

patient update form

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Date: _____ Name: _____

Which symptoms got BETTER since your last visit? Guess where each symptom has been in the last week, on a scale of 0 - 10. (0 = no problem, 10 = worst it has been in your life)

Which symptoms got WORSE since your last visit? Guess where each symptom has been in the last week, on a scale of 0 - 10. (0 = no problem, 10 = worst it has been in your life)

What % of your diet is raw or uncooked? How many quarts or liters of water do you drink each day?

List the TOTAL amount of each supplement you averaged per day since your last visit. (Example - 6 Liver).

Which instructions from your program did you follow? (ex: 9 hours of sleep each night)

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

Which body condition is your priority that we address today?

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