RE-EXAMINATION EVALUATION

NAME: _____ **Date:** _____

What was your primary goal when you began your chiropractic care with us?

_____

How much change have you felt in your body since you began your care? Please circle your level of progress to date:

No Change 1 2 3 4 5 6 7 8 9 Resolved

Please tell us about some of the changes that you have noticed with your body since beginning your care in our office (pain, sleep, ability to handle stress, etc.)

_____

_____

- Have we given you a good understanding of your health concern and the extent to which it can change or heal? **YES NO**
- Do you feel the doctor clearly understands your health concerns? **YES NO**
- Are you satisfied with your care and the results you are getting? **YES NO**
- Please let us know if there are questions or issues we have not yet fully addressed:

  _____

  _____

Stress Levels:

How do you rate your stress in the following areas at present? (Circle one in each category)

Physical: LOW/MID/HIGH **Emotional: LOW/MID/HIGH** **Chemical: LOW/MID/HIGH**
(What we eat, drink & breathe)

How do you perceive that your current stress levels are impacting your health?

_____

_____

Where do you feel chiropractic care fits into your future health care?

_____

_____

How can we improve your care and the environment in our office? _____

_____

Do you feel you have a good enough understanding of the work we do in the office to explain it to someone else? **YES NO**

Have you felt comfortable enough to refer family members or friends to our office? **YES NO**

Have you visited our website? **YES NO**

If Yes: 1) Did you watch any of our videos? **YES NO**

2) Was our website a helpful tool for you to understand more about our office and the care that we provide? **YES NO**

Would you be willing to provide a testimonial in order to allow others to understand what we do and what help is possible through care in our office? **YES NO**