VITALITY HEALING CENTER OF KANSAS CITY

14876 Metcalf Ave.
Overland Park, KS 66223
913-956-9370
Awesomeness happens here

Effects on Quality of Life

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

a. Medications
b. Emergency Room
c. Routine Medical
d. Exercise
e. Nutrition/Diet
f. Holistic Care
g. Vitamins
h. Chiropractic
i. Other (please specify):_____

2. How did the previous method(s) work out for you?

a. Bad results
b. Some results
c. Great results
d. Nothing changed
e. Did not get worse
f. Did not work very long
g. Still trying
h. Confused

3. How have others been affected by your health condition?

a. No one is affected
b. Haven't noticed any problem
c. They tell me to do something
d. People avoid me

4. What are you afraid this might be (or beginning) to affect (or will affect)?

a. Job
b. Kids
c. Future ability
d. Marriage
e. Self-Esteem
f. Sleep
g. Time
h. Finances
i. Freedom

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

a. Family health problems
b. Heart disease
c. Cancer
d. Diabetes
e. Arthritis
f. Fibromyalgia
g. Depression
h. Chronic Fatigue
i. Need surgery

6. How has your health condition affected your job, relationships, finances, family or other activities? please give examples:

_____
_____ **7. What has that cost you? (time, money, happiness, freedom, sleep, promotion, etc.) Give 3 examples:**

_____
_____
_____

8. What are you most concerned with regarding your problem?

_____
_____

9. Where do you picture yourself being in the next 1-3 years if this problem is not taken care of? Please be specific

_____
_____

10. What would be different/better without this problem? Please be specific

_____
_____ **11.**

What do you desire the most from working with us? Goals (name 2)

_____
_____

12.What would that mean to you?

_____
_____

On a scale from 1-10 (with 10 being the highest) what is your motivation in getting help today for this problem?

1 2 3 4 5 6 7 8 9 10

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Dear Patient:

A new requirement for medical practices is to assess your potential risk for falls. Please complete the following:

FALL RISK ASSESSMENT

Have you fallen in the last year? YES NO YES NO

Do you lose your balance when standing?

Do you lose balance when initially getting up from silting YES NO

Do you get dizzy, faint or have seizures?

Does ii take you more than one try to get up out of a chair or out of bed?

Do you trip over your own feet or objects on the floor?

Do you take corners too sharp; bump into corners or door frames?

Do you use a walker, cane or need assistance to get around?

YES NO YES NO

YES NO YES NO

YES NO