



OUTCOME ASSESSMENT QUESTIONNAIRE

Name _____ Date: _____

Our goal is to give you the highest quality health care imaginable. In addition to the “objective” tests the doctor will evaluate, we would like to find out more about your “experience.” As we correct the subluxations or nerve interference and you make appropriate lifestyle changes we find that the majority of our practice members not only “feel better” but also have some “unexpected improvements” in their overall health, well being and quality of life!

Health Concerns: Please rate your health concerns on a 0-10 scale; in which 10 is BEST and 0 is WORST imaginable	Re-Exam Date: _____	Re-Exam Date: _____	Re-Exam Date: _____	Re-Exam Date: _____
1.				
2.				
3.				
4.				
Any new health concerns since last evaluation: 10 = best, 0 = worst				
1.				
2.				
I would rate the overall movement and flexibility in my neck 10 = flexible, 0 = rigid				
I would rate the overall movement and flexibility in my mid back 10 = flexible, 0 = rigid				
I would rate the overall movement and flexibility in my low back 10 = flexible, 0 = rigid				
My overall posture & ease in standing straight 10 = great, 0 = terrible				
I sleep deep and wake up feeling rested 10 = rested, 0 = tired				
I feel I have energy for all my daily activities 10 = a lot, 0 = none				
I feel happy & grateful 10 = everyday, 0 = never				
I notice a deeper awareness of what my body wants from me in relation to (sleep, rest, exercise, movement, diet) since receiving adjustments 10 = yes, 0 = no				
I have less illness and recover faster. 10 = yes, 0 = no				
My self-perception is 10 = excellent, 0= terrible				
My spiritual connection 10 = excellent , 0= none NA= not applicable				
My diet is 10= excellent, 0 = terrible				
My exercise is 10 = excellent, 0 = none				
My strategies to deal with emotional stress 10 = excellent, 0 = terrible				
On the 1-100 scale, 50 being Symptoms, I believe I am now at:				
On the 1-100 scale, 50 being Symptoms, I would like to be at:				
My main goal is: 0 = still cannot do it, 10 = fully reached goal				

Please skim this section and make notes about anything you feel the doctor needs to know:

Since the last evaluation have you had any major relationship, job, residence or other life changes?

Since the last evaluation have you felt *forced* or felt the *need* to make any "negative" changes like: quit exercising or a sport you enjoy, stop working, or stop other things that you enjoy, etc?

Are there any things you would like to do that you are not able to do now, i.e. sports, eat certain foods, pick up children/grandchildren, etc.?

Have you made any other positive changes in your lifestyle? (Change your eating habits, add specific nutrients, less alcohol or drugs, begin or improve an exercise program or yoga etc., have healthier thoughts, better strategies to deal with stress, eliminate or change a stressful relationship, meditation or breathing, eliminate an unhealthy habit.) Feel free to give details.

How would you rate your healing: slower than you expected, the rate you expected or faster than you expected? (Circle one)

What other improvements have you noticed in your overall wellbeing and quality of life?

Please rate your overall satisfaction with our office. 0 = highly dissatisfied, 10 = highly satisfied
If not rated a "10", what can we do to improve your satisfaction rate? Please explain.

Do you want to continue working together at this time?

I feel the frequency I should have my nervous system checked for subluxations is?

Is there anything else you would like to discuss at this time?

Is there anyone who you wished was coming into the office to have their nervous system checked? Who? Why?

Dr. Stern conducts a series of health and wellness lectures. What groups do you know who may benefit from this information? (Such as work, teams, organizations.)
