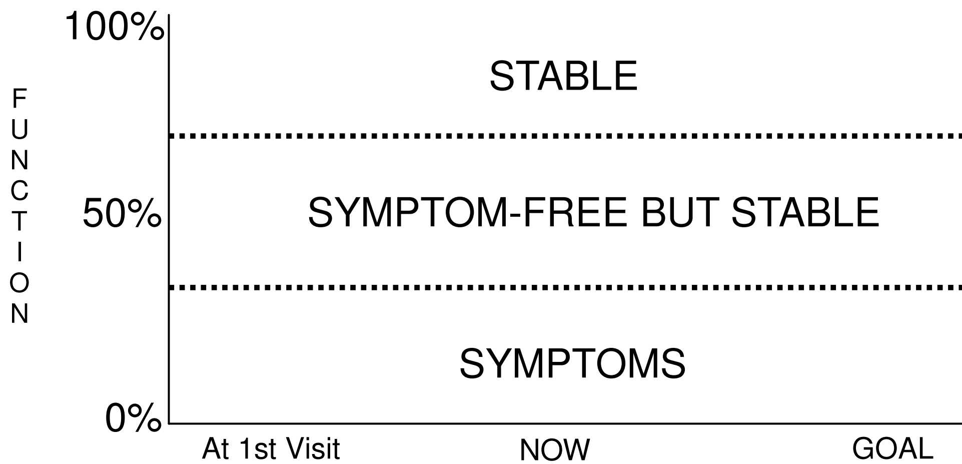
healthspace

- ○ Chiropractic
- ○ Acupuncture
- ○ Massage
- ○ Naturopathy/Nutrition
- ○ Kinesiology

YOUR PROGRESS

FULL NAME Date:

Our goal is to give you the highest quality health care imaginable. In addition to the "objective" tests your Practitioner will evaluate, we would like to find out more about your "experience". As we correct your health and you make appropriate lifestyle changes, we find that the majority of our clients not only "feel better" but also have some "unexpected improvements" in their overall health, wellbeing and quality of life!



Please read carefully through this section and make notes about anything you feel your Practitioner needs to know:

Are there any things you would like to do that you are not able to do now, i.e. Sports, eat certain foods, pick up children/grandchildren, train more consistently, etc.?

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Have you been able to make any other positive changes in your lifestyle? (Changed your eating habits, added specific nutrients, less alcohol or drugs, begun or improved an exercise program or yoga, etc., have healthier thoughts, better strategies to deal with stress, eliminated or changed a stressful relationship[, meditation or breathing, eliminated an unhealthy habit, etc). Please give details:

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Please list supplements, exercises, stretches and/or recommendations you are currently doing and any questions:

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How would you rate your healing: ○ slower than you expected ○ the rate you expected ○ faster than you expected

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What other improvements have you noticed in your overall wellbeing and quality of life? Please tick:

○ Walking	○ Standing	○ Sitting	○ Posture	○ Concentration
○ Digestion	○ Energy Levels	○ Reduced Stress	○ Sex Life	○ Mood
○ Toilet Habits	○ Sleep	○ Wellbeing	○ Menstruation	○ Focus
○ Breathing	○ Strength	○ Exercise	○ Fuzzy Head	○ Immune System
○ State of Mind	○ Stamina	○ Eating Habits	○ Alertness	

On a scale of 1—10, (1 being poor and 10 being excellent), please rate your current (please circle):

Energy Levels	1 2 3 4 5 6 7 8 9 10	Mood	1 2 3 4 5 6 7 8 9 10
Ability to exercise	1 2 3 4 5 6 7 8 9 10	Posture	1 2 3 4 5 6 7 8 9 10
Immune function	1 2 3 4 5 6 7 8 9 10	Concentration	1 2 3 4 5 6 7 8 9 10
Sleep	1 2 3 4 5 6 7 8 9 10	Stress	1 2 3 4 5 6 7 8 9 10

Other improvements:

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Please rate your overall satisfaction with our service. 0 = highly dissatisfied , 10 = highly satisfied

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Have we been attentive to your specific concerns? ○ Yes ○ No

Please give us some suggestions to improve our level of care and customer service.

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I feel the frequency I should be having appointments is:

○ Once a week ○ Twice a week ○ Three times a week ○ Once a fortnight ○ Once a month ○ OTHER, please detail:

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Do you want to continue working together at this time? ○ Yes ○ No

Have your short or long term goals changed since your first visit? If so, please add them here:

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Is there anything else you would like to discuss or ask at this time?

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Congratulations on taking the step to improve your greatest asset—your health! We are here to support you all the way!