Health & Wellness Questionnaire

1. How do you consider your overall health status? (Circle)

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

   Poor Fair Average Good Excellent

2. How often do you exercise?_____ times per week, _____ minutes per workout

   What do you do for exercise?____

   Has the pain stopped you from exercising?____

3. Are you sleeping well? _____Yes _____No _____At times

   If no, for what reason?____

   Do you have trouble: _____Falling asleep _____Staying asleep _____Trouble waking from sleep

4. Are you able to fully function at work? _____Yes _____No _____At times

   How many hours do you sit/stand before pain sets in?____

   Any work functions that you are not able to do?____

5. Are you able to fully function at home? _____Yes _____No _____At times

   If no, what home duties are you not able to do?____

6. Are you currently taking any prescription / over-the-counter drugs? _____Yes _____No

   If yes, what drug are you taking and for what reason?____

   ____

7. Have you had any surgical operations? _____Yes _____No

   If yes, when and for what reason?____

8. Have you had, or do you currently have, any of these conditions? (Circle)

   Asthma Diabetes Cancer Depression Anxiety ADD/ADHD Arthritis

   Constipation Diarrhea Heartburn High/Low Blood Pressure High Cholesterol

   Eczema Chronic Fatigue Sleep Disorder Allergies Vertigo Fibromyalgia

   Other:____