Optimized Wellness Center

PRACTICE MEMBER'S RE-EVALUATION

Name:_____Gender: ☐ M ☐ F Date: _____/_____/_____

Has all your personal contact information remained the same? ☐ **If Yes, please initial**_____☐ If No, please update below:

Home Address:_____ Home Phone: ( ) _____

City, State, Zip:_____ Work Phone: ( ) _____

Email Address:_____ Cell Phone: ( ) _____

Birth Date: _____ / _____/ _____ (Age)_____ Social Security #: _____ - _____ - _____ Marital Status: ☐S ☐M ☐D ☐W

Occupation: _____ Employer Name:_____

The Purpose of Today's Visit Is: (please select one)

☐ **Progress re-evaluation** – *I've been under active care and this is a periodic re-evaluation*

☐ **Maintenance patient** – *I'm under maintenance care with a new or returning health concern*

Please rate your level of:	Happiness	Poor	☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐ 10	Excellent
	Nutrition	Poor	☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐ 10	Excellent
	Exercise	Poor	☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐ 10	Excellent
	Rest	Poor	☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐ 10	Excellent
	Stress	High	☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐ 10	Low
	Overall Health	Poor	☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐ 10	Excellent
	Family's Health	Poor	☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐ 10	Excellent
How satisfied are you with your current state of health?		Not	☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐ 10	Completely
How committed are you to changing your situation?		Not	☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐ 10	Completely

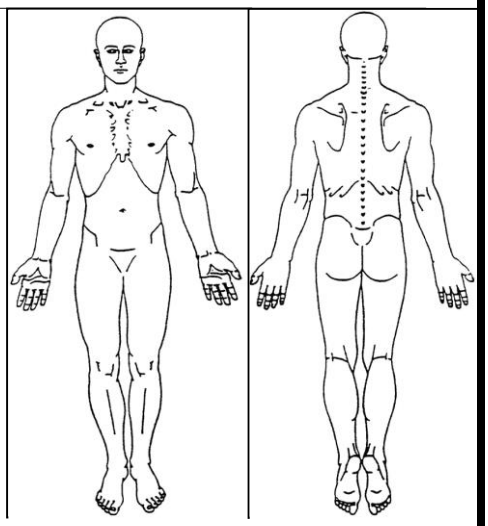
Number of uninterrupted hour of sleep at night? ☐3-4 ☐5-6 ☐7-8 ☐9-10 Do you wake feeling rested? Yes ☐ No ☐

Activities of Daily Living Please identify how your current condition(s) is affecting your ability to carry out your routine activities:

Activity	No Effect	Painful (can do)	Painful (limits)	Unable to Perform
Lifting Groceries				
Carrying Groceries				
Sit to Stand				
Climbing Stairs				
Pet Care				
Extended Computer Use				
Household Chores				
Lifting Children				
Concentration (reading)				
Bathing				
Dressing				
Shaving				
Sexual Activity				
Sleep				
Static Sitting				
Yard Work				
Walking				
Washing/Bathing				
Sweep/Vacuuming				
Dishes				
Laundry				
Garbage				
Other				

Previous Health Concerns

Main Complaint Began: _____/_____/_____ Please Mark Diagram



Is this condition getting: ☐ Better ☐ Worse ☐ Staying the same

What % improvement has there been: ☐10 ☐20 ☐30 ☐40 ☐50 ☐60 ☐70 ☐80 ☐90 ☐100%

How often do you experience these symptoms throughout the day? ☐100% Constant

☐75% Frequent ☐50% Often ☐25% Seldom ☐10% Rare ☐Only with Activity

Does your complaint(s) interfere with: ☐Work ☐Sleep ☐Hobbies ☐Daily Routine

Explain: _____

What makes it **worse**? ☐Nothing ☐Walking ☐Standing ☐Sitting ☐Exercise (Moving)

☐Lying Down ☐Other _____

What makes it **better**? ☐Nothing ☐Walking ☐Standing ☐Sitting ☐Exercise (Moving)

☐Lying Down ☐Other _____

Type of Pain: ☐Sharp ☐Dull ☐Ache ☐Burn ☐Throb ☐Spasm ☐Tingling ☐Shooting

Is the pain on one side ☐Left ☐Right or ☐Both? Does the Pain Radiate to your: ☐Arm ☐Leg ☐Does not radiate

Now your discomfort/pain: BEST ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10 WORST

Normally its: BEST ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10 WORST

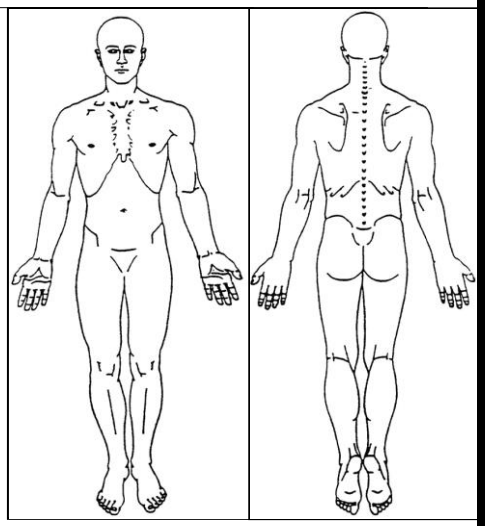
Notes: _____

_____

_____

_____

Second Complaint Began: _____/_____/_____ Please Mark Diagram



Is this condition getting: ☐ Better ☐ Worse ☐ Staying the same

What % improvement has there been: ☐10 ☐20 ☐30 ☐40 ☐50 ☐60 ☐70 ☐80 ☐90 ☐100%

How often do you experience these symptoms throughout the day? ☐100% Constant

☐75% Frequent ☐50% Often ☐25% Seldom ☐10% Rare ☐Only with Activity

Does your complaint(s) interfere with: ☐Work ☐Sleep ☐Hobbies ☐Daily Routine

Explain: _____

What makes it **worse**? ☐Nothing ☐Walking ☐Standing ☐Sitting ☐Exercise (Moving)

☐Lying Down ☐Other _____

What makes it **better**? ☐Nothing ☐Walking ☐Standing ☐Sitting ☐Exercise (Moving)

☐Lying Down ☐Other _____

Type of Pain: ☐Sharp ☐Dull ☐Ache ☐Burn ☐Throb ☐Spasm ☐Tingling ☐Shooting

Is the pain on one side ☐Left ☐Right or ☐Both? Does the Pain Radiate to your: ☐Arm ☐Leg ☐Does not radiate

Now your discomfort/pain: BEST ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10 WORST

Normally its: BEST ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10 WORST

Notes: _____

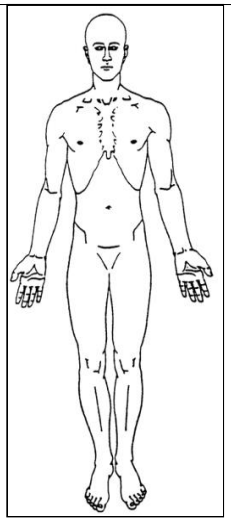
_____

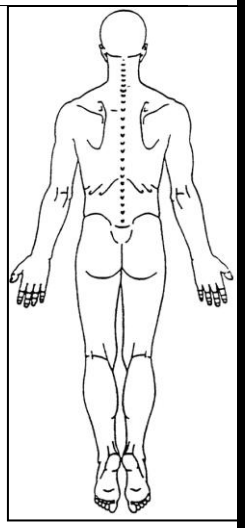
_____

_____

_____

Third Complaint Began: _____/_____/_____ Please Mark Diagram





Is this condition getting: ☐ Better ☐ Worse ☐ Staying the same

What % improvement has there been: ☐10 ☐20 ☐30 ☐40 ☐50 ☐60 ☐70 ☐80 ☐90 ☐100%

How often do you experience these symptoms throughout the day? ☐100% Constant

☐75% Frequent ☐50% Often ☐25% Seldom ☐10% Rare ☐Only with Activity

Does your complaint(s) interfere with: ☐Work ☐Sleep ☐Hobbies ☐Daily Routine

Explain: _____

What makes it **worse**? ☐Nothing ☐Walking ☐Standing ☐Sitting ☐Exercise (Moving)

☐Lying Down ☐Other _____

What makes it **better**? ☐Nothing ☐Walking ☐Standing ☐Sitting ☐Exercise (Moving)

☐Lying Down ☐Other _____

Type of Pain: ☐Sharp ☐Dull ☐Ache ☐Burn ☐Throb ☐Spasm ☐Tingling ☐Shooting

Is the pain on one side ☐Left ☐Right or ☐Both? Does the Pain Radiate to your: ☐Arm ☐Leg ☐Does not radiate

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Notes: _____

_____

_____

Review of Symptoms

Identify any changes since your most recent evaluation with us:	Worse	No Change	Improved
Musculoskeletal System - such as osteoporosis, arthritis, neck pain, back problems, poor posture, etc.	☐	☐	☐
Neurological System - such as anxiety, depression, headaches, dizziness, pins/needles, numbness, etc.	☐	☐	☐
Cardiovascular System - such as asthma, apnea, emphysema, hay fever, shortness of breath, pneumonia, etc.	☐	☐	☐
Digestive System - such as ulcers, food sensitivities, heartburn, constipation, diarrhea, anorexia/bulimia etc.	☐	☐	☐
Sensory System - such as blurred vision, ringing in ears, hearing loss, chronic ear infection, etc.	☐	☐	☐
Endocrine System - such as thyroid issues, immune disorders, hypoglycemia, frequent infections, etc.	☐	☐	☐
Genitourinary System - such as kidney stones, infertility, bedwetting, prostate issues, PMS, etc.	☐	☐	☐
Constitutional System - such as fainting, low libido, poor appetite, fatigue, sudden weight change, weakness, etc.	☐	☐	☐

New Health Concerns

Have you had any of the following Since Your Last Visit? (Please Check)

☐ New health concern ☐ Automobile accident ☐ Slip and fall ☐Hospitalization ☐ Lab work ☐Imaging

Please Explain: _____

_____

_____

If Yes, has this incident resulted in any increases in pain or symptoms since last visit? ☐ Yes ☐ No

Please Describe: _____

_____

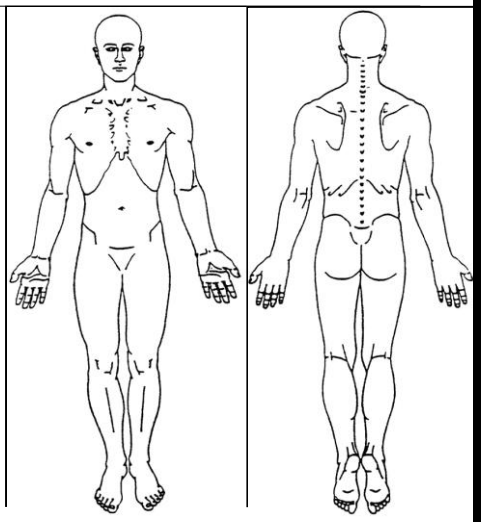
_____

_____

_____

_____

New Complaint Began: _____/_____/_____ Please Mark Diagram



Is this related to an auto accident / work injury? ☐ No ☐ If Yes, contact front desk.

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Does your complaint(s) interfere with: ☐Work ☐Sleep ☐Hobbies ☐Daily Routine

Explain: _____

What makes it **worse**? ☐Nothing ☐Walking ☐Standing ☐Sitting ☐Exercise (Moving)

☐Lying Down ☐Other _____

What makes it **better**? ☐Nothing ☐Walking ☐Standing ☐Sitting ☐Exercise (Moving)

☐Lying Down ☐Other _____

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Normally its: BEST ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10 WORST

Have you experienced this condition before? ☐ Yes ☐ No If so, please explain: _____

Have you seen anyone for this? ☐ Yes ☐ No If Yes, who_____, and What did they do? _____

How did you respond? _____

Notes: _____

_____

_____

_____

_____

Any comments about your condition or care you have received at this office that have not been addressed or you would like to share:

_____

_____

Would you be interested in sharing your story with a written and/or video Patient Testimonial? ☐ Yes ☐ No

I certify that I have read and understand the above information. To the best of my knowledge, the above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health.

Patient's Signature_____ Date_____/_____/_____

Clinical Remarks

Dr. Signature:_____ Dr. Tim Heath, D.C.

Practice Member's Name _____ Exam Date_____ Dr. Initials_____