

True Health Family Wellness Center

Confidential Patient Update

Name _____

Date _____

Your current symptoms

How would you rate your overall improvement as a percentage?

0...10...20...30...40...50...60...70...80...90...100 % improvement

Briefly describe your specific improvements (energy levels, pain levels, ability to sleep, work, play, etc.)

What are your current health goals? _____

Since we began correcting your subluxations, as well as our other biomarkers, have you noticed a change in:

- | | | | |
|--|---|---|--|
| <input type="checkbox"/> Bowel Function | <input type="checkbox"/> Bladder Function | <input type="checkbox"/> Digestive Function | <input type="checkbox"/> Ability to concentrate or think clearly |
| <input type="checkbox"/> Lung Capacity | <input type="checkbox"/> Heart/Circulation | <input type="checkbox"/> Mood or Attitude | <input type="checkbox"/> Immunity (illness) or Allergies |
| <input type="checkbox"/> Sexual Function | <input type="checkbox"/> Energy or Activity level | <input type="checkbox"/> Strength/Mobility | <input type="checkbox"/> Menstrual Cycle Function (women only) |

Have you found that you have needed less or no medications? YES NO If YES, please describe the changes in medications, and what you are currently using. _____

What is/are your current health concerns, in order of priority: _____

Patient's (parent or guardian if under 18) Signature _____