

# CLINICAL APPRAISAL: FOLLOW-UP

\_\_\_\_\_

Client Name

\_\_\_\_\_

Date

## INSTRUCTIONS

If you are an existing client, you are not required to complete a new Clinical Appraisal Indicator. However, please complete this Follow-up to update us on any changes in your condition, medications or supplements since your last appointment with us.

## IMPORTANT - Please list below your four main health complaints in order of importance:

- 1) \_\_\_\_\_
- 2) \_\_\_\_\_
- 3) \_\_\_\_\_
- 4) \_\_\_\_\_

## PLEASE FILL IN BELOW:

Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_

Zip: \_\_\_\_\_

Birthdate: \_\_\_\_\_ Weight: \_\_\_\_\_ Height: \_\_\_\_\_ Married: Yes / No Gender: Male / Female

Email Address: \_\_\_\_\_ Occupation: \_\_\_\_\_

Present Diagnosed Illnesses: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Please List any Medications or Supplements you are presently taking: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Client Signature

\_\_\_\_\_

Date

\_\_\_\_\_