PATIENT EVALUATION FORM

PATIENT APPOINTMENT

Your health and wellness are of the utmost importance to us. To better understand how you are doing, and to better serve you, please fill out this form as best you can.

Today's Date: ____ /____ /____

Patient Name: ______________________________
Last Name First Name

Checked-In By: ______________________________

CURRENT STATUS

On a scale of 1 to 10, how do you feel today?

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

Terrible → Great

What percentage of improvement have you experienced since your last visit?

☐ 0% ☐ 10% ☐ 20% ☐ 30% ☐ 40% ☐ 50% ☐ 60% ☐ 70% ☐ 80% ☐ 90% ☐ 100%

In what areas are you showing improvement? ______________________________

____

Do you have any questions we need to address?

1.) ______________________________

____

2.) ______________________________

____

3.) ______________________________

____

Your Energy Level: ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5
Low → High

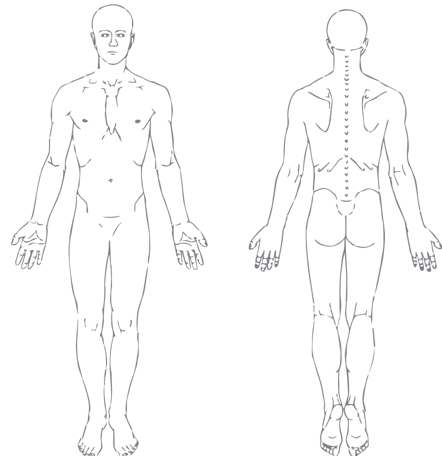
Your Sleep Quality: ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5
Low → High

Your Activity Level: ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5
Low → High

Your Digestion: ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5
Bad → Good

Your Mental Attitude: ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5
Poor → Great

Please indicate below your areas of concern of pain and rate them in order of priority (1,2, and 3).



CURRENT STATUS

List your top five main complaints in order from worst to least, and rate their severity.

1.) ______________________ ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10
Terrible → Great

2.) ______________________ ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10
Terrible → Great

3.) ______________________ ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10
Terrible → Great

4.) ______________________ ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10
Terrible → Great

5.) ______________________ ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10
Terrible → Great

IN-OFFICE USE ONLY

Vitals Before Tx:

Blood Pressure: _______ / _______ Heart Rate: ____________ bpm Oxygen: ____________ bpm

Vitals After Tx:

Blood Pressure: _______ / _______ Heart Rate: ____________ bpm Oxygen: ____________ bpm

Physician's Notes: ____

____

Today's Treatment Plan

	TREATMENT	TREATMENT NOTES	COMPLETED	STAFF INITIALS
1.)			☐	
2.)			☐	
3.)			☐	
4.)			☐	
5.)			☐	

Office Notes: ____

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