☐ **no** ☐	**comments:**	_____
Take vacations?	**yes** ☐ **no** ☐	**comments:**	_____

Is there an aspect in your life that very much pleases you, brings you joy, or helps you to feel better about yourself?

_____

_____

Are there any particular factors or elements about your life experiences, family, work, recreation, past injuries, dietary program, exercises, outlook, etc. that you feel *impair your opportunity* for full glowing health?

_____

_____

Are there any particular factors or elements about your life experiences, family work, recreation, past injuries, dietary program, exercises, outlook, etc. that you feel *give you an edge* or add to your health?

_____

_____

As your spine and nervous system achieve new states of balance, flexibility & upgraded strategies for living optimally, how would you envision your life now… and in the future?

_____

_____

_____

_____

_____

Any additional information you would like to let us know:

_____

_____

_____

_____

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Name:_____ **Date:**_____

Answer each of the following below by checking the box(s) that best represents you at this time.

PHYSICAL STATE

	Never	Rarely	Occasionally	Regularly	Constantly
Presence of physical pain(neck/backache sore arms/legs, etc.					
Feeling of tension or stiffness or lack of flexibility in your spine					
Fatigue or low energy					
Colds and flu					
Headaches(of any kind)					
Nausea or constipation					
Menstrual discomfort					
Allergies or skin rashes					
Dizziness or light-headedness					
Accidents or near accidents or falling/tripping					

MENTAL/EMOTIONAL STATE

	Never	Rarely	Occasionally	Regularly	Constantly
If pain is present, how distressed are you about it?					
Presence of negative or critical feelings about yourself?					
Experience of moodiness, temper, or outbursts					
Experience of depression or lack of interest					
Being overly worries about small things					
Difficulty thinking or concentrating or indecisiveness					
Experience of vague fears or anxiety					
Being fidgety or restless; difficulty sitting/being still					
Difficulty falling or staying asleep					
Experience of recurring thoughts or dreams					

STRESS

	None	Slight	Moderate	Pronounced	Extensive
Family					
Significant Relationship					
Health					
Finances					
Sexual Connection(s)					
Work/Career/School					
General well-being					
Emotional well-being					
Coping with daily challenges					

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LIFE ENJOYMENT

	Not at all	Slight	Moderate	Considerable	Extensive
Openness to guidance from your inner voice/ feelings					
Experience of relaxation, ease or well-being					
Positive feelings about yourself					
Feeling open and connected when relating to others					
Interest in maintaining a healthy lifestyle					
Confidence in your ability to deal with adversity					
Compassion and acceptance of others					
Satisfaction with amount and quality of recreation in your life					
Feeling joy or happiness					

OVERALL QUALITY OF LIFE

	Unhappy	Mixed	Mostly Satisfied	Pleased	Delighted
Personal Life					
Relationship with significant other(primary relationships)					
Co-workers					
The job you actually do					
The way you handle problems in your life					
Your physical appearance- how you look to yourself					
Your ability to adjust to change your life					

OVERALL INTERNAL AWARNESS

SKIP THIS SECTION IF TODAY IS YOUR FIRST VISIT. ANSWER THESE QUESTIONS IN COMPARISON TO WHEN YOU FIRST CAME TO THE OFFICE FOR CARE.	Better	Same	Worse	More Creative responses	Aware of more Choices
My overall physical well-being is…					
My overall mental state is…					
My overall emotional state is…					
My overall ability to handle stress is…					
My overall life enjoyment is…					
Overall my quality of life is…					