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?

<table>
<thead>
<tr>
<th>Medications</th>
<th>Holistic</th>
</tr>
</thead>
<tbody>
<tr>
<td>Routine medical</td>
<td>Vitamins</td>
</tr>
<tr>
<td>Exercise</td>
<td>Chiropractic</td>
</tr>
<tr>
<td>Diet and Nutrition</td>
<td>Other: _______________</td>
</tr>
</tbody>
</table>

How did the previous methods work for you? ________________________________

_____________________________________________________________________

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

<table>
<thead>
<tr>
<th>Job</th>
<th>Freedom</th>
</tr>
</thead>
<tbody>
<tr>
<td>Kids</td>
<td>Future abilities</td>
</tr>
<tr>
<td>Marriage</td>
<td>Finances</td>
</tr>
<tr>
<td>Sleep</td>
<td>Time</td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Diminished Future abilities</th>
<th>Surgery</th>
</tr>
</thead>
<tbody>
<tr>
<td>Stress</td>
<td>Arthritis</td>
</tr>
<tr>
<td>Weight gain</td>
<td>Cancer</td>
</tr>
<tr>
<td>Heart disease</td>
<td>Diabetes</td>
</tr>
<tr>
<td>Depression</td>
<td>Other: _______________</td>
</tr>
</tbody>
</table>

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

_____________________________________________________________________

_____________________________________________________________________

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

<table>
<thead>
<tr>
<th>Diminished stress</th>
<th>Sleep</th>
</tr>
</thead>
<tbody>
<tr>
<td>More energy</td>
<td>Work</td>
</tr>
<tr>
<td>Self esteem</td>
<td>Outlook</td>
</tr>
<tr>
<td>Confidence</td>
<td>Family</td>
</tr>
</tbody>
</table>
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)

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

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

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

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

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!