Member Satisfaction Evaluation

Member:_____ Date:____/____/____

PRIMARY CONCERNS:	Choose the intensity of this concern.
Back Problems	(Lo) 1: 2: 3: 4: 5: (Hi)
Chronic Health Conditions Allergies, headaches, heart, blood pressure, lupus, etc.	(Lo) 1: 2: 3: 4: 5: (Hi)
Stress Reduction	(Lo) 1: 2: 3: 4: 5: (Hi)
Body Tone, Strength, Flexibility, Rehab	(Lo) 1: 2: 3: 4: 5: (Hi)
Weight Loss	(Lo) 1: 2: 3: 4: 5: (Hi)

1. How long have you had each of these concerns? _____

_____

2. Was there an event that caused this? _____

_____

3. What are your main symptoms? _____

_____

_____

4. What else have you done to address this? _____

_____

5. What are your 3 main goals? 1) _____

2) _____

3) _____

Office Use Only

Classes: a) type: _____ , _____ dys/wk b) type: _____ , _____ dys/wk

Comments _____

Cardio: _____ days/wk _____ minutes type: _____

Weights: _____ days/wk _____ minutes written routine: Yes No

1. Goals: _____

2. _____

3. _____

Comments _____

More 0-0? Other service? _____