## Return Visit Update Sheet

Name _____ Date _____

1. Since your last visit, list any improvements you have felt:

2. Please list any condition that has stayed the same or gotten worse:

3. Please list anything else you'd like to address today:

4. Please list all current remedies, supplements or medications you take:

5. Are all electromagnetic fields far enough from your bed? (circle one) **YES** **NO**
6. Are you turning off your wireless router at night? (circle one)
   ALWAYS NEVER SOMETIMES YES, BUT I LIVE IN AN APT COMPLEX

7. What percentage of the time have you taken your remedies or supplements?
8. How many glasses of water are you averaging per day?

9. How many bowel movements do you have per day? Per week?

10. How many hours of sleep are you averaging per night?

11. Do you exercise regularly? How often? What type?

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