OUTCOME ASSESSMENT FORM

Name _____ Date _____

1. Main Reason(s) you received care? _____

2. How is your response to care so far?

   Excellent _____ Good _____ Fair_____ Poor_____

   How much improvement had you had? _____%

3. What has improved? _____

4. What symptoms do you still have? _____

5. Have you rung the Better Bell? _____

6. Circle changes:

Feel Stronger	More Energy	Feel Younger	
More Relaxed	Sleep Better	Think More Clearly	Move Easier
Better Attitude	Feel Healthier	Less Allergies	Less Pain

7. Any conditions or concerns you want to discuss?_____

   _____

8. Do you intend to receive periodic 'tune-ups' to maintain your health?

   Yes _____ No _____ I need more information to decide _____

9. Have you had the opportunity to refer your friends or family for care?

   _____

10. Please comment on areas where we can improve _____

    _____

    _____

Please Sign _____