

# Health Status Questionnaire

Name \_\_\_\_\_ Date \_\_\_\_\_

If there are any questions you would prefer not to answer, please feel free to skip those.

**Physical State: Rate the following questions on a frequency scale of 1 to 5.**

**1 = never or N/A, 2 = rarely, 3 = occasional, 4 = regularly, 5 = constantly**

- |   |   |   |   |   |   |
|---|---|---|---|---|---|
| 1. Presence of physical pain (neck/back ache, sore arms/legs, etc.)     | 1 | 2 | 3 | 4 | 5 |
| 2. Feeling of tension, stiffness, or lack of flexibility in your spine. | 1 | 2 | 3 | 4 | 5 |
| 3. Incidence of fatigue or low energy.                                  | 1 | 2 | 3 | 4 | 5 |
| 4. Incidence of colds and flu.  | 1 | 2 | 3 | 4 | 5 |
| 5. Incidence of headaches (any kind).                                   | 1 | 2 | 3 | 4 | 5 |
| 6. Incidence of nausea or constipation.                                 | 1 | 2 | 3 | 4 | 5 |
| 7. Incidence of menstrual discomfort.                                   | 1 | 2 | 3 | 4 | 5 |
| 8. Incidence of eczema or skin rash.                                    | 1 | 2 | 3 | 4 | 5 |
| 9. Incidence of dizziness or lightheadedness.                           | 1 | 2 | 3 | 4 | 5 |
| 10. Incidence of accidents or near accidents or falling or tripping.    | 1 | 2 | 3 | 4 | 5 |

**Mental/Emotional State: Rate the following questions on a frequency scale of 1 to 5.**

**1 = never, 2 = rarely, 3 = occasional, 4 = regularly, 5 = constantly**

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|--|---|---|---|---|---|
| 1. If pain is present, how stressed are you about it?        | 1 | 2 | 3 | 4 | 5 |
| 2. Presence of negative or critical feelings about yourself. | 1 | 2 | 3 | 4 | 5 |
| 3. Experience of moodiness or temper or angry outbursts.     | 1 | 2 | 3 | 4 | 5 |
| 4. Experience of depression or lack of interest.             | 1 | 2 | 3 | 4 | 5 |
| 5. Being overly worried about small things.                  | 1 | 2 | 3 | 4 | 5 |
| 6. Difficulty thinking or concentrating or indecisiveness.   | 1 | 2 | 3 | 4 | 5 |
| 7. Experience of vague fears or anxiety.                     | 1 | 2 | 3 | 4 | 5 |
| 8. Being fidgety or restless; difficulty sitting still.      | 1 | 2 | 3 | 4 | 5 |
| 9. Difficulty falling or staying asleep.                     | 1 | 2 | 3 | 4 | 5 |
| 10. Experience of recurring thoughts or dreams.              | 1 | 2 | 3 | 4 | 5 |

**Stress Evaluation: Evaluate your stress relative to the following with,  
 1 = none or N/A, 2 = slight, 3 = moderate, 4 = pronounced, 5 = extensive**

1. Family	1	2	3	4	5
2. Significant Relationship	1	2	3	4	5
3. Health	1	2	3	4	5
4. Finances	1	2	3	4	5
5. Work	1	2	3	4	5
6. School	1	2	3	4	5
7. General well-being	1	2	3	4	5
8. Emotional well-being	1	2	3	4	5
9. Coping with daily problems	1	2	3	4	5

**Life Enjoyment: Rate the following questions on a degree scale of 1-5 with,  
 1 = not at all, 2 = slight, 3 = moderate, 4 = considerable, 5 = extensive**

1. Openness to guidance by your 'inner voice/feelings'.	1	2	3	4	5
2. Experience of relaxation or ease or well-being.	1	2	3	4	5
3. Presence of positive feelings about yourself.	1	2	3	4	5
4. Interest in maintaining a healthy lifestyle (e.g., diet, fitness)	1	2	3	4	5
5. Feeling of being open and aware/connected when relating to others.	1	2	3	4	5
6. Level of confidence in your ability to deal with adversity.	1	2	3	4	5
7. Level of compassion for, and acceptance of, others.	1	2	3	4	5
8. Satisfaction with the level of recreation in your life.	1	2	3	4	5
9. Incidence of feelings of joy and or happiness.	1	2	3	4	5
10. Time devoted to things you enjoy.	1	2	3	4	5

**Overall Quality of Life: Evaluate your feelings relative to the quality of your life with,**  
1 = terrible, 2 = unhappy, 3 = mostly dissatisfied, 4 = mixed, 5 = mostly satisfied 6 = pleased, 7 = delighted

1. Your personal life.	1	2	3	4	5	6	7
2. Your wife/husband or partner/significant other.	1	2	3	4	5	6	7
3. Your job.	1	2	3	4	5	6	7
4. Your co-workers.	1	2	3	4	5	6	7
5. The actual work you do.	1	2	3	4	5	6	7
6. Your handling of problems in your life.	1	2	3	4	5	6	7
7. What you are actually accomplishing in your life.	1	2	3	4	5	6	7
8. Your physical appearance - the way you look to others.	1	2	3	4	5	6	7
9. Your self.	1	2	3	4	5	6	7
10. The extent to which you adjust to the changes in your life.	1	2	3	4	5	6	7
11. Your life as a whole.	1	2	3	4	5	6	7
12. Overall contentment with your life.	1	2	3	4	5	6	7
13. The extent to which your life has been what you wanted.	1	2	3	4	5	6	7

**Is there anything else that you feel is significant in helping us to understand your present life status ?**

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Thank you for taking the time to fill out this questionnaire. Your responses help us to serve you better! We are happy that you have chosen this office and will do everything we can to help you to achieve your health goals through chiropractic!