LIFECHIROPRACTIC
COLLEGE WEST

Monte H. Greenawalt Health Center

Re-Evaluation

(to be used for your periodic re-evaluations)

LIFECHIROPRACTIC
COLLEGE WEST

Instructions for completing our online forms:

1. Open and SAVE THE FORMS to your computer.

   ***Please note that you could lose all of your data if you fill out the forms in your browser instead of first saving to your computer. The PDF is a fillable form, and the information can be saved when used with Adobe Reader 8 or higher.*

2. Open the file in Adobe Reader 8 or higher or Adobe Acrobat. Complete the form and save.

3. To expedite service please email the completed form as an attachment to HCADMIT@lifewest.edu.

4. Alternatively you may print the forms and bring them with you to your appointment. This may increase the time for our staff to process your paperwork.

Patient Survey

LIFECHIROPRACTIC COLLEGE WEST

Intern:_____Doc#_____Patient:_____File#_____Date_____

List complaints at time of last exam. Add any new complaints.	Pain Level 0-10	How Many Days A Week?	How Long Does It Last?	% improvement

What percentage do you estimate that you have adhered to the appointment of your intern?_____

What percentage do you estimate that you have adhered to the recommendations of your intern?_____

Have you had any injuries, illnesses, surgeries or hospitalizations since your last evaluation? No_____ Yes_____

If yes, please explain_____

Do you have any complaints other than what is listed above? No_____ Yes_____

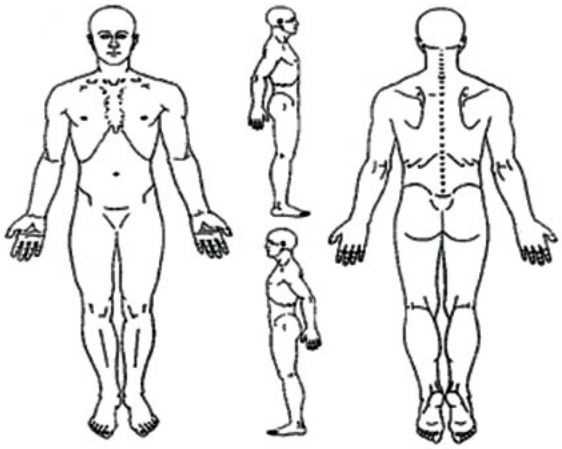
If yes, please explain_____

VISUAL ANALOG PAIN SEVERITY SCALE

Instructions: Please place a mark on the line that corresponds to your current pain levels for each complaint.

Absence ——— Extreme

Indicate below, the locartion and type of pain that is current or ongoing.



Numbness +++

Burning xxx

Pins and needles 000

Stabbing or Sharp ///

Aching ^^^

Please comment about your condition and/or your care in the Health Center. Thank you.

_____

Patient signature_____Date:_____

(Please do not write below this line)

Intern comment _____

_____

_____

Patient Survey

LIFECHIROPRACTIC
COLLEGE WEST

Intern:_____Doc#_____Patient:_____File#_____Date_____

GENERAL PAIN DISABILITY INDEX QUESTIONNAIRE

The rating scales below are designed to measure the degree to which several aspects of your life are presently disrupted by pain. Respond to each category by indicating the overall impact of pain in your life, not just when the pain is at its worst. For each of the six categories of daily living listed, PLEASE CHECK THE BOX NEXT TO THE NUMBER WHICH BEST DESCRIBES HOW MUCH YOUR ACTIVITIES ARE AFFECTED. 0 means you can perform all your normal activities without any pain, and 10 means that you can't perform any of those activities because of the pain it causes.

1. Family/Home responsibilities. This category refers to activities related to the home or family. It includes chores and duties performed around the house (e.g. yard work) and errands or factors for other family members (e.g., driving the children to school).

☐0 ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10

Completely able to function — Totally unable to function

2. Recreation. This includes hobbies, sports, and other similar leisure time activities.

☐0 ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10

Completely able to function — Totally unable to function

3. Social Activity. This refers to activities which involve participation with friends and acquaintances other than family members. It includes parties, theater, concerts, dining out and other social functions.

☐0 ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10

Completely able to function — Totally unable to function

4. Occupation. This refers to activities that are a part of or directly related to one's job. This includes nonpaying jobs as well, such as that of a homemaker or volunteer worker.

☐0 ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10

Completely able to function — Totally unable to function

5. Self Care. This category includes activities which involve personal maintenance and independent daily living (e.g., taking a shower, driving, getting dressed, etc.)

☐0 ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10

Completely able to function — Totally unable to function

6. Life-Support Activity. This category refers to basic life-supporting behaviors such as eating, sleeping, and breathing.

☐0 ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10

Completely able to function — Totally unable to function

Score (to be completed by intern)_____

Patient/Guardian Signature_____Date_____

Wellness Questionnaire

LIFECHIROPRACTIC COLLEGE WEST

Intern:_____Doc#_____Patient:_____File#_____Date_____

Please answer the following questions on a scale of 1-10, 10 being the best:

General State of Well-being _____ General Outlook and Attitude _____

Please answer the following question on a scale of 1-10, 10 being the most stress:

Average Level of Stress _____

In the past 30 days, how many days have you felt healthy and full of energy? _____

In the past 30 days, how many days was your physical health not good? _____

What is your occupation? _____

Please describe your work duties _____

How many hours/week do you work?_____ Are you content with your work? No☐ Yes☐

If not, please describe_____

What other interests/hobbies do you engage in?_____

Diet and Nutrition: How many meals do you eat per day?_____ Do you skip meals? No☐ Yes☐

If you eat junk food, what kind?_____

Any changes to your appetite? No☐ Yes☐ If yes, explain_____

How many servings/day of Fruit_____Vegetables_____Sweets_____ Fast Food_____

Do you have any food intolerances? No☐ Yes☐ If yes, what?_____

How many 8 oz glasses of water do you drink per day?_____

How many caffeinated beverages do you drink per day?_____

Please indicate how much of each:

Coffee_____Tea_____Green Tea_____Energy Drinks_____Sodas/Colas_____

Do you drink Alcohol? No☐ Yes☐ How often?_____

Please indicate how much of each: Beer _____ Wine_____ Hard Liquor_____

Do you smoke cigarettes or cigars? No☐ Yes☐ If so, how many per day?_____ How many years_____

Other/recreational drugs? No☐ Yes☐ If so, what drugs?_____How much/often?_____

Do you exercise? No☐ Yes☐ If so, what kind?_____How often?_____

How many minutes per session?_____ What is your exercise goal?_____

Did you participate in sports while growing up? No☐ Yes☐ If so, what?_____

How many hours of sleep do you get each night?_____ Is it restful? Yes☐ No☐

Why not?_____

Do you currently experience anxiety or depression? No☐ Yes☐

If yes, please explain._____

Are you currently under treatment for it? No☐ Yes☐

If yes, please describe treatment _____

Do you feel the treatment is effective_____

Patient Signature_____

Date_____

Intern Notes:_____

_____

Give Us A Grade

LIFECHIROPRACTIC COLLEGE WEST

We would appreciate if you would answer the following questions for our ongoing patient survey. We will be using the information from these surveys to improve patient services. Please feel free to include comments.

For questions aksing for a letter grade please use the following guidelines:
A=Excellent, best grade possible 90-100% | B=Better than average 80-90% | C=Average performance 70-80%
D= Below average/Poor 60-70% | F=Unacceptable performance <60%

1. Satisfaction with the Health Center Facility

Health Center Hours	A	B	C	D	F
Overall Appearance of Facility	A	B	C	D	F
Fee Schedule	A	B	C	D	F

1. Satisfaction with the Waiting Time in the Health Center.

How long did you wait at the front desk to check in

A. 0-5min. B. 6-10min. C. 11-15min. D. 16-20min. F. over 20 N/A

How long did you wait inthe waiting room for your intern?

A. 0-5min. B. 6-10min. C. 11-15min. D. 16-20min. F. over 20 N/A

How long did you wait for faculty observations?

A. 0-5min. B. 6-10min. C. 11-15min. D. 16-20min. F. over 20 N/A

How long did you wait for the cashier?

A. 0-5min. B. 6-10min. C. 11-15min. D. 16-20min. F. over 20 N/A

3. Satisfaction with intern in charge of your care?

Availability for Appointments	A	B	C	D	F
Professional Appearance	A	B	C	D	F
Overall Satisfaction wwith Intern	A	B	C	D	F

3. Satisfaction with the explanation of your care and care plan?

Explanation of what is Chiropractic?	A	B	C	D	F
Explanation of what is a subluxation?	A	B	C	D	F
Explanation of how Chiropractic can help you?	A	B	C	D	F
Explanation of how long it will take	A	B	C	D	F
Teaching you how you can actively participate in bettering your health	A	B	C	D	F

3. Satisfaction with Faculty Doctors?

Accessibility	A	B	C	D	F
Adequately supervised my care	A	B	C	D	F
Professional appearance	A	B	C	D	F

3. Satisfaction with our front desk and cashier staff?

Friendly/helpful	A	B	C	D	F
Answering your questions	A	B	C	D	F
Respected your privacy	A	B	C	D	F
Professional appearance	A	B	C	D	F

How many people have you referred to the Health Center? _____

Comments: _____

_____