RE-EXAMINATION FOR: _________________________________ DATE:_________________

A. WHAT SYMPTOMS HAVE IMPROVED?
1.____________________________________
2.____________________________________
3.____________________________________

B. WHAT SYMPTOMS STILL EXIST?
1. ______________________________
2. ______________________________
3. ______________________________

C. AS OF TODAY, CIRCLE THE PERCENTAGE OF RELIEF YOU FEEL YOU HAVE RECEIVED.
10% 20% 30% 40% 50% 60% 70% 80% 90% 100%

D. WHAT HAVE YOU LIKED MOST/LEAST ABOUT YOUR CARE THUS FAR?
____
____
____

E. HOW IS THE STAFF TREATING YOU?
____
____

F. HAVE YOU NOTICED ANY CHANGES IN YOUR GENERAL HEALTH PICTURE YET?
1. NERVES____
2. PAIN____
3. ENERGY____
4. GENERAL STRENGTH____________________________________
5. MENTAL OUTLOOK______________________________________

G. LIST ANY NEW CONDITIONS OR SYMPTOMS YOU HAVE NOTICED:
____
____

H. CLASSIFY YOUR IMPROVEMENT: Excellent______ Good______ Fair______

I. ARE YOU CONFUSED ABOUT ANY PHASE OF YOUR PROGRESS? Yes____ No____
____
____

J. HAS ANYONE ASKED YOU ABOUT YOUR PROGRESS? Yes____ No_____
REMARKS:____
____

K. HAVE YOU TRIED TO REFER ANYONE TO THIS OFFICE FOR HEALTH CARE? Yes____ No____

L. WOULD YOU LIKE US TO MAIL INFORMATION CONCERNING OUR OFFICE TO ANY PROSPECTIVE PATIENTS?
Yes____ No_____

M. ANY OTHER QUESTION(S) CONCERNING YOUR PROGRESS: Yes____ No____

Patient Signature: ____________________________________