

## BODY SCAN RETEST PROGRESS QUESTIONNAIRE

Name \_\_\_\_\_ Date \_\_\_\_\_

1. How do you classify your improvement so far since beginning your care?  
Excellent \_\_\_\_\_ Good \_\_\_\_\_ Fair \_\_\_\_\_ Poor \_\_\_\_\_
2. On a scale of 1 to 10, with 10 being the best, how would you rate your improvement? \_\_\_\_\_
3. What symptoms have improved? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
4. What symptoms do you still have? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
5. What changes have been made in the following areas? Please indicate by using  
I=Improved, S=same, or W= worse.  

Sleep _____	Bowel Movements _____	Sinus Drainage _____
Stress _____	Eating Habits _____	Mental Fog _____
Pain _____	Exercise Habits _____	Dental Issues _____
Digestion _____	Water Intake _____	
6. Is there any other condition you have that we have not covered that you now wish to go into?  
If yes, please explain \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
7. Is there any confusion or question about any phase of your progress?  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
8. Has anyone asked about your progress? Yes \_\_\_\_\_ No \_\_\_\_\_
9. Have you referred anyone for wellness care? Yes \_\_\_\_\_ No \_\_\_\_\_  
If yes, would you like us to contact them for a courtesy consultation? (*Please write their name, address & phone number.*) \_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
*Patient's Signature*