SCOTT S. SARDONICUS, DC

215 BROWNS RIDGE RD; OSSIPEE NH 03864

REVIEW EXAM QUESTIONNAIRE

Name: ____ Date: ____________________

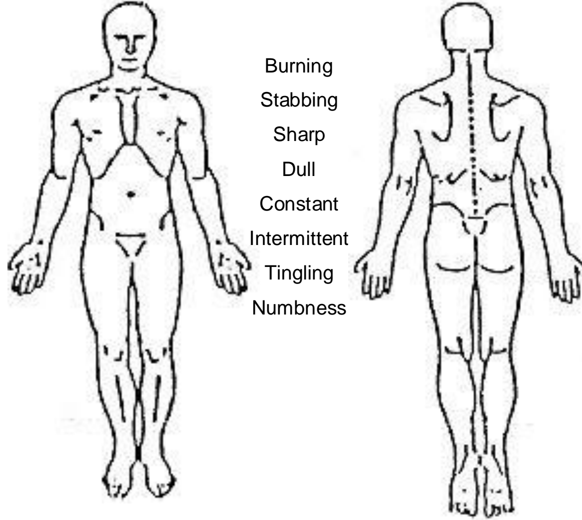
What changes have you noticed (positive or negative) in your condition since beginning care? ____________________

____

____

____

Please mark areas of pain or discomfort on the illustration. Circle the word descriptions of what you're experiencing.



If you have new pain, please mark in a separate color.

Present health concerns	How often	Duration	Severity (1-10)

On a scale of 1-10, how would you rate your level of improvement so far?

NO CHANGE 1 2 3 4 5 6 7 8 9 10 AWESOME

Would you say your improvement is:

___ Progressing at the speed you expected ___ Progressing faster than you expected ___ Taking longer than expected

Rate your ability to perform your normal activities (work, play, sports, housework, driving, sitting, walking, sleeping etc)

UNABLE 1 2 3 4 5 6 7 8 9 10 AWESOME

Describe any limitations: ____

____

Please tell us what type of care you are most interested in receiving:

_______ Relief care: for the relief of pain/symptoms only; will not correct what caused the pain.

_______ Corrective: to feel better and *stay* better, and strengthen and heal the spine; this may take several months to several years depending on the condition of your spine.

_______ Maintenance: Periodic checkups to maintain an already healthy spine.

Have you been consistent with your outlined treatment plan? Y N

OVER

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What do you do for exercise and how often? (ie walking, running, biking, weight training, swimming, yoga etc)

____

____

____

What do you do for stress management and how often? (ie meditate, yoga, gardening, reading, listen to music, sports etc)

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____

____

How would you rate your level of stress: NONE 1 2 3 4 5 6 7 8 9 10 HIGH

Explain what causes your stress? (ie health, family issues, work etc) ____________________________

____

____

Are you currently under the care of any other health care provider? (ie medical doctor, physical therapist, naturopath, acupuncturist, massage therapist etc) Please list name, address, reason for care, results: ____________________

____

____

Are you currently taking any prescription drugs, herbs, vitamins, supplements or homeopathic remedies? If so, please indicate reason, how much, results: ____

____

____

Please circle Yes or No as the following applies to you. Indicate how much and how often.

Do you drink water	Y	N	________	Red meat	Y	N	________	White sugar	Y	N	________
Whole grains	Y	N	________	Fruit juice	Y	N	________	Soda	Y	N	________
Fresh vegetables	Y	N	________	Sweets	Y	N	________	Alcohol	Y	N	________
Salad/raw veggies	Y	N	________	Dairy products	Y	N	________	Tobacco	Y	N	________
Fresh fruit	Y	N	________	Junk food	Y	N	________	Coffee	Y	N	________
Seafood	Y	N	________								

Are there any dietary improvements that you would like to make or are currently working on? ______________

____

____

How many hours of sleep do you get each night? _________ Is it enough? Y N If no, indicate why? ______________

____

Additional comments/concerns: ____

____

____

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