NEW PATIENT SURVEY

Please take a few minutes to fill out this survey. Please make sure you answer all the questions as your data is invaluable. Thank you for your assistance!

1. Which of the following contributed to your finding out about Dr. Pepi's office? Check ALL that apply:

   ( ) Word of mouth (someone told you about it)
   ( ) Written "success stories" by satisfied patients
   ( ) Advertisement in "Who What Where"
   ( ) Saw a promotional piece/flyer
   ( ) Other – please specify: _____

2. Which promo pieces/flyers interested you in Dr. Pepi's services? Check all that apply:

   ( ) The Truth about Cell Phones
   ( ) Energy flyer
   ( ) Trouble Relaxing
   ( ) Boost Your Immune System
   ( ) Energy postcard
   ( ) Headaches postcard
   ( ) Treatment postcard
   ( ) Health Reserve postcard
   ( ) Energy Mini Catalog
   ( ) Meet Dr. Pepi postcard
   ( ) Email promotion
   ( ) Other: _____

3. What year did you first hear about us?
4. What did you read or hear about us that sparked your interest in using our services?

5. What was the deciding factor that prompted you to book your first appointment with us?

6. What was it about Dr. Pepi that interested you in coming to her for services?

7. What body condition(s) have you come to us to handle?

8. What specific symptoms come associated with this?

9. Which of these symptoms do you have the most attention on?

10. On a scale of 1-5, how interested are you in handling the following kinds of body conditions? Circle the appropriate number: 5 = VERY INTERESTED 1 = COMPLETELY DISINTERESTED

Back pain	1 2 3 4 5
Neck trouble	1 2 3 4 5
Headaches	1 2 3 4 5
Pains in body	1 2 3 4 5
Weight problems	1 2 3 4 5
Difficulty with exercise	1 2 3 4 5
Increasing your metabolism	1 2 3 4 5
Body rejuvenation	1 2 3 4 5
Improving overall health	1 2 3 4 5
Immune system	1 2 3 4 5
Low energy/fatigue	1 2 3 4 5
Insomnia	1 2 3 4 5
Stress	1 2 3 4 5
Irritability	1 2 3 4 5
Mood	1 2 3 4 5
Ability to concentrate/focus	1 2 3 4 5
Problems connected to menstrual cycle	1 2 3 4 5
Fertility problems	1 2 3 4 5
Pregnancy problems	1 2 3 4 5
Menopause problems	1 2 3 4 5
Arthritic symptoms	1 2 3 4 5
Heart/circulation disorders	1 2 3 4 5
Eye problems	1 2 3 4 5
Ear/nose/throat problems	1 2 3 4 5
Respiratory complaints	1 2 3 4 5
Skin disorders	1 2 3 4 5
Allergies	1 2 3 4 5
Problems with fungus/candida	1 2 3 4 5
Liver/gallbladder problems	1 2 3 4 5
Urinary tract/kidney problems	1 2 3 4 5
Digestive problems	1 2 3 4 5

11. What kinds of "alternative" or complementary medicine have you used previously?

( ) Chiropractic
( ) Acupuncture
( ) Acupressure
( ) Other: _____
( ) Nutritional consulting
( ) Herbalist
( ) Homeopathy

12. What did you like about the above treatment(s)?

13. What could have been improved about them?

14. What do you hope is different about the treatment you will be getting here?

15. Now a few questions to help us better identify the kinds of people we service:

( ) Homeowner
( ) Rent apartment ( ) Rent house

Zip code where you live: _____

Your age:
( ) Under 18
( ) 18 – 25
( ) 26 – 34
( ) 35 – 45
( ) 46 – 55
( ) Over 55

Your occupation: _____

Religious affiliation: _____

( ) Male ( ) Female

Marital Status:
( ) Single
( ) Married
( ) Divorced
( ) Separated
( ) Widowed

Children:
( ) None
( ) Have children
Ages of children: _____

Combined annual household income:

( ) Under $25,000
( ) $26,000 - $40,000
( ) $41,000 - $60,000
( ) $61,000 - $75,000
( ) $76,000 - $100,000
( ) Over $100,000

Thank you very much for your help!