Full Circle Center for Integrative Medicine
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FEEDBACK SHEET FOR HEALING GROUP

Name:_____ Date: ____/____/____

1) Please review your medication list and indicate any changes you have you made in your medications, supplements, or over the counter meds since the last group (i.e. stopped any, increased any, decreased any, added new ones).

_____

_____

What refills do you need today? _____

2) Have you had any injuries, events in your personal life, any nerve blocks, physical therapy, other treatments, exercise, etc. since our last group that made your pain worse or better? ☐ Yes ☐ No
If yes, please give details._____

_____

3) Over the past 2 weeks has your pain level:
☐ Decreased ☐ Stayed the Same ☐ Increased ☐ All over the place
What changes have you noticed? Please be as specific as you can:_____

_____

4) Rate your average pain score for the past 2 weeks:
NO PAIN 1 2 3 4 5 6 7 8 9 10 VERY SEVERE PAIN

5) Rate your pain score today:
NO PAIN 1 2 3 4 5 6 7 8 9 10 VERY SEVERE PAIN

6) Over the past 2 weeks has your emotional state:
☐ Decreased ☐ Stayed the Same ☐ Increased ☐ All over the place
What changes have you noticed? Please be as specific as you can:_____

_____

7) Rate your average mood for the past 2 weeks:
VERY SAD 1 2 3 4 5 6 7 8 9 10 VERY HAPPY

8) Do you address special nutritional needs as part of your healing plan? ☐ Yes ☐ No If yes, what nutritional goals are you addressing? _____

_____

9) For how long and how often did you do physical exercise in the past 2 weeks?
☐ Aerobic Time _____ How often? _____
☐ Stretching Time _____ How often? _____
☐ Strengthening Time _____ How often? _____

10) Did you meditate? ☐ Yes ☐ No How long? _____ How often?_____

11) Did you use other relaxation techniques or mini relaxation response exercises? ☐ Yes ☐ No
What did you do? _____ How often?_____

12) What goal did you set last time? _____
Did you accomplish it? ☐ Yes ☐ No If no, can you come up with a plan to help you succeed by identifying the obstacle and a solution to the obstacle?

Obstacle	Solution
_____	_____

FUNCTIONAL IMPACT OF PAIN

13) Did you miss social events, work, or other appointments this month because of your health?
☐ Yes ☐ No What did you miss and why? _____

14) Indicate the word that describes how, during the past 24 hours, pain has interfered with your:

General activity	☐ Not at all	☐ Some	☐ Often	☐ Completely
Mood	☐ Not at all	☐ Some	☐ Often	☐ Completely
Ability to work (in or out of home)	☐ Not at all	☐ Some	☐ Often	☐ Completely
Interactions with other people	☐ Not at all	☐ Some	☐ Often	☐ Completely
Sleep	☐ Not at all	☐ Some	☐ Often	☐ Completely
Enjoyment of life	☐ Not at all	☐ Some	☐ Often	☐ Completely

15) What did you do for fun or pleasure this month? Or what gave you pleasure this month?_____
_____

16) Have you used any recreational drugs this month? _____

17) How many drinks of alcohol did you drink this week? _____ What kind? _____

18) How many cigarettes did you smoke this week? _____

19) How much caffeine did you drink this past week? _____ What kind? _____

20) How much candy, soda, or other sweets did you eat this past week? _____

21) The following could be medication side effects or from your underlying condition. Are you feeling/experiencing:

Symptom(s): Check box if present	**Medication(s) or other condition(s) you think caused it:**	**How did you deal with it:**	**Do you want suggestions?**
☐ Constipation:			☐ Yes ☐ No
☐ Difficulty sleeping:			☐ Yes ☐ No
☐ Dizzy, dopey:			☐ Yes ☐ No
☐ Nausea/vomiting:			☐ Yes ☐ No
☐ Difficulty waking in the morning:			☐ Yes ☐ No
☐ Loss of libido:			☐ Yes ☐ No

22) Any other physical complaints or questions you'd like your physician to respond to_____
_____
_____
_____

Can this be discussed in group? ☐ Yes ☐ No *If no, please ask physician if you should make an appointment.*
23) Any feedback or suggestions you would like to share with the staff? _____
_____