Case Review Process

Thank you for your interest in becoming a patient in our practice. All new patients must conduct a case review process in order to determine if they are amendable to the type of care that we provide. The goal of the case review process is to avoid unnecessary case management, loss of financial resources, loss of time, and loss of energy. Successful management of any complicated case requires appropriate testing, diagnosis, financial commitments, and realistic clinical expectations. A deficiency in any of these variables may lead to clinical failure.

The single most important criteria for effective case management is a comprehensive and detailed health history. Please answer the following questions with as much detail as possible. It is important for us to know everything about you and your case. Failure to provide a detailed answer indicates you are not serious about your case.

It takes tremendous time and energy for any healthcare provider to manage a complicated case. Our practice is limited to a very small number of patients and therefore the case review process is very important.

Please schedule appropriate time in a setting that allows you to complete the questions to the best of your abilities.

Following this page you will find:

1. **CASE REVIEW QUESTIONS** – please use a Microsoft Word document to answer these questions and email responses back to docboydston@gmail.com (Microsoft Word Format Only).
2. **COMPREHENSIVE CASE HISTORY –** This follows the CASE REVIEW QUESTIONS. Some questions will overlap between the Care Review Questions and Case History, don't worry, answer all questions with as much detail as possible.

Please mail the completed forms AND previous lab and diagnostic reports to:

Dr. Robert Boydston
255 W Bullard Ave Ste 116
Clovis, CA 93612

We need to receive your typed Case Review Questions, History Forms, and Previous Lab and Diagnostic Reports before your scheduled appointment. It will allow us to review it prior to your appointment and be very focused on your specific needs.

In addition to the comprehensive Case History that follows, please answer the following CASE REVIEW QUESTIONS.

- **Some of the questions will be duplicated in the Case History, so don't worry.**
- **Please type your answers and with as much detail as possible.**

These typed questions must be returned with your Case History forms before your appointment.

HEALTH HISTORY QUESTIONS

1. Please list your education, profession, sports and hobbies
2. List your chief complaints in order of your importance
3. Provide a detailed narrative (story) of your health history in a timeline sequence
4. List all diagnoses given to you in a timeline sequence and your personal opinions about the diagnosis
5. List your opinion on what you think has happened to your health
6. List of all healthcare providers you have consulted and their opinions and treatments about your case
7. List any treatments, medications, or supplements that have improved your health
8. List any treatments, medications, or supplements that have caused reactions or decreased your health
9. List in a timeline sequence and medications you have taken
10. List in a timeline sequence any medical procedures or surgeries you have had
11. List in a timeline sequence any significant laboratory or imaging results
12. List in a timeline sequence any exposure to environmental, industrial, or toxic compounds.
13. List any history of infections (excluding common colds).

PERSONAL OPINION QUESTIONS

Please do not answer, "I don't know" to any of these questions

1. Why do you think healthcare practitioners have failed with your case?
2. Do you think your condition can be cured, or improved?
3. What do you consider a realistic time frame to see changes in your health under our care?
4. What are your expectations from us?
5. Is there anyone you blame for your health condition?
6. What specific improvements in your health would you consider a successful outcome in your case?
7. Is there anything you feel you should tell us about yourself or your case?
8. Is there anything in what you believe about health and the body that you may think is holding back your health?
9. Are there any emotional experiences that can be affecting to your health condition?
10. Are there any patterns in childhood or adulthood that has contributed to your health problems?
11. Is your spouse and/or family unit supportive of you with your health condition?
12. Are your spouse and/or family unit supportive of you seeking care at our office?
13. How did you feel about answering all of these questions and the case review process?

CONFIDENTIAL PATIENT HISTORY

Name _____

How do you wish to be addressed in our office? ❑First name ❑ Mr ❑ Mrs ❑Ms ❑Miss ❑ Dr

Address _____ City _____State_____ Zip_____

SSN#_____ Date of Birth _____ Marital Status: Single Married Widowed Divorced

Home Telephone _____ Cell _____Work_____

Email address: _____

Occupation _____ Employer _____

Spouse/Partner's Name _____ Employer _____

Spouse/Partner's Work Ph_____ Cell Ph _____

Name of person to contact in case of emergency:_____

Relationship:_____ Phone_____

How did you choose our office? (e.g. Referral, internet, advertisement etc.)

_____

What is the main problem or symptom that made you come here today?:

_____

When and How did this begin? _____

Have you had this or similar conditions in the past? ❑Yes ❑No If yes, when? _____

What aggravates your condition? _____

What makes it better? _____

Describe what you are feeling? _____

Do you experience Numbness or Tingling? ❑No ❑Yes If yes, where? _____

SYMPTOM INTENSITY: Please circle the number describing the intensity of your symptoms.

None→ 0 1 2 3 4 5 6 7 8 9 10 **←Unbearable**

When you're awake, how often are you feeling these symptoms?(0-100%) _____%

Is this getting progressively worse? ❑Yes ❑ No **Is your condition:** ❑Constant ❑Comes & goes

Is this condition interfering with your: ❑Work ❑Sleep ❑Daily routine ❑Other _____

Has there been any medical diagnosis of your complaint? ❑ Yes ❑ No If yes, list the Dr.'s name and the Diagnosis _____

How have you tried to take care of this problem in the past? <u>Circle all that apply</u>

Medications • Emergency Room • Surgery • Routine Medical • Exercise • Supplements • Regular Chiropractic

Other (please specify)_____

How did the previous method(s) work out for you? Circle all that apply

Bad results • Some Results • Great Results • Nothing Changed • Didn't get worse • Didn't work very long

What are you afraid this might be? _____

Please list any medications you currently take and for what conditions:

_____

_____

Please list any natural supplements you currently take and for what conditions:

_____

_____

Please list your 5 major health concerns in order of importance to you.

1. _____
2. _____
3. _____
4. _____
5. _____

Please use this space to give us more details about the history of your problem(s).
Please tell us about:

- **When these problems started? How have they changed over time?**
- **What have you tried to help this (medications, therapies, diets, supplements etc.)**
- **What was the response? (helped, worse, no change)**
- **What do you think makes these symptoms/behaviors worse?**
- **What do you think makes these symptoms/behaviors better.**
- **TELL US AS MUCH AS YOU CAN!! USE EXTRA PAPER IF NECESSARY**

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Past Evaluations

Here is a list of possible testing and evaluations you may have. If you have any of these please make sure to send copies of these results and reports with this questionnaire. (We do not need daily office notes).

- MRI, CT, EEG
- Psychological / Neuropsychological Evaluations
- Psychiatric
- Neurological Evaluations
- Gastroenterology Evaluations
- Rheumatology Evaluations
- Internal Medicine Evaluations
- Genetic Evaluations
- Celiac/Gluten testing

Hospitalizations

Age	Reason for Hospitalization	Discharge Summary Attached?

Age	Operations	
	Appendix	
	Hernia	
	Tonsils	
	Adenoids	
	Tubes in Ears	
	Other Surgery:	
	Other Surgery:	

Please describe any head injuries, broken bones or other injuries/ traumas	Age

List surgical operations and years: _____

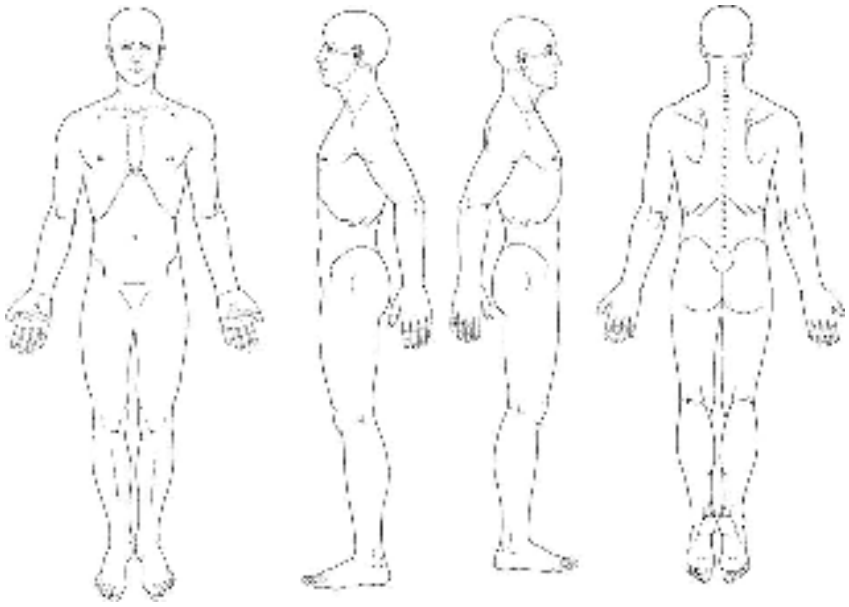
Other Medical or Physical conditions you have been diagnosed with (e.g. diabetes, heart conditions, arthritis, osteoporosis, low thyroid, hormone imbalance, food allergies, anxiety or panic attacks etc.) _____

_____

_____

Please mark off the areas of your complaint on the diagram above. Please use the following symbols on the diagram to accurately describe your problem.

PPP	PAIN
WWW	WEAKNESS
NNN	NUMBNESS
HHH	HEAT
TTT	TINGLING
BBB	BURNING
CCC	CRAMPING
FFF	STIFFNESS



Write "YES" or "NO" in the box next to each of the questions.

	Weakness		Fatigue
	Pins & Needles feelings, electric shock feelings		Racing heart beat
	Trouble controlling bowels or bladder		Angina—chest pain or shortness of breath
	Hair loss on the arms or legs		Left arm pain
	Balance problems		Swelling in the lower legs
	Fingernails are brittle or have ridges or look different		Extreme shortness of breath; feel like drowning / suffocating
	Symptom changes with arm, leg or neck movement		Blackouts
	Twitching muscles		Light headedness
	Decrease in size or tone of your arms or legs		Cramping pains in the legs that start after walking
	Uncoordinated		Poor exercise tolerance
	Muscle cramping		Erectile dysfunction

	Double vision?		Sensitivity to light
	Difficulty talking?		Sweat more on one side (armpit, face etc.)
	You feel unsteady or you fall		Dry mouth
	Vomiting, sick to stomach		Dry eyes
	Abnormal jerking of the eyes		Cold arms, legs, hands, feet
	Numbness? Where?		

Please mark the following in each category by ranking each one 0-4.
0=Never, 1=Rarely, 2=Occasionally, 3=Frequently, 4=Very Frequently, 5=Always

	0	1	2	3	4	5	Past ONLY	Comments
Letters seen backwards	☐	☐	☐	☐	☐	☐	☐	
Difficulty counting, calculating	☐	☐	☐	☐	☐	☐	☐	
You have difficulty understanding how you feel	☐	☐	☐	☐	☐	☐	☐	
Without looking, have difficulty knowing "where" in space foot or hand is.	☐	☐	☐	☐	☐	☐	☐	
Feel odd sensations (bugs crawling, tingling, burning etc)	☐	☐	☐	☐	☐	☐	☐	**Where?**
Get claustrophobic, tunnel vision, or feeling that the world is closing in	☐	☐	☐	☐	☐	☐	☐	
Have difficulty understanding how others feel	☐	☐	☐	☐	☐	☐	☐	
Gets surprised by things coming from the left side (more than from opposite side)	☐	☐	☐	☐	☐	☐	☐	
Difficulty with "spatial" skills	☐	☐	☐	☐	☐	☐	☐	
Difficulty with word problems in math	☐	☐	☐	☐	☐	☐	☐	
Difficulty getting dressed	☐	☐	☐	☐	☐	☐	☐	
Difficulty reading people's facial expressions	☐	☐	☐	☐	☐	☐	☐	
Difficulty interpreting emotional content of a verbal conversation	☐	☐	☐	☐	☐	☐	☐	
Confusion between right and left	☐	☐	☐	☐	☐	☐	☐	
Dry eyes, nose, mouth or tearing of eyes and running of nose, excess saliva.	☐	☐	☐	☐	☐	☐	☐	
Difficulty with arousal (i.e. waking up), seem to be half asleep all the time.	☐	☐	☐	☐	☐	☐	☐	
Speech is slurred	☐	☐	☐	☐	☐	☐	☐	
Movement does not look coordinated	☐	☐	☐	☐	☐	☐	☐	
Trip	☐	☐	☐	☐	☐	☐	☐	
Fall, get hurt running climbing	☐	☐	☐	☐	☐	☐	☐	
Have trouble maintaining balance	☐	☐	☐	☐	☐	☐	☐	
Knock over things when reaching	☐	☐	☐	☐	☐	☐	☐	
Drop things	☐	☐	☐	☐	☐	☐	☐	

NT Assessment Form

Please circle mark the appropriate number "0 - 3" on all questions below.

0 as the least/never to 3 as the most/always.

SECTION 1 - S				
Are you losing your pleasure in hobbies and interests?	0	1	2	3
How often do you feel overwhelmed with ideas to manage?	0	1	2	3
How often do you have feelings of inner rage (anger)?	0	1	2	3
How often do you have feelings of paranoia?	0	1	2	3
How often do you feel sad or down for no reason?	0	1	2	3
How often do you feel like you are not enjoying life?	0	1	2	3
How often do you feel you lack artistic appreciation?	0	1	2	3
How often do you feel depressed in overcast weather?	0	1	2	3
How much are you losing your enthusiasm for your favorite activities?	0	1	2	3
How much are you losing enjoyment for your favorite foods?	0	1	2	3
How much are you losing your enjoyment of friendships and relationships?	0	1	2	3
How often do you have diffi culty falling into deep restful sleep?	0	1	2	3
How often do you have feelings of dependency on others?	0	1	2	3
How often do you feel more susceptible to pain?	0	1	2	3
How often do you have feelings of unprovoked anger?	0	1	2	3
How much are you losing interest in life?	0	1	2	3

SECTION 2 - D				
How often do you have feelings of hopelessness?	0	1	2	3
How often do you have self-destructive thoughts?	0	1	2	3
How often do you have an inability to handle stress?	0	1	2	3
How often do you have anger and aggression while under stress?	0	1	2	3
How often do you feel you are not rested even after long hours of sleep?	0	1	2	3
How often do you prefer to isolate yourself from others?	0	1	2	3
How often do you have unexplained lack of concern for family and friends?	0	1	2	3
How easily are you distracted from your tasks?	0	1	2	3
How often do you have an inability to finish tasks?	0	1	2	3
How often do you feel the need to consume caffeine to stay alert?	0	1	2	3
How often do you feel your libido has been decreased?	0	1	2	3
How often do you lose your temper for minor reasons?	0	1	2	3
How often do you have feelings of worthlessness?	0	1	2	3

SECTION 3 - G				
How often do you feel anxious or panic for no reason?	0	1	2	3
How often do you have feelings of dread or impending doom?	0	1	2	3
How often do you feel knots in your stomach?	0	1	2	3
How often do you have feelings of being overwhelmed for no reason?	0	1	2	3
How often do you have feelings of guilt about everyday decisions?	0	1	2	3
How often does your mind feel restless?	0	1	2	3
How difficult is it to turn your mind off when you want to relax?	0	1	2	3
How often do you have disorganized attention?	0	1	2	3
How often do you worry about things you were not worried about before?	0	1	2	3
How often do you have feelings of inner tension and inner excitability?	0	1	2	3

SECTION 4 - ACH				
Do you feel your visual memory (shapes & images) is decreased?	0	1	2	3
Do you feel your verbal memory is decreased?	0	1	2	3
Do you have memory lapses?	0	1	2	3
Has your creativity been decreased?	0	1	2	3
Has your comprehension been diminished?	0	1	2	3
Do you have difficulty calculating numbers?	0	1	2	3
Do you have difficulty recognizing objects & faces?	0	1	2	3
Do you feel like your opinion about yourself has changed?	0	1	2	3
Are you experiencing excessive urination?	0	1	2	3
Are you experiencing slower mental response?	0	1	2	3

THIS SPACE INTENTIONALLY LEFT BLANK

Metabolic Assessment Form

Please check mark the appropriate number "0 - 3" on all questions below.
0 as the least/never to 3 as the most/always.

Category I	**0**	**1**	**2**	**3**
Feeling that bowels do not empty completely	☐	☐	☐	☐
Lower abdominal pain relief by passing stool or gas	☐	☐	☐	☐
Alternating constipation and diarrhea	☐	☐	☐	☐
Diarrhea	☐	☐	☐	☐
Constipation	☐	☐	☐	☐
Hard dry or small stool	☐	☐	☐	☐
Coated tongue or "fuzzy" debris on tongue	☐	☐	☐	☐
Pass large amount of foul smelling gas	☐	☐	☐	☐
More than 3 bowel movements daily	☐	☐	☐	☐
Do you use laxatives frequently	☐	☐	☐	☐

Category II	**0**	**1**	**2**	**3**
Excessive belching burping or bloating	☐	☐	☐	☐
Gas immediately following a meal	☐	☐	☐	☐
Offensive breath	☐	☐	☐	☐
Difficult bowel movements	☐	☐	☐	☐
Sense of fullness during and after meals	☐	☐	☐	☐
Difficulty digesting fruits and vegetables; undigested foods found in stools	☐	☐	☐	☐

Category III	**0**	**1**	**2**	**3**
Stomach pain, burning or aching 1- 4 hours after eating	☐	☐	☐	☐
Do you frequently use antacids	☐	☐	☐	☐
Feeling hungry an hour or two after eating	☐	☐	☐	☐
Heartburn when lying down or bending forward	☐	☐	☐	☐
Temporary relief from antacids, food, milk, carbonated beverages	☐	☐	☐	☐
Digestive problems subside with rest and relaxation	☐	☐	☐	☐
Heartburn due to spicy foods, chocolate, citrus, peppers, alcohol and caffeine	☐	☐	☐	☐

Category IV	**0**	**1**	**2**	**3**
Roughage and fiber cause constipation	☐	☐	☐	☐
Indigestion and fullness lasts 2-4 hours after eating	☐	☐	☐	☐
Pain, tenderness, soreness on left side	☐	☐	☐	☐
Under rib cage bloated	☐	☐	☐	☐
Excessive passage of gas	☐	☐	☐	☐
Nausea and/or vomiting	☐	☐	☐	☐
Stool undigested, foul smelling, mucous -like, greasy or poorly formed	☐	☐	☐	☐
Frequent urination	☐	☐	☐	☐
Increased thirst and appetite	☐	☐	☐	☐
Difficulty losing weight	☐	☐	☐	☐

Category V	**0**	**1**	**2**	**3**
Greasy or high fat foods cause distress	☐	☐	☐	☐
Lower bowel gas and or bloating several hours after eating	☐	☐	☐	☐
Bitter metallic taste in mouth, especially in the morning	☐	☐	☐	☐
Unexplained itchy skin	☐	☐	☐	☐
Yellowish cast to eyes	☐	☐	☐	☐
Stool color alternates for clay colored to normal brown	☐	☐	☐	☐
Reddened skin, especially palms	☐	☐	☐	☐
Dry or flaky skin and/or hair	☐	☐	☐	☐
History of gallbladder attacks or stones	☐	☐	☐	☐
Have you had your gallbladder removed?				

Category VI	**0**	**1**	**2**	**3**
Crave sweets during the day	☐	☐	☐	☐
Irritable if meals are missed	☐	☐	☐	☐
Depend on coffee to keep yourself going or started	☐	☐	☐	☐
Get lightheaded and if meals are missed	☐	☐	☐	☐
Eating relieves fatigue	☐	☐	☐	☐
Feel shaky, jittery, tremors	☐	☐	☐	☐
Agitated, easily upset, nervous	☐	☐	☐	☐
Poor memory, forgetful	☐	☐	☐	☐
Blurred vision	☐	☐	☐	☐

Category VII	**0**	**1**	**2**	**3**
Fatigue after meals	☐	☐	☐	☐
Crave sweets during the day	☐	☐	☐	☐
Eating sweets does not relieve cravings for sugar	☐	☐	☐	☐
Must have sweets after meals	☐	☐	☐	☐
Waist girth is equal or larger than hip girth	☐	☐	☐	☐
Frequent urination	☐	☐	☐	☐
Increased thirst & appetite	☐	☐	☐	☐
Difficulty losing weight	☐	☐	☐	☐

Category VIII	**0**	**1**	**2**	**3**
Cannot stay asleep	☐	☐	☐	☐
Crave salt	☐	☐	☐	☐
Slow starter in the morning	☐	☐	☐	☐
Afternoon fatigue	☐	☐	☐	☐
Dizziness when standing up quickly	☐	☐	☐	☐
Afternoon headaches	☐	☐	☐	☐
Headaches with exertion or stress	☐	☐	☐	☐
Weak nails	☐	☐	☐	☐

Category IX	0	1	2	3
Cannot fall asleep	☐	☐	☐	☐
Perspire easily	☐	☐	☐	☐
Under high amounts of stress	☐	☐	☐	☐
Weight gain when under stress	☐	☐	☐	☐
Wake up tired even after 6 or more hours of sleep	☐	☐	☐	☐
Excessive perspiration or perspiration with little or no activity	☐	☐	☐	☐

Category X	0	1	2	3
Tired, sluggish	☐	☐	☐	☐
Feel cold – hands, feel, all over .	☐	☐	☐	☐
Require excessive amounts of sleep to function properly	☐	☐	☐	☐
Increase in weight gain even with low-calorie diet	☐	☐	☐	☐
Gain weight easily	☐	☐	☐	☐
Difficult, infrequent bowel movements	☐	☐	☐	☐
Depression, lack of motivation	☐	☐	☐	☐
Morning headaches that wear off as the day progresses	☐	☐	☐	☐
Outer third of eyebrow thins	☐	☐	☐	☐
Thinning of hair on scalp, face or genitals or excessive falling hair	☐	☐	☐	☐
Dryness of skin and/or scalp				
Mental sluggishness	☐	☐	☐	☐

Category XI	0	1	2	3
Heart palpations	☐	☐	☐	☐
Inward trembling	☐	☐	☐	☐
Increased pulse even at rest	☐	☐	☐	☐
Nervousness and emotional	☐	☐	☐	☐
Insomnia	☐	☐	☐	☐
Night sweats	☐	☐	☐	☐
Difficulty gaining weight	☐	☐	☐	☐

Category XII	0	1	2	3
Diminished sex drive	☐	☐	☐	☐
Menstrual disorders of lack of menstruation	☐	☐	☐	☐
Increased ability to eat sugars without symptoms	☐	☐	☐	☐

Category XIII	0	1	2	3
Increased sex drive	☐	☐	☐	☐
Tolerance to sugars reduced	☐	☐	☐	☐
Splitting" type headaches	☐	☐	☐	☐

Category XIV (Male Only)	0	1	2	3
Urination difficulty or dribbling	☐	☐	☐	☐
Urination frequent	☐	☐	☐	☐
Pain inside of legs or heels	☐	☐	☐	☐
Feeling of incomplete bowel evacuation	☐	☐	☐	☐
Leg nervousness at night	☐	☐	☐	☐

Category XV (Males Only)	0	1	2	3
Decrease in libido	☐	☐	☐	☐
Decrease in spontaneous morning erections	☐	☐	☐	☐
Decrease in fullness of erections	☐	☐	☐	☐
Difficulty in maintain morning erections	☐	☐	☐	☐
Spells of mental fatigue	☐	☐	☐	☐
Inability to concentrate	☐	☐	☐	☐
Episodes of depression	☐	☐	☐	☐
Muscle soreness	☐	☐	☐	☐
Decrease in physical stamina	☐	☐	☐	☐
Unexplained weight gain	☐	☐	☐	☐
Increase in fat distribution around chest and hips	☐	☐	☐	☐
Sweating attacks	☐	☐	☐	☐
More emotional than in the past	☐	☐	☐	☐

Category XVI (Menstruating Females Only)	0	1	2	3
Are you a menopausal ?		Yes	No	
Alternating menstrual cycle lengths ?		Yes	No	
Extended menstrual cycle, greater than 32 days?		Yes	No	
Shortened menses, less than every 24 days?		Yes	No	
Pain and cramping during periods	☐	☐	☐	☐
Scanty blood flow	☐	☐	☐	☐
Heavy blood flow	☐	☐	☐	☐
Breast pain and swelling during menses	☐	☐	☐	☐
Pelvic pain during menses	☐	☐	☐	☐
Irritable and depressed during menses	☐	☐	☐	☐
Acne break outs	☐	☐	☐	☐
Facial hair growth	☐	☐	☐	☐
Hair loss/thinning	☐	☐	☐	☐

Category XVII (Menopausal Females only)	0	1	2	3
How many years have you been menopausal?	_____			
Do you ever have uterine bleeding since menopause?		Yes	No	
Hot flashes	☐	☐	☐	☐
Mental fogginess	☐	☐	☐	☐
Disinterest in sex	☐	☐	☐	☐
Mood swings	☐	☐	☐	☐
Depression	☐	☐	☐	☐
Painful intercourse	☐	☐	☐	☐
Shrinking breast	☐	☐	☐	☐
Facial hair growth	☐	☐	☐	☐
Acne	☐	☐	☐	☐
Increased vaginal, pain, dryness or itching	☐	☐	☐	☐

PART II

How many alcohol beverages they consume per week? _____

How many caffeinated beverages do you consume per day? ____

How many times do you eat out per week? _____

How many times a week do you eat raw nuts or seeds? _____

How many times a week do you eat fish? _____

How many times a week do you workout? _____

List the three worst foods you eat during the average week: 1. _____ 2._____ 3._____

List the three healthiest foods you eat during the average week: 1. _____ 2. _____3. _____

Do you smoke?_____ If yes, how many times a day _____ , how many times a week _____.

Rate your stress levels on a scale of 1-10 during the average week. _____

What do you eat for the following meals on a typical day?

Breakfast: _____

Lunch: _____

Dinner: _____

***Write down EVERYTHING you eat & drink for 3 days. What you're eating and when you're eating can have a HUGE NEGATIVE EFFECT on your health.**

Day 1

Breakfast	Lunch	Dinner
Time:	**Time:**	**Time:**
Snack **Time**:	**Snack** **Time:**	**Snack** **Time:**

Day 2

Breakfast	Lunch	Dinner
Time:	**Time:**	**Time:**
Snack **Time**:	**Snack** **Time:**	**Snack** **Time:**

Day 3

Breakfast	Lunch	Dinner
Time:	**Time:**	**Time:**
Snack **Time**:	**Snack** **Time:**	**Snack** **Time:**

Where do you picture yourself being in the next 1-3 years if this problem is not taken care of? Please be specific _____

What would be different/better without this problem? Please be specific _____

_____

What do you desire most to get from working with us?_____

_____

What is that worth to you? _____

_____

What is your idea of the ideal doctor? _____

_____

_____

We thank you for your patience and cooperation in completely filling out this form.

Patient's Signature: _____ **Date:** _____

For Doctor's Use Only

Dr. Robert Boydston D.C.
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