



Dr. Paul Given
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Patient Name: _____ **ID#** _____

Wellness Care Reassessment

Please reflect on your health and the activities that matter to you over the last few months.

Name _____ Date _____ Last reassessment _____

How you are doing

Compared with your original concern, how much remains? ____% (0% none; 100% as at the start)

Overall health: ☐ Improving ☐ Stable ☐ Declining ☐ Unsure

What activities are you maintaining or enjoying? _____

What feels more difficult lately, even if it is not painful? _____

Any change in balance, confidence walking, falls or near falls? ☐ No ☐ Yes: _____

Any change in focus, clarity or energy that affects daily life? ☐ No ☐ Yes: _____

Any new or returning symptoms? ☐ No ☐ Yes: _____

Load and recovery

Any crisis or period of overload in recent months? ☐ No ☐ Yes: _____

Main stressors (check any): ☐ Physical ☐ Chemical or environmental ☐ Mental or emotional ☐ Heat or cold

What helps you recover? _____ What seems to drain your resilience? _____

Your five foundations

Rate each from 1 (needs attention) to 10 (strong). These are conversation prompts, not a medical score.

Chiropractic function and mobility ____ / 10

Nutrition and clean water ____ / 10

Movement, exercise and breathing ____ / 10

Mindfulness and outlook ____ / 10

Reducing stressors and toxins ____ / 10

Which one would you most like to improve? _____ One realistic next step: _____



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Looking ahead

What would you like to protect or improve over the next 3–6 months? _____

Any health change, injury, diagnosis or medication change Dr. Given should know about? _____

Clinician notes

Relevant findings, shared goals, care plan and next reassessment:



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Reassessment Consent

Consent for Chiropractic Care

Following today's reassessment and discussion, I consent to the chiropractic care and plan described to me by Dr. Paul Given. Any proposed diagnostic imaging or materially different procedure will be discussed separately before it occurs.

We have discussed the purpose and expected benefits of the proposed care, material risks and side effects, reasonable alternatives, and the likely effects of declining care. Risks may include soreness, muscle or ligament injury, disc injury, and the rare but potentially serious risk of stroke associated with cervical adjustments. No result is guaranteed.

I had an opportunity to ask questions and received answers. I understand that I may decline or withdraw consent at any time. A new plan, significant change in my condition, or changed material risk requires further discussion.

Plan discussed today

Care or plan reviewed _____

Alternatives or concerns discussed _____

Patient or authorized person signature _____ Date _____

If signing for the patient, name and relationship _____

Discussion or changes to consent _____

Clinician signature _____ Date _____



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Early Care Reassessment

Please tell us what has changed since your last assessment. Your answers help guide the next stage of care.

Name _____ Date _____ Last reassessment _____

Progress toward your goals

Original main concern and the activity or goal you wanted to regain

How much of the original concern remains? ____% (0% none; 100% as at the start)

Current intensity 0–10: ____ At the start 0–10: ____ Frequency: ☐ Less ☐ Same ☐ More

Overall change: ☐ Much better ☐ Somewhat better ☐ No change ☐ Worse

Important activity: _____ Ability now ____ / 10 (0 unable; 10 usual ability)

What can you do now that you could not do before? _____

What still limits you? _____

Since your last assessment

Any new symptoms, injury, illness, medication change or major stressor? ☐ No ☐ Yes: _____

Home exercises or traction, if prescribed: ☐ Most days ☐ Some days ☐ Rarely ☐ Not prescribed

Any barriers to following the care plan? _____

What would make the next phase of care worthwhile to you? _____

Clinician notes

Objective findings, goal review, care plan and next reassessment:

