MedMasters
MASTER THE ART OF HEALING

PATIENT EVALUATION FORM

PATIENT APPOINTMENT

Today's Date: ____ /____ /____

Patient Name: ______________________________
Last Name First Name

Checked-In By: ______________________________

CURRENT STATUS

On a scale of 1 to 10, how do you feel today?

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

Terrible → Great

What percentage of improvement have you experienced since your last visit?

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

In what areas are you showing improvement? ______________________________

____

Do you have any questions we need to address?

1.) ______________________________

____

2.) ______________________________

____

3.) ______________________________

____

Mental Clarity: ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 (Low → High)

Physical Energy: ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 (Low → High)

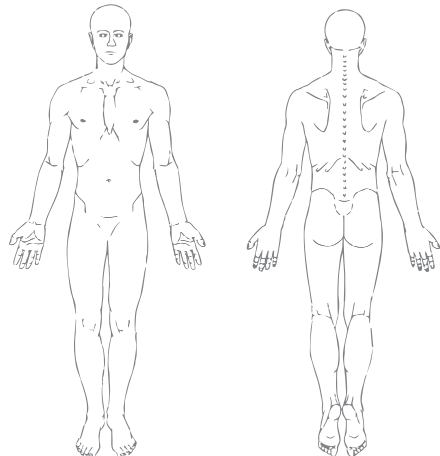
Drive: ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 (Low → High)

Sleep Quality: ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 (Bad → Good)

Digestion: ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 (Poor → Great)

Pain: ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 (Poor → Great)

Please indicate below your areas of concern of pain and rate them in order of priority (1,2, and 3).



CURRENT STATUS

List your top five main complaints in order from worst to least, and rate their severity.

1.) ______________________ ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 (Terrible → Great)

2.) ______________________ ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 (Terrible → Great)

3.) ______________________ ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 (Terrible → Great)

4.) ______________________ ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 (Terrible → Great)

5.) ______________________ ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 (Terrible → Great)

IN-OFFICE USE ONLY

Vitals Before Tx:

Blood Pressure: _______ / _______ Heart Rate: ____________ bpm Oxygen: ____________

Vitals After Tx:

Blood Pressure: _______ / _______ Heart Rate: ____________ bpm Oxygen: ____________

Patient Requirements

Patient has eaten within two hours of the treatment:	☐ Yes	☐ No
Labs drawn before treatment:	☐ Yes	☐ No
Labs drawn after treatment:	☐ Yes	☐ No

Patient Case Study Category

☐ Stage I

☐ Stage II

☐ Stage III

Notes: ____

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