ABUNDANCE ACUPUNCTURE, INC.

☯ 126 N Dickason Blvd, Columbus WI 53925 (920) 484-5000 ☯

"Realize the wonderful benefits of Oriental Medicine"

RE-EVALUATION QUESTIONAIRE

Name:	Date:

Treatment # _____ of ____ Re-exam # ____ Current frequency of treatments per week/month: 1 2 3 4 5

☯ What aspects of your treatment are you most satisfied with?

____

____

____

____

☯ If you are currently taking herbal formulas or supplements, are you taking them as prescribed?

____

____

____

____

☯ List any new conditions since the last re-evaluation (or initial treatment).

____

____

____

____

☯ How has Oriental Medicine improved your health?

____

____

____

____

____

____

____

____

Please describe any symptoms, mood, or energy level changes. Have you made any lifestyle or dietary changes? Any improvements daily life and routine?

Please leave this space blank for office notes.

CONTINUE ON OTHER SIDE

☯If your health continues to improve what changes or opportunities would this create in your life? __________ __________ __________ __________ ☯ Please list the most important health improvements you currently wish to make. Go ahead and include <u>any</u> goals even if they seem impossible. __________ __________ __________ __________ ☯ Our staff works as a team and we all review this information. Would you like to make any acknowledgements or compliments? __________ __________ __________ __________	Please leave this space blank for office notes
Would you recommend a friend for a free, complimentary initial consultation? There will be no charges or obligations for further services with this consultation. __________ __________ Name of friend or family member Phone #	

Your Signature:

Please leave this space blank for office notes:

Pulse:

Tongue:

Recommended Changes/Treatment Frequency

Assessed by: