

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