Subjective Evaluation

Name: ____ **Date:** _____/_____/_____

0 ----- 1 ----- 2 ----- 3 ----- 4 ----- 5 ----- 6 ----- 7 ----- 8 ----- 9 ----- 10

No problems **Worst imaginable**

Use the scale above to rate the things in your life listed below based on how you are feeling today by writing a number next to the description: (Write **0** if not applicable)

Pain with:

___ **Walking**

___ **Sitting**

___ **Standing**

___ **Lifting**

___ **Bending**

___ **Driving**

___ **Exercising**

Quality of:

___ **Energy**

___ **Concentration**

___ **Digestion**

___ **Breathing**

___ **Posture**

___ **Emotional Balance**

___ **Strength/ Endurance**

___ **Reaction Time**

___ **Clear Thinking**

___ **Headache Frequency**

___ **Range of Motion**

___ **Stress Level**

___ **Circulation**

___ **Sleep**

___ **Overall Health**

___**Other:**____ **Total for Pain**___ **Total for Quality**___

What activity is this **health problem** stopping you from doing. Be specific. (Example: *"Getting a full night sleep"*, *"Picking up my Child/Grandchild"*, *"Golfing"*, *"Winning an Olympic gold in shuffleboard."*) Please list as many activities and use as many lines as you need.

____

____

____

I would like more information about…

___ **Nutrition**

___ **More productive sleep**

___ **Stress reduction**

___ **Exercise regimens**

___ **Massage therapy and chiropractic**

___ **How chiropractic can treat a wide spectrum of health problems**

___ **Things I can do to reinforce my chiropractic care**

___ **Why children need to receive chiropractic care**

___ **Other:**____