Monte H. Greenawalt

LIFE WEST
HEALTH CENTER

Chiropractic | Health | Wellness

Re-Evaluation

(to be used for your periodic re-evaluations)

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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.

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RE-EVALUATION PATIENT SURVEY AND EXAMINATION

Intern: ____________________**Doc #:** __________**Patient:** ____________________ **File #:** ___________ **Date:** ______________

******TO BE COMPLETED BYTHE PATIENT ONLY******

Average values since your last physical exam

List Concerns at time of last exam. Add any new Concerns.	Pain level 0-10?	How many days a week?	How many hours per day?	% improvement
1.				
2.				
3.				
4.				
5.				

*Every active Concern needs to be marked on the additional diagram.

What percentage do you estimate that you have adhered to your appointment schedule? ________________________
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 Concerns other than what is listed above? No____ Yes____ Explain:_________________________
____

Please comment about how you have been able to meet your health goals as stated at your first visit.
____
____

Patient Signature: ____Date:______________________

Indicate below, the location and type of pain since the last exam.

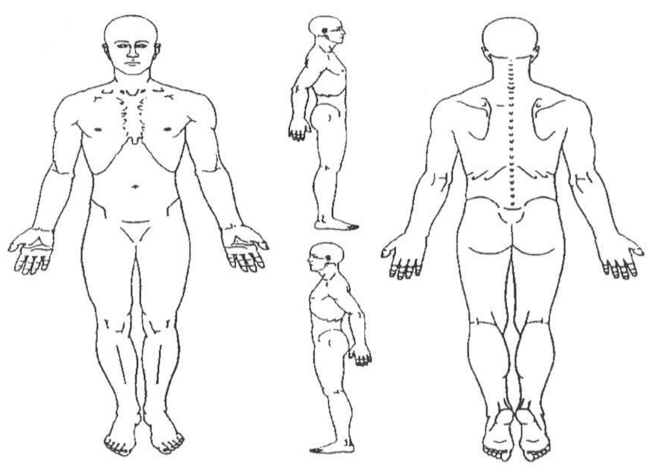
Numbness = = = =

Pins and Needles o o o

Burning x x x x

Stabbing / / / / /

Aching a a a a



(PLEASE DO NOT WRITE BELOW THIS LINE)*

Intern Comments: ____
____

Previous Significant Subjective Findings:
INCLUDE FREQUENCY, SEVERITY, AND DURATION
(use numbers, not modifiers)
____
____
____
____
____
____

Current Significant Subjective Findings:
INCLUDE FREQUENCY, SEVERITY, AND DURATION
(use numbers, not modifiers)
____
____
____
____
____
____

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RE-EVALUATION PATIENT SURVEY AND EXAMINATION

Intern: _____ **Doc #:** _____ **Patient:** _____ **File #:** _____ **Date:** _____

Date of last exam _____

	Previous Objective Findings	Current Objective Findings
Inspection/ Posture		
Palpation Include all edema, muscle spasms, hypertonic, myofascial pain, taut & tender areas and **subluxations including motion palpation findings**		
Range of Motion If pain, comment on back of page	CERVICAL Pain/Location Flx:_____ Y_____ Ext: _____ Y_____ RLF: _____ Y_____ LLF: _____ Y_____ Rt Rot: _____Y_____ Lt Rot: _____ Y_____ LUMBAR Pain/Location Flx:_____ Y_____ Ext: _____ Y_____ RLF: _____ Y_____ LLF: _____ Y_____ Rt Rot: _____ Y_____ Lt Rot: _____ Y_____	CERVICAL Pain/Location Flx:_____ Y_____ Ext: _____ Y_____ RLF: _____ Y_____ LLF: _____ Y_____ Rt Rot: _____Y_____ Lt Rot: _____ Y_____ LUMBAR Pain/Location Flx:_____ Y_____ Ext: _____ Y_____ RLF: _____ Y_____ LLF: _____ Y_____ Rt Rot: _____ Y_____ Lt Rot: _____ Y_____
Ortho/Neuro Perform complete examination of area of Concern. Record significant results of all prior positive tests and any new positive tests		
Extremities *Use BLUE Extremity Exam form		
HEENT/Visceral Cranial Nerves/ TMJ	☐not indicated	☐not indicated
Instrumentation	Nervoscope Date _____ Titron Date _____ Subluxation Station Date _____ Myovision Date _____	

Vital Signs:

Weight _____lbs Height _____ft _____in Blood Pressure (seated) Lt. _____/_____ Rt. _____/_____

Resp. Rate _____/min, Rhythm _____ Pulse Rate _____/min, Rhythm _____ Temp. _____F

Faculty Signature: _____ Date: _____

Complete Re-evaluation Narrative and CMR Actions form prior to CMR

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WELLNESS QUESTIONNAIRE

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: Do you currently follow any of the following special diets or nutritional programs? Circle all that apply:

Vegetarian Vegan Allergy Elimination Low Fat Low Carb High Protein Blood Type Low Sodium No Dairy No Wheat Gluten Free Other:_____

How many of each ½ cup servings/day of fruit: _____ vegetables:_____

How many of each per day (on average) sweets:_____ fast food:_____

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

How many meals do you eat out per week? Please circle: 0-1 1-3 3-5 >5 meals per week

Do you have sensitivities/intolerances to certain foods? No __ Yes __ If yes, list food and symptoms:

_____

Do you drink Alcohol? No ___ Yes ___

If yes: How many alcoholic beverages do you drink in a week? Please circle.

(1 drink = 5 ounces of wine, 12 ounces of beer, or 1.5 ounces of hard alcohol)

None 1-3 4-6 7-10 >10

Do you drink caffeine? No __ Yes __ How often: _____ How many 8 oz cups/day :_____

Circle all that apply:

Coffee Tea Green Tea Energy Drinks Sodas

Do you use tobacco products? No __ Yes __ If so, Number of years_____

What type? Circle all that apply and note amount per day

Cigarettes_____ smokeless pipe_____ cigar_____ e-cig/vape_____

Do you exercise? No __ Yes __If so, what kind? Circle all that apply:

Cardio/Aerobic Strength/resistance Flexibility/stretching Balance Sports/leisure Other:_____

Frequency _____ Duration _____

How many hours of sleep do you get each night?_____ Do you have problems falling asleep? Yes __ No __

Do you have problems staying asleep? Yes __ No __ Is it restful? Yes __ No __

Other concerns?:_____

Please circle all that apply: Do you currently experience **Stress, Anxiety, Depression,** or **NONE?**

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:_____

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GIVE US A GRADE

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 asking 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 less than 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

2. Satisfaction with the Waiting Time in the Health Center
   - How long did you wait at the front desk to check in
     A. 0-5 min. B. 5-10 min. C. 10-15 min. D. 15-20 min. F. over 20 N/A
   - How long did you wait in the waiting room for your intern?
     A. 0-5 min. B. 5-10 min. C. 10-15 min. D. 15-20 min. F. over 20 N/A
   - How long did you wait for faculty observations?
     A. 0-5 min. B. 5-10 min. C. 10-15 min. D. 15-20 min. F. over 20 N/A
   - How long did you wait for the cashier?
     A. 0-5 min. B. 5-10 min. C. 10-15 min. D. 15-20 min. 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 with intern — A B C D F

4. 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 benefit 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

5. 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

6. 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: _____

_____

_____