PATIENT UPDATE FORM

DATE: _____ NAME: _____

Since your last visit, which symptoms got better? Estimate % change by symptom. (example: headaches = 50%)

Since your last visit which symptoms are worse? Estimate % change by symptom. (example: allergies = 50%)

What % of the volume of what you eat is salad/low starch vegetables? What % of your overall diet is raw?

List the *total* amount of each supplement you take per day. (example: 6 Health Reserve, 16 drops prime Ph, etc.)

Which instructions from your program did you follow? (example: go to sleep earlier, reduce cell phone use)

Since your last visit, have there been any changes in your lifestyle, schedule, stress levels, etc?

Which body condition is your priority that we address today?

If you need extra space for your answers, write below:

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