Select-Care Chiropractic, PC
Nutrition • Chiropractic • Wellness
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Patient Name: _____ Date: _____

PATIENT POSTURE AND ERGONOMIC EVALUATION

1. Do you sleep on: ___ Your Stomach? ___ Your Side? ___ Your Back?

2. How many hours per night do you usually sleep? _____

3. Is your sleep interrupted during the night? ___ Yes ___ No

4. Do you wake up in the morning with: Lower Back Pain? _____ Neck Pain? _____ Tingling in fingers? _____

5. How old is your mattress? _____ years

6. What type of mattress do you sleep on? (please circle)
   Spring Coil Pillow Top Water Bed Memory Foam Air Brand: _____

7. Do you feel that your mattress is comfortable? ___ Yes ___ No Supportive? ___ Yes ___ No

8. If applicable, is your spouse/partner happy with your present mattress? ___ Yes ___ No

9. How many pillows do you use under your head to sleep? _____
   What *type* of pillow(s) do you use to sleep? _____

10. Does sitting for prolonged periods cause you Lower Back Pain? ___ Yes ___ No
    Mid Back Pain? ___ Yes ___ No Neck Pain? ___ Yes ___ No

11. Does prolonged computer use cause you Neck Pain? ___ Yes ___ No
    Mid Back Pain? ___ Yes ___ No Wrist Pain? ___ Yes ___ No
    Headaches? ___ Yes ___ No Hand Tingling? ___ Yes ___ No

12. Do you utilize a lumbar back cushion when you sit? ___ Yes ___ No

13. Do your shoes wear unevenly? ___ Yes ___ No Do you "toe-out" when walking? ___ Yes ___ No

14. Do you have bunions, calluses, corns, or flat feet? ___ Yes ___ No

15. Is one of your legs shorter than the other? ___ Yes ___ No

16. Do you have foot, ankle, knee or hip pain while standing, walking or running? ___ Yes ___ No

17. Does your job or house work require you to do a lot of lifting? ___ Yes ___ No

18. *Each day*, do you eat fruits and vegetables, lean protein, omega-3 fats and do you drink 60 oz. of water?
    ___ Yes ___ No

19. Females only: Do you suffer from PMS and menstrual cramps? ____ Yes ____ No