



## Wellness Checkpoint 6

**Name:** \_\_\_\_\_ **Date:** \_\_\_\_\_

Please answer the questions to the best of your ability. We will review any answers that you are not sure of.

1. What do you think is the biggest difference between medical care and chiropractic care? \_\_\_\_\_  
 \_\_\_\_\_

2. What do you attribute your improved health to? \_\_\_\_\_  
 \_\_\_\_\_

3. Do you brush your teeth and gums so that they are healthy, or do you brush them to avoid bad breath and tooth decay? \_\_\_\_\_

4. On a scale of 0% to 100%, with 100% being completely pain-free and resolved, how much improvement would you give yourself thus far? \_\_\_\_\_

5. What symptoms (if any) still occur? \_\_\_\_\_

6. Life Completely Out of Balance \_\_\_\_\_ All Areas of Life In Excellent Balance  
 | \_\_\_\_\_ |

Please place an "X" on the line above to indicate your current level of balance

7. What changes have you seen in your quality of life?

<input type="checkbox"/> Stronger	<input type="checkbox"/> More Relaxed	<input type="checkbox"/> More energy
<input type="checkbox"/> Sleep Better	<input type="checkbox"/> Emotional Stability	<input type="checkbox"/> Better Family Life
<input type="checkbox"/> Improved Diet	<input type="checkbox"/> More Alert	<input type="checkbox"/> Better Work Life

8. Do you find it easier: (please check all that apply)

<input type="checkbox"/> Walking	<input type="checkbox"/> Bending	<input type="checkbox"/> Standing
<input type="checkbox"/> Lifting	<input type="checkbox"/> Sitting	<input type="checkbox"/> Running

9. Which phase of care do you think that you are in?

Active (Symptomatic Relief/Correction)  Passive (Wellness)

10. Do you intend to continue care to avoid problems in the future?  Yes  No

11. What has been the biggest change in your life since starting chiropractic care?  
 \_\_\_\_\_  
 \_\_\_\_\_

**Patient Signature** \_\_\_\_\_ **Date** \_\_\_\_\_