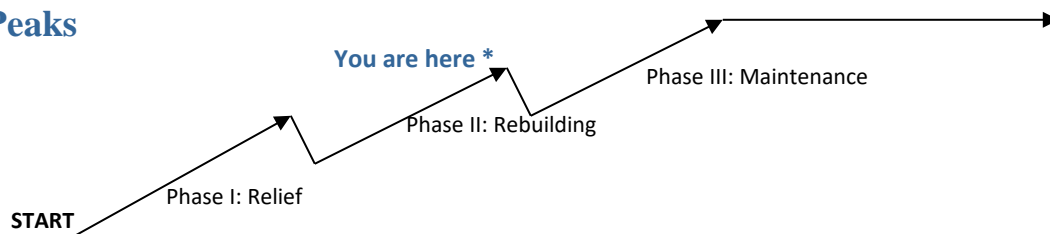


## Progress Evaluation #3

Congratulations! You have laid a solid foundation in your care by completing the Health Rebuilding Phase of your Health Rebuilding Process and now you're ready for your **personalized Health Maintenance Phase (Phase III)**. To help us plan the best approach for you going forward, we first need to evaluate your progress so far. Your **Progress Evaluation visit** is a special time to comprehensively review your overall care so far; what has improved and what still needs attention for your health and well being. We want to help you maintain the positive changes you have gained and optimize your health further.

### Health Peaks



### What to know about your Progress Evaluation visit

- ☑ Schedule a 1-hour visit for your Progress Evaluation. (30 minutes consult / 30 minutes exam) (Allow 90 minutes in the office.)
- ☑ Schedule a 30 minute visit for your **Report of Findings** — 2 weeks after your Progress Evaluation visit. (Allow 45 minutes in the office.)
- ☑ Complete and return to us the **Progress Evaluation #3 questionnaire** at least **48 hours** before your Progress Evaluation visit. (*See the following page for more information and instructions.*)

### On the day of your Progress Evaluation visit

- When you arrive at our office, please check in with our receptionist, then proceed to our restroom to **leave a urine sample**. One of our staff will then direct you to an exam room to get ready for the visit (changing into a gown, etc.)
- **Fasting blood draw:** Please do not consume any food or drink except water for at least 10 hours prior to coming in. **Drinking plenty of water** helps make the blood draw easier. Remember to take your usual early morning medications before coming in.
- **Body composition analysis:** For best results on this exam and during the 24 hours prior to it:
  1. Drink at least 6-8 glasses of water.
  2. Avoid alcohol and caffeine consumption.
  3. Avoid solid foods for at least 4 hours prior to the exam.
  4. On the day of the exam, do not exercise.
- Please remove nail polish so the doctor can evaluate your nails during the exam. If you do not wish to remove your fingernail polish, please remove polish from at least one big toenail.



## Progress Evaluation #3 Questionnaire

### What to know about the Progress Evaluation questionnaire

This questionnaire is to help you assess your own health progress so far. Getting your feedback is an important part of refining your treatment plan to best meet your needs and health goals. We will evaluate your progress using your questionnaire along with results from nutritional and hormonal exams, consultation, and lab tests. After your **Progress Evaluation** and **Report of Findings** visits, we will get you started on **your new Health Maintenance Treatment Plan**, designed to get the best results for you now.

- Please complete ALL pages of this questionnaire **based on the last few months while you've been in treatment with us** (we'll compare this Progress Evaluation questionnaire with the ones you completed earlier).
- Follow the instructions on each page, and answer questions **based on the BEST your body was able to feel during the last few months** (i.e., a good day).
- Include your name and date on **every** page.
- **Please return your completed form to us at least 48 HOURS before your Progress Evaluation visit.**

### How to complete and return this questionnaire to us

1. Complete this form using Microsoft Word. Save the file with a new filename that includes **your name** (e.g., "*WatersEdge-Progress-Evaluation3-MarySmith.doc*").  
(NOTE: Please leave the document in MSWord *.doc* format; do not convert it to another format such as HTML.)
2. Return the form to us by mail to: **3131 Elliott Ave, Suite 740, Seattle, WA 98121**  
or by fax: **206-283-1924**

**NOTE: \*\*Please be sure to mail it at least 5 days before your appointment so we receive it 48 hours in advance.**

If you have any questions, please call us at **206. 283. 1383**. Thank you and we look forward to seeing you again!

**Progress Evaluation #3 Questionnaire**

Name \_\_\_\_\_ Date \_\_\_\_\_

**Current Health Condition**

(Please list your present health problems and concerns.)

Problem or Concern	Date of Onset
1.	
2.	
3.	
4.	
5.	

**1. For your care at this office to be a huge success for you, what do you see happening over the next 3 months, 6 months, 12 months?**

**2. What has improved with your health and well being since you began treatment with us?**

**3. What has not improved? Has anything gotten worse?**

**4. Which foods cause you any stress? List items and what reactions.**

**5. Please update the information on allergies, hospitalization, surgeries, serious injuries since your last report (dates and types of illness or operation):**


6. What behavior and lifestyle habits do you need to change in order to improve your health? CHECK the one(s) that is the most important to change.

<input type="checkbox"/>	Exercise	<input type="checkbox"/>	Proper sleep and rest	<input type="checkbox"/>	Diet and nutrition
<input type="checkbox"/>	Stress management	<input type="checkbox"/>	Mental Attitude	<input type="checkbox"/>	Smoking
<input type="checkbox"/>	Recreational drugs	<input type="checkbox"/>	Alcohol	<input type="checkbox"/>	Medications
<input type="checkbox"/>	Unhealthy occupation	<input type="checkbox"/>	Other: _____	<input type="checkbox"/>	Other: _____

7. What do you think is your doctor's responsibility in your health care?

8. What is your degree of responsibility for your own health?

9. What is your current level of commitment to learn and adopt habits to improve your health?

(Rate on a scale of 1 to 10):                      **LOW ← 1 2 3 4 5 6 7 8 9 10 → HIGH**

If your level of commitment is low, what do you think it would take to raise it?

10. What specifically would you like to focus on during your Health Rebuilding Phase?

**Health Data**  
(Please fill in completely)

Exam	Date	Result	Due	Screening Recommendations
Last Pap Smear/Gynecologic Exam				Yearly starting after first intercourse or age 21
Mammogram				Yearly starting at age 40
Bone Density Test (DEXA)				Every 2 years starting at age 50
Colonoscopy				Every 10 years starting at age 50
Prostate or Testicular Exam				Yearly for men starting at age 40
Other	Date	Location	Result	
Physical Exam				
Foreign Travel History & Immunizations				
Tuberculosis (TB) skin test				
Diagnostic Imaging (X-Ray, Ultrasound, MRI, CT, Angiogram, etc.)				



## Health Update

Please CHECK any of the following that you **currently have** or **have had in the past month**.

General	Gastrointestinal	Eye/Ear/Nose/Throat	Cardiovascular
<input type="checkbox"/> Chills <input type="checkbox"/> Depression <input type="checkbox"/> Dizziness <input type="checkbox"/> Fainting <input type="checkbox"/> Fever <input type="checkbox"/> Forgetfulness <input type="checkbox"/> Headache <input type="checkbox"/> Loss of sleep <input type="checkbox"/> Nervousness <input type="checkbox"/> Numbness <input type="checkbox"/> Sweats	<input type="checkbox"/> Poor Appetite <input type="checkbox"/> Bloating <input type="checkbox"/> Bowel changes <input type="checkbox"/> Constipation <1 stool/day <input type="checkbox"/> Diarrhea <input type="checkbox"/> Excessive hunger <input type="checkbox"/> Excessive thirst <input type="checkbox"/> Gas <input type="checkbox"/> Hemorrhoids <input type="checkbox"/> Indigestion <input type="checkbox"/> Nausea <input type="checkbox"/> Rectal bleeding <input type="checkbox"/> Stomach pain <input type="checkbox"/> Vomiting <input type="checkbox"/> Vomiting blood <input type="checkbox"/> Parasites	<input type="checkbox"/> Bleeding gums <input type="checkbox"/> Blurred vision <input type="checkbox"/> Crosses eyes <input type="checkbox"/> Difficulty of swallowing <input type="checkbox"/> Double vision <input type="checkbox"/> Ear ache <input type="checkbox"/> Ear discharge <input type="checkbox"/> Hay fever <input type="checkbox"/> Hoarseness <input type="checkbox"/> Loss of hearing <input type="checkbox"/> Nosebleeds <input type="checkbox"/> Ringing in the ears <input type="checkbox"/> Sinus infections <input type="checkbox"/> Vision "flashes" <input type="checkbox"/> Vision "halos"	<input type="checkbox"/> Chest pain/pressure <input type="checkbox"/> High blood pressure <input type="checkbox"/> Irregular heart beats <input type="checkbox"/> Low blood pressure <input type="checkbox"/> Poor circulation <input type="checkbox"/> Rapid heart beat <input type="checkbox"/> Varicose veins <input type="checkbox"/> Edema

Respiratory	Skin	Muscle/Joint/Bone	Genito-Urinary
<input type="checkbox"/> Shortness of breath <input type="checkbox"/> Persistent cough <input type="checkbox"/> Wheezing <input type="checkbox"/> Cough with blood	<input type="checkbox"/> Acne <input type="checkbox"/> Bruise easily <input type="checkbox"/> Itching <input type="checkbox"/> Change in mole(s) <input type="checkbox"/> Rash <input type="checkbox"/> Scars <input type="checkbox"/> Sore that won't heal	Pain, weakness, numbness in: <input type="checkbox"/> Arms <input type="checkbox"/> Back <input type="checkbox"/> Feet <input type="checkbox"/> Hands <input type="checkbox"/> Hips <input type="checkbox"/> Legs <input type="checkbox"/> Neck <input type="checkbox"/> Shoulders <input type="checkbox"/> Loss of height	<input type="checkbox"/> Blood in the urine <input type="checkbox"/> Frequent urination <input type="checkbox"/> Lack of bladder control <input type="checkbox"/> Painful urination

## Vitality Survey

Scoring: Never —0 Seldom — 1 Occasionally —2 Often —3 Very Often —4

How often do you...	Score
Lose your sense of humor/take life too seriously?	
Experience doubt or indecision?	
Experience worry and anxiety?	
Feel over-cautious or pessimistic?	
Lack self confidence or feel low self-esteem? -	
Experience stress or feel nervous or tense?	
Feel irritable or oversensitive?	
Experience difficulty concentrating and loss of clear thought?	
Experience inadequate energy (fatigue)?	
Have coffee, tea, tobacco, sugar or other stimulants as a pick up?	
Experience nervous indigestion?	
Experience loss of sex drive?	
Experience difficulty sleeping?	
Experience difficulty getting up in the morning?	
Feel run down?	
Feel depressed?	
Feel like crying for no reason?	
Find it difficult to sit quietly (without fidgeting, talking, reading, watching TV, etc.)?	
Find it difficult to express your feelings?	
Experience rapid heart beat or panic? -.	
Feel moody?	
Feel suicidal or wonder whether life is worth living?	
Have anxiety about not having enough money?	
Fear ill health?	
Fear criticism?	
Fear loss of love?	
Fear old age or death?	
Feel "something is the matter with me" but don't know what?	
Think that you might be going crazy (losing it)?	
<b>TOTAL SCORE:</b>	

0 — 30 POINTS = Powerful Nerve Force HIGH VITALITY 31— 45 POINTS = Strong Nerve Force GOOD VITALITY 46 — 60 POINTS = Moderate Nerve Force AVERAGE VITALITY 61 — 75 POINTS = Low Nerve Force LOW VITALITY	76 — 90 POINTS = Nervous Fatigue NERVOUS FATIGUE 91 — 105 POINTS = Nervous Depletion NERVOUS EXHAUSTION 106 — 120 POINTS = Serious Nervous Exhaustion SEVERE BURNOUT
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## Female Hormone Imbalance Rating

Please rate the severity of the symptom(s) or condition **if it's present** by rating it on a **Wellness Gauge Scale 0 to 10** when **0 = symptom is not present ☺** and **10 = symptom is severe ☹**

Abdominal pain	Fibroids	Mood swings
Allergies	Fluid retention	Night sweats
Anger easily	Food cravings/binge eating	Ovarian cyst(s)
Back pain	Heavy menstrual bleeding	PMS
Bloating	Vaginal dryness	Rheumatoid arthritis
Chronic stress	Hot flashes	Skin problems
Depression	Insomnia	Spotting
Disinterest in sex/low sex drive	Irregular menstrual cycle	Subfertility
Endometriosis	Irritable or anxious	Other:
Fatigue	Meat eater (rate frequency)	
Fibrocystic breast disease	Menstrual migraines	
<b>TOTAL SCORE:</b>		

**Past or Present Condition (0 = none, 10 = yes)**

Ovarian Cancer	Infertility (never able to conceive)
Uterine Cancer	Loss of height/ bone loss
Cervical Cancer	Miscarriage
Breast Cancer	Premature menopause (<45 yrs old)
Estrogen/Progesterone sensitive Cancer	Pain with intercourse
<b>TOTAL SCORE:</b>	
<b>GRAND TOTAL SCORE:</b>	

<p><b>Are you completely satisfied with your sexual experience:</b> Yes ____ No ____</p>
<p>Please explain:</p>



## Men Only

	Yes	No		Yes	No
Breast lump			DES – did your mother take it during pregnancy?		
Lump in testicle			Date of last genital exam:		
Penis discharge			Date of last prostate exam:		
Sore on the penis			Date of last PSA test:	Result:	
Erection difficulties					

## Male Hormone Imbalance Rating

Please rate the severity of the symptom(s) or condition **when it's present** by rating it on a **Wellness Gauge Scale 0 to 10**, when **0= symptom is not present ☺**, **10= symptom is severe ☹**

Abdominal pain	Thinning armpit, head, pubic hair	Urine flow dribbling at the end
Joint pain/Stiffness	Skin problems/dryness	Blood in urine
Anger easily	Excessive sweating (day or night)	Urinary incontinence
Back pain	Mood swings	Pain with urination
Rheumatoid arthritis	Lack interest in leisure/social activities	Pain with ejaculation
Chronic stress	Low stamina	Bloody ejaculation
Depression	Difficulty obtaining erection	Pain with intercourse
Disinterest in sex/low sex drive	Difficulty maintaining erection	Unable to conceive (subfertility)
Erectile dysfunction	Pain with erection	Mass in genital organs
Fatigue	Lack of nocturnal erections	Heavy drinking (past/ present)
Insomnia	Lack of morning erections	Frequent urination
Irritable or anxious	Urine flow slow to start	Other:
Food cravings/binge eating	Weak urine stream	
Breast enlargement	Unable to void bladder completely	
<b>TOTAL SCORE:</b>		

### Past or Present Condition (0 = none, 10 = yes)

History of mumps infection	Infertility (never able to conceive)
History of mass in genitalia	Loss of height/bone loss
History of testicular/scrotal surgery	Cancer: (list type)
Developmental issues w/sex organs	Other:
Family history of prostate cancer	<b>TOTAL SCORE:</b>
<b>GRAND TOTAL SCORE:</b>	