

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_

## Active Edge Chiropractic and Functional Medicine

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**Comprehensive Evaluation & Goal Identification:** Please answer the following questions. Physical symptoms and physiological dysfunction are often related. This form will help us assess any underlying conditions or causes of physical aches, pains, or complaints you may have. We will also consider your goals and motivation.

Describe specific complaints ordering most problematic to least (1=most 4=least).

1) \_\_\_\_\_ 2) \_\_\_\_\_  
3) \_\_\_\_\_ 4) \_\_\_\_\_

How long have you suffered with these problems?

1) \_\_\_\_\_ 2) \_\_\_\_\_  
3) \_\_\_\_\_ 4) \_\_\_\_\_

What have you tried doing to resolve this problem that Did Not work?

\_\_\_\_\_  
\_\_\_\_\_

Have you become discouraged or stressed about handling this problem?

\_\_\_\_\_  
\_\_\_\_\_

When your problem is at its worst, how does it make you feel?

\_\_\_\_\_

How does this problem interfere with the following areas in your life?

Work: \_\_\_\_\_

Family: \_\_\_\_\_

Hobbies: \_\_\_\_\_

Life: \_\_\_\_\_

When it's at it's worst, how much older does this make you feel? \_\_\_\_\_

Do you know how this problem may have started? \_\_\_\_\_

\_\_\_\_\_

What effect does this have on your body functions? \_\_\_\_\_

\_\_\_\_\_

Are you here visiting us to:

- a) Resolve my immediate problem
- b) Life style program for optimized living
- c) Both
- d) Other: \_\_\_\_\_

How have you taken care of your health in the past?

Medications	Holistic
Routine medical	Vitamins
Exercise	Chiropractic
Diet and Nutrition	Other: _____

How did the previous methods work for you? \_\_\_\_\_

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What are you afraid this might be or will be affecting without change? Please circle

Job	Freedom
Kids	Future abilities
Marriage	Finances
Sleep	Time

Are there any health conditions you are afraid this might turn into?

Diminished Future abilities	Surgery
Stress	Arthritis
Weight gain	Cancer
Heart disease	Diabetes
Depression	Other: _____

Where do you picture yourself being in the next 3-5 years if this problem is not taken care of? Please be specific \_\_\_\_\_

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What would be different or better without this problem? Please circle:

Diminished stress	Sleep
More energy	Work
Self esteem	Outlook
Confidence	Family

If we were to sit down and discuss your life 3 years from now and look back at today, what would have to have happened for you to be happy with your progress?  
(Please take your time and don't sell yourself short! Include anything that is part of your happiness, whether health, family, work, finances, travel, marriage or bucket list)

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What potential barriers do you foresee that would prevent these things from happening?

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Do you feel it is possible to eliminate or prevent these potential barriers?

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What are your strengths that will enable you to accomplish your goals?

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Rate on a scale of 1-10:

- \_\_\_\_\_ How important is it for you to resolve your health concerns?
- \_\_\_\_\_ Do you feel that you are coachable and would enjoy a mentor in helping you?
- \_\_\_\_\_ Are you prepared to make the appropriate lifestyle changes that may be necessary in order to achieve your goals?

**Thank You!**

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