

True Health Center

New Patient Assessment

Last Name:	First:	Date:
Gender: (F) (M)	Age:	Chart #
Vitals / Metrics (Office Use)		
BP :	HR:	02: Walking 02:
A1C Test Score:	V02 CPX Score:	Weight: BMI:

Chief Complaint Assessment	
CC:	Onset:
Location:	Severity:
Duration:	Quality:
Modifying Factors:	Associated S&S:

Review Health / Risk Metrics	
<input type="checkbox"/> V02 Cardiopulmonary Test Score _____ () Not Tested <input type="checkbox"/> Poor Cardiorespiratory Health / Fitness <input type="checkbox"/> Activity level below AHA Recommendations <input type="checkbox"/> Diagnosed with Hypertension () On meds () Betablockers <input type="checkbox"/> Diagnosed High Cholesterol / Statins <input type="checkbox"/> Pre-Diabetic or Diabetic - A1C _____ Glucose _____ <input type="checkbox"/> Diagnosed CAD or has had CVE <input type="checkbox"/> Body Composition Scan and Risk <input type="checkbox"/> Family Hx. (BP) (HLD) (T2DM) (CAD / CVE) (COPD)	<input type="checkbox"/> Obesity <input type="checkbox"/> BMI is 30.0 to 34.9. (Moderate Risk) <input type="checkbox"/> BMI is 35.0 to 39.9 (High Risk) <input type="checkbox"/> Weakness / Frailty / Poor Energy <input type="checkbox"/> COPD / Asthma / Chronic Bronchitis / Emphysema <input type="checkbox"/> Chronic Pain limiting activity <input type="checkbox"/> Shortness of Breath / Ankle Swelling <input type="checkbox"/> Smoking <input type="checkbox"/> Poor Sleep / Sleep Apnea

--	--

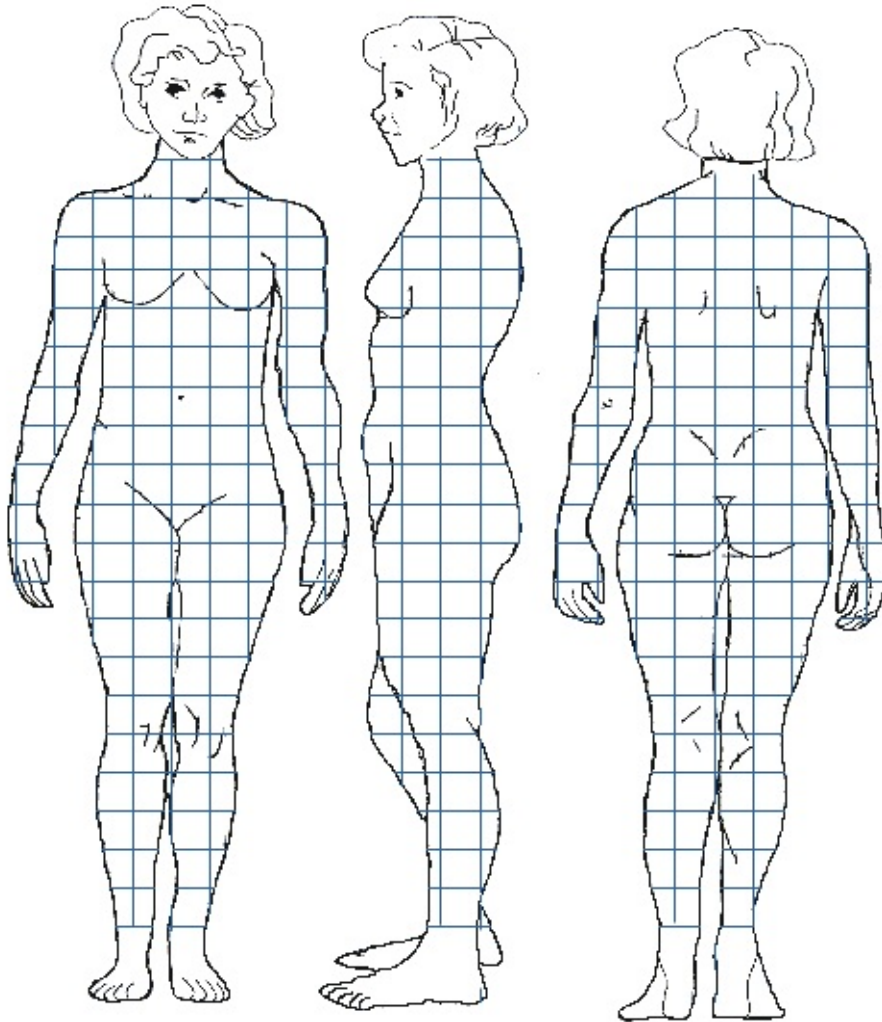
Global Self Reporting Health Categories												
<input type="checkbox"/> Stress Level -----	Low	1	2	3	4	5	6	7	8	9	10	High
<input type="checkbox"/> Anxiety / Depression -----	Low	1	2	3	4	5	6	7	8	9	10	High
<input type="checkbox"/> Physical Mobility and Activity -----	Poor	1	2	3	4	5	6	7	8	9	10	Good
<input type="checkbox"/> I feel Physical Health Status is: -----	(Very Poor)	(Poor)	(Fair)	(Good)	(Very Good)							
<input type="checkbox"/> Physical Well-being - (Energy - Digestion - Sleep - How you feel) -----	Poor	1	2	3	4	5	6	7	8	9	10	Good
<input type="checkbox"/> Personal Relationships (Spouse / Mate / Children / Friends / etc.)-----	Poor	1	2	3	4	5	6	7	8	9	10	Good
<input type="checkbox"/> Emotional Well-being (Loneliness - Confusion - Hurt - Hopeless - Etc.)-	Poor	1	2	3	4	5	6	7	8	9	10	Good

LEVEL OF PHYSICAL ACTIVITY <input type="checkbox"/> Sedentary - Desk/Seated Job - No Regular Exercise <input type="checkbox"/> Lite Activity - Walk 2-3x week - Total time 90+ mins <input type="checkbox"/> Active - Work Manual Job 40+ hours week <input type="checkbox"/> Moderate Activity - Aerobic Exercise 3x wk 150+ mins <input type="checkbox"/> High Activity - Aerobic / Anaerobic - 300+ mins week <input type="checkbox"/> Athlete - Regular Intense Vigorous Training	NOTES: Other Relevant Factors
--	--------------------------------------

True Health Center New Patient Treatment Plan

Physical Exam

Notes:



EXAM CHECKLIST

CERVICAL / THORACIC (Focal)

- C1 - C2 - C3 - C4 - C5 - C6
- C7 - T1 - T2 - T3 - T4 - T5
- T6 - T7 - T8 - T9 - T11 - T12
- (Caps) (Lev.Scap) (Up Trap) (Scalene)

LUMBOSACRAL (Focal Areas)

- Lumbar Muscles
- Focus (Left) (Right) (Bilateral)
- T12 - L1 - L2 - L3 - L4 - L5
- S1 - S2 - S3 - S4 - Coccyx
- L SI Joint - R SI Joint
- Glut Origins at SI (R) (L)
- Back Mice (R) (L) (B)
- Gluts (Min.) (Med.) (Max.)
- Hip Bursitis (R) (L) (B)
- QL Strain

SHOULDER (R) (L) (B)

- Strain Deltoid (Ant.) (Post) (Lat)
- Strain Infraspinatus / Teres
- Bicep Ten. Long / Bicep Tendon Short
- AC Joint / Acromion / Clavicle /

TENTATIVE DIAGNOSIS:

1. _____

2. _____