

## 5/13 Norval Court, Maroochydore QLD 4558

## Ph: 07 5313 3577 Fax: 07 5302 6468

# **Client Progress Questionnaire**

Name:

Date of Appointment:

The following questionnaire is a significant part of your program. May it be good, bad or indifferent; your communication with us on your progress plays a major role in how best to proceed.

Each client has a different viewpoint on how well they are progressing. Giving well considered and honest responses for each of the below symptoms will enable each of us to establish an accurate picture how well you are doing.

We want to reassure you that your time in completing this valuable questionnaire will help us to help you.

Please keep in mind the following for your appointments:

- Avoid taking any supplements or minerals within the 24 hour period leading up to each appointment
- Please avoid using nail polish on your fingers on the day of each appointment
- Ensure fingernails are cut relatively short

## 1. Your Symptoms

Please list your primary symptoms and grade your level of progress. Use the following grading scale and place an "X" in the appropriate box below.

#### Worse

No Improvement: Still the same - 0% improvement

Slightly Better: Symptoms are still present; however 25% reduced in duration or intensity - 25% improved Good: Symptoms are still present; however 50%+ reduction in the duration or intensity - 50% improved Excellent: No symptoms - 100% improvement

Symptom	Worse	No Improvement	Slightly Better	Good	Excellent
e.g. headaches				Х	

2. How are your energy levels?
3. Overall Progress
Our main objective in having you complete this progress questionnaire is to help you succeed in accomplishing your health goals. Please spend extra time on this comments section; this is where you can express what is going well for you, what is not going so well & what may be frustrating you. We encourage you to dig deep and tell it like it really is.
4. Please list any new supplements of medications that you have started. Please also note if you have increased or decreased any dosages of your current supplements or medications.
nate increased or decreased any decayes or your current supplements or medications.
5. Have you had any diagnostic tests performed since your last consult? Tests by any other doctor?
YES NO
If yes, what tests have you
had done and by which Lab?
6. Please express any concerns you have about our service or anything that involves how your
health is being taken care of. We promise you won't hurt our feelings – please let us know.
7. Please express any concerns or questions you may have about your symptoms or condition or
the approach we are taking to improve your health. Do you feel that you understand the role of
nutritional/functional testing in helping you get well?

8.Please list exactly what you ate for breakfast, lunch and dinner over the last two days. We want				
to know exactly what foods and beverages you have consumed, including snacks.				
Day1				
Breakfast				
Lunch				
Dinner				
Snacks				
Beverages				
Day2				
Breakfast				
Lunch				
Dinner				
Snacks				
Beverages				
Any other comments about your diet?				

10. Is there anything you want to ask doctor regarding your health that you may have forgotten?
Any new symptoms or concerns?

9. What has been your greatest challenge in sticking with the program?

#### 11. Will you need any pathology request forms or repeat scripts during your next consultation?

Prescriptions

Pathology Request Forms

Other – please state:

### 12. Please check off any of the following that you would like to achieve with doctors help:

Have more energy	Feel less sleepy in the afternoon
Sleep better	Lose weight
Improve digestion	Increase sex drive
Be able to eat greater food variety	Increase metabolism and burn more fat
Get rid of allergies	Increase flexibility
Improve my skin	Reduce stress
Not be dependent on laxatives	Improve memory
Be able to exercise again	Feel more focused
Have better muscle tone	Improve mood
Be in less pain	Reduce risk for chronic disease
No longer use pain medication	Work on an anti-ageing program
No longer use allergy medication	Improve my diet
No longer use sleep medication	Detoxify my body
Have a better immune system	

Please either print out your completed progress questionnaire and bring it with you to your next consultation or email it prior to your consultation to <u>admin@lotusholisticmedicine.com.au</u>

In good health,

The Team at Lotus Holistic Medicine