REVIEW Form

Client Name:	**Date:**

1. Do you have any questions regarding your care?

_____

_____

2. What conditions have improved so far?

_____

_____

3. Please mark your average pain(A), least pain(L) and worst pain(W) in last <u>week:</u>

No Pain Unbearable Pain

0	1	2	3	4	5	6	7	8	9	10

4. What conditions are still aggravating you?

_____

_____

5. Is it easier when you (please circle if yes):

Walk Stand Sit Sleep Exercise Perform at work
Perform house duties Other (Please name)_____

6. On a scale 1 to 10 how would you rate your pain right now

No Pain Unbearable Pain

0	1	2	3	4	5	6	7	8	9	10

7. Please circle if you've noticed any improvement yet in the following:

Digestion	**Energy levels**	**Reduced Stress**
Bowel/Bladder Function	**Improved wellbeing**	**State of Mind**
Concentration	**Breathing**	**Headaches**

8. Have we been attentive to your specific concerns? (Please circle)
Yes/No
If not, please explain:

_____

9. Is there anything you think the chiropractor should know concerning your condition/s which you have not mentioned or would like to further highlight?

_____

_____

10. What are your health goals through Chiropractic? (Please circle)
A) Pain relief.
B) Pain relief plus increased strength.
C) Better vitality and over improved whole body performance.
D) Other (please specify)_____

11. When do you think your next chiropractic appointment should be?

_____

Signed:…… Thank you for your feedback!