

Select Health
15720 Brixham Hill Ave.,
#130 Charlotte, NC 28277
704-541-5555

Patient Feedback and Functional Self-Assessment

PATIENT NAME: DAVID [REDACTED]

Date of Birth: [REDACTED] 11/19/55

Overall, was your experience at Select Health? Positive Negative

How would you rate Select Health? (please circle one)

1 2 3 4 5

TERRIBLE OK GOOD GREAT EXCELLENT

Please Tell Us About:

Cleanliness of the Office:	<input checked="" type="radio"/> 5-Excellent	4-Great	3-Good	2-Okay	1-Terrible
Check-In Process/Wait	<input checked="" type="radio"/> 5-Excellent	4-Great	3-Good	2-Okay	1-Terrible
Time: Courtesy of Staff:	<input checked="" type="radio"/> 5-Excellent	4-Great	3-Good	2-Okay	1-Terrible
Courtesy of Physician:	<input checked="" type="radio"/> 5-Excellent	4-Great	3-Good	2-Okay	1-Terrible
Ease of Traveling to Office:	<input checked="" type="radio"/> 5-Excellent	4-Great	3-Good	2-Okay	1-Terrible

Functional Self-Assessment:

Thinking **ONLY** about the symptoms for which you **treated in OUR office...**
Please circle any of the functions below that you struggle to perform:

- | | | |
|--------------|--------------------------|---------------------------------|
| Sitting | Doing Desk/Computer Work | Getting to sleep-Staying asleep |
| Sit to Stand | Driving | Exercising-Playing sports |
| Standing | Lifting | House work-Yard work |
| Walking | Getting Dressed | Climbing stairs |
| Running | Sexual Activity | Other _____ |
| Pushing | Rolling Over | _____ |

In summary, tell us how Select Health has improved your quality of function (quality of life):

SYMPTOMS OF BURNING HOT FEET IMPROVED ALOT (REDUCTION TO MUCH LOWER NUMBERS). STILL HAVE SOME NUMBNESS ON LEFT HEEL.

By signing this document, I certify that the above statements are true, and accurately reflect my opinions of Select Health and my functional self-assessment. I hereby authorize Select Health to publish this document, or any portion of my protected health information, in any media, website, venue, court, or publication necessary to defend the treatment plan and/or my reputation of Select Health and the integrity of the Doctor. I also give Select Health permission to use the statements I made on this document for any marketing, advertising, or promotional purposes they choose, on-line or off-line, in any media.

Patient/Guardian Signature X David [REDACTED]

Today's Date 3/12/26

Provider: [Signature]

Select Health
15720 Brixham Hill Ave.,
#130 Charlotte, NC 28277
704-541-5555

Patient Feedback and
Functional Self-Assessment

PATIENT NAME: WAYNE [REDACTED]

Date of Birth: [REDACTED] 1937

Overall, was your experience at Select Health? Positive Negative

How would you rate Select Health? (please circle one)



Please Tell Us About:

Cleanliness of the Office:	<u>5-Excellent</u>	4-Great	3-Good	2-Okay	1-Terrible
Check-In Process/Wait	<u>5-Excellent</u>	4-Great	3-Good	2-Okay	1-Terrible
Time: Courtesy of Staff:	<u>5-Excellent</u>	4-Great	3-Good	2-Okay	1-Terrible
Courtesy of Physician:	<u>5-Excellent</u>	4-Great	3-Good	2-Okay	1-Terrible
Ease of Traveling to Office:	<u>5-Excellent</u>	4-Great	3-Good	2-Okay	1-Terrible

Functional Self-Assessment:

Thinking ONLY about the symptoms for which you treated in OUR office...
Please circle any of the functions below that you struggle to perform:

- | | | |
|---------------------|--------------------------|---------------------------------|
| <u>Sitting</u> | Doing Desk/Computer Work | Getting to sleep-Staying asleep |
| <u>Sit to Stand</u> | Driving | Exercising-Playing sports |
| <u>Standing</u> | Lifting | House work-Yard work |
| <u>Walking</u> | Getting Dressed | <u>Climbing stairs</u> |
| Running | Sexual Activity | Other _____ |
| Pushing | Rolling Over | _____ |

In summary, tell us how Select Health has improved your quality of function (quality of life):

NEUROPATHY IN LEGS SHOWS DEFINITE IMPROVEMENT.
CAN STAND MUCH LONGER WITHOUT LEG PAIN
CAN WALK WITH MORE STABILITY

By signing this document, I certify that the above statements are true, and accurately reflect my opinions of Select Health and my functional self-assessment. I hereby authorize Select Health to publish this document, or any portion of my protected health information, in any media, website, venue, court, or publication necessary to defend the treatment plan and/or my reputation of Select Health and the integrity of the Doctor. I also give Select Health permission to use the statements I made on this document for any marketing, advertising, or promotional purposes they choose, on-line or off-line, in any media.

Patient/Guardian Signature X Wayne [REDACTED]

Today's Date 3/12/26

Provider: [Signature]

Select Health
15720 Brixham Hill Ave.,
#130 Charlotte, NC 28277
704-541-5555






Patient Feedback and Functional Self-Assessment

PATIENT NAME: LISA C [REDACTED]

Date of Birth: [REDACTED] 1962

Overall, was your experience at Select Health? Positive Negative

How would you rate Select Health? (please circle one)

				
TERRIBLE	OK	GOOD	GREAT	EXCELLENT

Please Tell Us About:

Cleanliness of the Office:	<u>5-Excellent</u>	4-Great	3-Good	2-Okay	1-Terrible
Check-In Process/Wait	<u>5-Excellent</u>	4-Great	3-Good	2-Okay	1-Terrible
Time: Courtesy of Staff:	<u>5-Excellent</u>	4-Great	3-Good	2-Okay	1-Terrible
Courtesy of Physician:	<u>5-Excellent</u>	4-Great	3-Good	2-Okay	1-Terrible
Ease of Traveling to Office:	5-Excellent	<u>4-Great</u>	3-Good	2-Okay	1-Terrible

Functional Self-Assessment:

Thinking **ONLY** about the symptoms for which you treated in OUR office...
Please circle any of the functions below that you struggle to perform:

Sitting	Doing Desk/Computer Work	Getting to sleep-Staying asleep
Sit to Stand	Driving	Exercising-Playing sports
Standing	Lifting	House work-Yard work
<u>Walking</u>	Getting Dressed	<u>Climbing stairs</u>
<u>Running</u>	Sexual Activity	Other _____
Pushing	Rolling Over	_____

In summary, tell us how Select Health has improved your quality of function (quality of life):

Great improvement - definitely
benefitted from treatments

By signing this document, I certify that the above statements are true, and accurately reflect my opinions of Select Health and my functional self-assessment. I hereby authorize Select Health to publish this document, or any portion of my protected health information, in any media, website, venue, court, or publication necessary to defend the treatment plan and/or my reputation of Select Health and the integrity of the Doctor. I also give Select Health permission to use the statements I made on this document for any marketing, advertising, or promotional purposes they choose, on-line or off-line, in any media.

Patient/Guardian Signature X [Signature]

Today's Date [REDACTED] 2026

Provider: [Signature]

Select Health
15720 Brixham Hill Ave.,
#130 Charlotte, NC 28277
704-541-5555

Patient Feedback and Functional Self-Assessment

PATIENT NAME: Cortina [Redacted]

Date of Birth: [Redacted]

Overall, was your experience at Select Health? Positive Negative

How would you rate Select Health? (please circle one)

★ TERRIBLE ★ OK ★ GOOD ★ GREAT ★ EXCELLENT

Please Tell Us About:

Cleanliness of the Office:	5-Excellent	4-Great	3-Good	2-Okay	1-Terrible
Check-In Process/Wait	5-Excellent	4-Great	3-Good	2-Okay	1-Terrible
Time: Courtesy of Staff:	5-Excellent	4-Great	3-Good	2-Okay	1-Terrible
Courtesy of Physician:	5-Excellent	4-Great	3-Good	2-Okay	1-Terrible
Ease of Traveling to Office:	5-Excellent	4-Great	3-Good	2-Okay	1-Terrible

45 minute commute, 4.5 But 50000 worth it!!!!!!

Functional Self-Assessment:

Thinking ONLY about the symptoms for which you treated in OUR office...
Please circle any of the functions below that you struggle to perform:

- Sitting
- Sit to Stand
- Lifting
- Getting Dressed
- Rolling Over
- Housework or
- Yardwork Walking
- Driving
- Standing
- Climbing Stairs
- Pushing
- Sleeping
- Doing Desk/Computer
- Work Sexual Activity
- Running
- Playing Sports/Exercise
- Other
- None of These

In summary, tell us how Select Health has improved your quality of function (quality of life):

Hearing about neuropathy and KNOWING/EXPERIENCING neuropathy are TWO TOTALLY DIFFERENT things! I am forever grateful that God allowed me to find Select Health. I walked 13 miles yesterday in honor and memory of my daughter.

By signing this document, I certify that the above statements are true, and accurately reflect my opinions of Select Health and because my functional self-assessment. I hereby authorize Select Health to publish this document, or any portion of my protected health information, in any media, website, venue, court, or publication necessary to defend the treatment plan and/or my reputation of success of the Select Health and the integrity of the Doctor. I also give Select Health permission to use the statements I made on this document of the treatments I received here. Showing loud and proud. "Blessed to be a Select patient!"

SCANNED

Patient/Guardian Signature X [Signature]

Today's Date 12/18/24 Health patient!!

Provider: [Signature]

BTW: My feet were absolutely fine; but, my knee and calves are singing another song!
#grateful4selecthealth






Select Health
15720 Brixham Hill Ave.,
#130 Charlotte, NC 28277
704-541-5555

Patient Feedback and Functional Self-Assessment

PATIENT NAME: Sheila  Date of Birth: 8 / 21 / 25

Overall, was your experience at Select Health? Positive Negative

How would you rate Select Health? (please circle one)

TERRIBLE OK GOOD GREAT EXCELLENT

Please Tell Us About:

Cleanliness of the Office:	<u>5-Excellent</u>	4-Great	3-Good	2-Okay	1-Terrible
Check-In Process/Wait	<u>5-Excellent</u>	4-Great	3-Good	2-Okay	1-Terrible
Time: Courtesy of Staff:	<u>5-Excellent</u>	4-Great	3-Good	2-Okay	1-Terrible
Courtesy of Physician:	<u>5-Excellent</u>	4-Great	3-Good	2-Okay	1-Terrible
Ease of Traveling to Office:	5-Excellent	<u>4-Great</u>	3-Good	2-Okay	1-Terrible

Functional Self-Assessment:

Thinking **ONLY** about the symptoms for which you **treated in OUR office...**
Please circle any of the functions below that you **struggle** to perform:

- | | | |
|---------------------|--------------------------|---------------------------------|
| <u>Sitting</u> | Doing Desk/Computer Work | Getting to sleep-Staying asleep |
| <u>Sit to Stand</u> | Driving | Exercising-Playing sports |
| Standing | Lifting | House work-Yard work |
| Walking | Getting Dressed | <u>Climbing stairs</u> |
| Running | Sexual Activity | Other _____ |
| Pushing | <u>Rolling Over</u> | _____ |

In summary, tell us how Select Health has improved your quality of function (quality of life):
The pain has greatly decreased. Inflammation is basically gone (I can feel it in my clothes . they have become looser)

By signing this document, I certify that the above statements are true, and accurately reflect my opinions of Select Health and my functional self-assessment. I hereby authorize Select Health to publish this document, or any portion of my protected health information, in any media, website, venue, court, or publication necessary to defend the treatment plan and/or my reputation of Select Health and the integrity of the Doctor. I also give Select Health permission to use the statements I made on this document for any marketing, advertising, or promotional purposes they choose, on-line or off-line, in any media.

Patient/Guardian Signature X Sheila  Today's Date 8 / 21 / 25

Provider: Shapiro DC






Select Health
15720 Brixham Hill Ave.,
#130 Charlotte, NC 28277
704-541-5555

Patient Feedback and Functional Self-Assessment

PATIENT NAME: Sheila  Date of Birth: 8 / 21 / 25

Overall, was your experience at Select Health? Positive Negative

How would you rate Select Health? (please circle one)

TERRIBLE OK GOOD GREAT EXCELLENT

Please Tell Us About:

Cleanliness of the Office:	<u>5-Excellent</u>	4-Great	3-Good	2-Okay	1-Terrible
Check-In Process/Wait	<u>5-Excellent</u>	4-Great	3-Good	2-Okay	1-Terrible
Time: Courtesy of Staff:	<u>5-Excellent</u>	4-Great	3-Good	2-Okay	1-Terrible
Courtesy of Physician:	<u>5-Excellent</u>	4-Great	3-Good	2-Okay	1-Terrible
Ease of Traveling to Office:	5-Excellent	<u>4-Great</u>	3-Good	2-Okay	1-Terrible

Functional Self-Assessment:

Thinking **ONLY** about the symptoms for which you **treated in OUR office...**
Please circle any of the functions below that you **struggle** to perform:

- | | | |
|---------------------|--------------------------|---------------------------------|
| <u>Sitting</u> | Doing Desk/Computer Work | Getting to sleep-Staying asleep |
| <u>Sit to Stand</u> | Driving | Exercising-Playing sports |
| Standing | Lifting | House work-Yard work |
| Walking | Getting Dressed | <u>Climbing stairs</u> |
| Running | Sexual Activity | Other _____ |
| Pushing | <u>Rolling Over</u> | _____ |

In summary, tell us how Select Health has improved your quality of function (quality of life):
The pain has greatly decreased. Inflammation is basically gone (I can feel it in my clothes. they have become looser)

By signing this document, I certify that the above statements are true, and accurately reflect my opinions of Select Health and my functional self-assessment. I hereby authorize Select Health to publish this document, or any portion of my protected health information, in any media, website, venue, court, or publication necessary to defend the treatment plan and/or my reputation of Select Health and the integrity of the Doctor. I also give Select Health permission to use the statements I made on this document for any marketing, advertising, or promotional purposes they choose, on-line or off-line, in any media.

Patient/Guardian Signature X Sheila  Today's Date 8 / 21 / 25

Provider: Shapiro DC

Select Health
15720 Brixham Hill Ave.,
#130 Charlotte, NC 28277
704-541-5555

Patient Feedback and Functional Self-Assessment

PATIENT NAME: Larry [Redacted]

Date of Birth: [Redacted] / [Redacted] / [Redacted]

Overall, was your experience at Select Health? Positive Negative

How would you rate Select Health? (please circle one)



Please Tell Us About:

Cleanliness of the Office:	<u>5</u> -Excellent	4-Great	3-Good	2-Okay	1-Terrible
Check-In Process/Wait Time:	<u>5</u> -Excellent	4-Great	3-Good	2-Okay	1-Terrible
Courtesy of Staff:	<u>5</u> -Excellent	4-Great	3-Good	2-Okay	1-Terrible
Courtesy of Physician:	<u>5</u> -Excellent	4-Great	3-Good	2-Okay	1-Terrible
Ease of Traveling to Office:	<u>5</u> -Excellent	4-Great	3-Good	2-Okay	1-Terrible

Functional Self-Assessment:

Circle any of the functions below that you struggle to perform:

- | | |
|-----------------------|--------------------------|
| Sitting | Climbing Stairs |
| Sit to Stand | Pushing |
| Lifting | <u>Sleeping</u> |
| Getting Dressed | Doing Desk/Computer Work |
| Rolling Over | Sexual Activity |
| Housework or Yardwork | Running |
| Walking | Playing Sports/Exercise |
| Driving | Other _____ |
| Standing | None of These |

In summary, tell us how Select Health has improved your quality of function (quality of life):

Nocepathy is much better

By signing this document, I certify that the above statements are true, and accurately reflect my opinions of Select Health and my functional self-assessment. I hereby authorize Select Health to publish this document, or any portion of my protected health information, in any media, website, venue, court, or publication necessary to defend the treatment plan and/or my reputation of Select Health and the integrity of the Doctor. I also give Select Health permission to use the statements I made on this document for any marketing, advertising, or promotional purposes they choose, on-line or off-line, in any media.

Patient/Guardian Signature [Redacted]

Today's Date 4/24/25

Provider: [Signature]

Select Health
15720 Brixham Hill Ave.,
#130 Charlotte, NC 28277
704-541-5555

Patient Feedback and
Functional Self-Assessment

PATIENT NAME: Susan B. [Redacted]

Date of Birth: [Redacted]

Overall, was your experience at Select Health? Positive Negative

How would you rate Select Health? (please circle one)



Please Tell Us About:

Cleanliness of the Office:	5	Excellent	4-Great	3-Good	2-Okay	1-Terrible
Check-In Process/Wait	5	Excellent	4-Great	3-Good	2-Okay	1-Terrible
Time: Courtesy of Staff:	5	Excellent	4-Great	3-Good	2-Okay	1-Terrible
Courtesy of Physician:	5	Excellent	4-Great	3-Good	2-Okay	1-Terrible
Ease of Traveling to Office:	5	Excellent	4-Great	3-Good	2-Okay	1-Terrible

Functional Self-Assessment:

Thinking **ONLY** about the symptoms for which you **treated in OUR office...**
Please circle any of the functions below that you struggle to perform:

- | | |
|------------------|-------------------------|
| Sitting | Climbing Stairs |
| Sit to Stand | Pushing |
| Lifting | Sleeping |
| Getting Dressed | Doing Desk/Computer |
| Rolling Over | Work Sexual Activity |
| Housework or | Running |
| Yardwork Walking | Playing Sports/Exercise |
| Driving | Other _____ |
| Standing | None of These |

In summary, tell us how Select Health has improved your quality of function (quality of life):

I can begin to feel my feet.

By signing this document, I certify that the above statements are true, and accurately reflect my opinions of Select Health and my functional self-assessment. I hereby authorize Select Health to publish this document, or any portion of my protected health information, in any media, website, venue, court, or publication necessary to defend the treatment plan and/or my reputation of Select Health and the integrity of the Doctor. I also give Select Health permission to use the statements I made on this document for any marketing, advertising, or promotional purposes they choose, on-line or off-line, in any media.

Patient/Guardian Signature X [Redacted]

Today's Date 1/27/25

Provider:

[Signature]

Select Health
15720 Brixham Hill Ave.,
#130 Charlotte, NC 28277
704-541-5555






Patient Feedback and Functional Self-Assessment

PATIENT NAME: Kathy B. [Redacted]

Date of Birth: [Redacted] / [Redacted] / [Redacted]

Overall, was your experience at Select Health? Positive Negative

How would you rate Select Health? (please circle one)

				
TERRIBLE	OK	GOOD	GREAT	EXCELLENT

Please Tell Us About:

Cleanliness of the Office:	<u>5</u> -Excellent	4-Great	3-Good	2-Okay	1-Terrible
Check-In Process/Wait	<u>5</u> -Excellent	4-Great	3-Good	2-Okay	1-Terrible
Time: Courtesy of Staff:	<u>5</u> -Excellent	4-Great	3-Good	2-Okay	1-Terrible
Courtesy of Physician:	<u>5</u> -Excellent	4-Great	3-Good	2-Okay	1-Terrible
Ease of Traveling to Office:	<u>5</u> -Excellent	4-Great	3-Good	2-Okay	1-Terrible

Functional Self-Assessment:

Thinking **ONLY** about the symptoms for **which you treated in OUR office...**
Please circle any of the functions below that you struggle to perform:

- | | |
|------------------|-------------------------|
| Sitting | Climbing Stairs |
| Sit to Stand | Pushing |
| Lifting | Sleeping |
| Getting Dressed | Doing Desk/Computer |
| Rolling Over | Work Sexual Activity |
| Housework or | Running |
| Yardwork Walking | Playing Sports/Exercise |
| Driving | Other _____ |
| Standing | <u>None of These</u> |

In summary, tell us how Select Health has improved your quality of function (quality of life):

My treatment was more for preventative as light cause of neuropathy. No significant impact to functional activities.

By signing this document, I certify that the above statements are true, and accurately reflect my opinions of Select Health and my functional self-assessment. I hereby authorize Select Health to publish this document, or any portion of my protected health information, in any media, website, venue, court, or publication necessary to defend the treatment plan and/or my reputation of Select Health and the integrity of the Doctor. I also give Select Health permission to use the statements I made on this document for any marketing, advertising, or promotional purposes they choose, on-line or off-line, in any media.

Patient/Guardian Signature X Kathy B. [Redacted]

Today's Date 1.28.25

Provider: [Signature]

Select Health
15720 Brixham Hill Ave.,
#130 Charlotte, NC 28277
704-541-5555

Patient Feedback and
Functional Self-Assessment

PATIENT NAME: Judith A. [REDACTED] Date of Birth: 1/1/19

Overall, was your experience at Select Health? Positive Negative

How would you rate Select Health? (please circle one)



Please Tell Us About:

Cleanliness of the Office:	<u>5-Excellent</u>	4-Great	3-Good	2-Okay	1-Terrible
Check-In Process/Wait	<u>5-Excellent</u>	4-Great	3-Good	2-Okay	1-Terrible
Time: Courtesy of Staff:	<u>5-Excellent</u>	4-Great	3-Good	2-Okay	1-Terrible
Courtesy of Physician:	<u>5-Excellent</u>	4-Great	3-Good	2-Okay	1-Terrible
Ease of Traveling to Office:	5-Excellent	4-Great	<u>3-Good</u>	2-Okay	1-Terrible

Functional Self-Assessment:

Thinking **ONLY** about the symptoms for which you **treated in OUR office...**
Please circle any of the functions below that you **struggle** to perform:

- | | |
|---------------------|-------------------------|
| Sitting | Climbing Stairs |
| Sit to Stand | Pushing |
| Lifting | <u>Sleeping</u> |
| Getting Dressed | Doing Desk/Computer |
| Rolling Over | Work Sexual Activity |
| <u>Housework or</u> | Running |
| Yardwork Walking | Playing Sports/Exercise |
| <u>Driving</u> | Other _____ |
| <u>Standing</u> | None of These |

In summary, tell us how Select Health has improved your quality of function (quality of life):

No longer have freezing feet & wite or pain
up calves. Legs don't start hurting in
evenings

By signing this document, I certify that the above statements are true, and accurately reflect my opinions of Select Health and my functional self-assessment. I hereby authorize Select Health to publish this document, or any portion of my protected health information, in any media, website, venue, court, or publication necessary to defend the treatment plan and/or my reputation of Select Health and the integrity of the Doctor. I also give Select Health permission to use the statements I made on this document for any marketing, advertising, or promotional purposes they choose, on-line or off-line, in any media.

Patient/Guardian Signature X [Signature]

Today's Date 1-30-25

Provider: [Signature]

Select Health
15720 Brixham Hill Ave.,
#130 Charlotte, NC 28277
704-541-5555






Patient Feedback and
Functional Self-Assessment

PATIENT NAME: Wendy [REDACTED]

Date of Birth: [REDACTED] / [REDACTED] / [REDACTED]

Overall, was your experience at Select Health? Positive Negative

How would you rate Select Health? (please circle one)

				
TERRIBLE	OK	GOOD	GREAT	EXCELLENT

Please Tell Us About:

Cleanliness of the Office:	<u>5-Excellent</u>	4-Great	3-Good	2-Okay	1-Terrible
Check-In Process/Wait	<u>5-Excellent</u>	4-Great	3-Good	2-Okay	1-Terrible
Time: Courtesy of Staff:	<u>5-Excellent</u>	4-Great	3-Good	2-Okay	1-Terrible
Courtesy of Physician:	<u>5-Excellent</u>	4-Great	3-Good	2-Okay	1-Terrible
Ease of Traveling to Office:	5-Excellent	<u>4-Great</u>	3-Good	2-Okay	1-Terrible

Functional Self-Assessment:

Thinking **ONLY** about the symptoms for which you treated in OUR office...
Please circle any of the functions below that you struggle to perform:

<u>Sitting</u>	<u>Climbing Stairs</u>
<u>Sit to Stand</u>	Pushing
Lifting	Sleeping
Getting Dressed	Doing Desk/Computer
Rolling Over	Work Sexual Activity
Housework or	Running
Yardwork Walking	Playing Sports/Exercise
Driving	Other _____
<u>Standing</u>	None of These

In summary, tell us how Select Health has improved your quality of function (quality of life):

My neuropathy pain is much less daily I'm
Feeling better

By signing this document, I certify that the above statements are true, and accurately reflect my opinions of Select Health and my functional self-assessment. I hereby authorize Select Health to publish this document, or any portion of my protected health information, in any media, website, venue, court, or publication necessary to defend the treatment plan and/or my reputation of Select Health and the integrity of the Doctor. I also give Select Health permission to use the statements I made on this document for any marketing, advertising, or promotional purposes they choose, on-line or off-line, in any media.

Patient/Guardian Signature X [Signature]

Today's Date 2 / 2 / 25

Provider: [Signature]

Select Health
15720 Brixham Hill Ave.,
#130 Charlotte, NC 28277
704-541-5555

Patient Feedback and Functional Self-Assessment

PATIENT NAME: BARTON [REDACTED]

Date of Birth: [REDACTED]

Overall, was your experience at Select Health? Positive Negative

How would you rate Select Health? (please circle one)

1 TERRIBLE 2 OK 3 GOOD 4 GREAT 5 EXCELLENT

Please Tell Us About:

Cleanliness of the Office:	<u>5-Excellent</u>	4-Great	3-Good	2-Okay	1-Terrible
Check-In Process/Wait	<u>5-Excellent</u>	4-Great	3-Good	2-Okay	1-Terrible
Time: Courtesy of Staff:	<u>5-Excellent</u>	4-Great	3-Good	2-Okay	1-Terrible
Courtesy of Physician:	<u>5-Excellent</u>	4-Great	3-Good	2-Okay	1-Terrible
Ease of Traveling to Office:	<u>5-Excellent</u>	4-Great	3-Good	2-Okay	1-Terrible

Functional Self-Assessment:

Thinking **ONLY** about the symptoms for which you **treated in OUR office...**
Please circle any of the functions below that you struggle to perform:

- | | |
|---------------------------------------------------------------------------|--------------------------------------------------------------------|
| <input type="checkbox"/> Sitting | <input type="checkbox"/> Climbing Stairs |
| <input type="checkbox"/> Sit to Stand | <input type="checkbox"/> Pushing |
| <input checked="" type="checkbox"/> <u>Lifting</u> <i>not over 10 lbs</i> | <input checked="" type="checkbox"/> <u>Sleeping</u> |
| <input type="checkbox"/> Getting Dressed | <input type="checkbox"/> Doing Desk/Computer |
| <input type="checkbox"/> Rolling Over | <input type="checkbox"/> Work Sexual Activity |
| <input checked="" type="checkbox"/> <u>Housework</u> or | <input checked="" type="checkbox"/> <u>Running</u> |
| <input checked="" type="checkbox"/> <u>Yardwork/Walking</u> | <input checked="" type="checkbox"/> <u>Playing Sports/Exercise</u> |
| <input type="checkbox"/> Driving | Other _____ |
| <input type="checkbox"/> Standing | None of These |

In summary, tell us how Select Health has improved your quality of function (quality of life) of Feet.
I have less pain in Feet, MOST of Numbness has gone, pain in HANDS
about 30% Less, 30% less pain in neck. Lower Back 30% Less pain.
DR. Shapiro, the improvement has helped me to Feel Better. Thank you

By signing this document, I certify that the above statements are true, and accurately reflect my opinions of Select Health and my functional self-assessment. I hereby authorize Select Health to publish this document, or any portion of my protected health information, in any media, website, venue, court, or publication necessary to defend the treatment plan and/or my reputation of Select Health and the integrity of the Doctor. I also give Select Health permission to use the statements I made on this document for any marketing, advertising, or promotional purposes they choose, on-line or off-line, in any media.

Patient/Guardian Signature X [Signature]

Today's Date 2/4/2025

Provider: [Signature]






Select Health
15720 Brixham Hill Ave.,
#130 Charlotte, NC 28277
704-541-5555

Patient Feedback and Functional Self-Assessment

PATIENT NAME: Jim [REDACTED] Date of Birth: [REDACTED] / [REDACTED] / [REDACTED]

Overall, was your experience at Select Health? Positive Negative

How would you rate Select Health? (please circle one)

TERRIBLE OK GOOD GREAT EXCELLENT

Please Tell Us About:

Cleanliness of the Office:	<u>5-Excellent</u>	4-Great	3-Good	2-Okay	1-Terrible
Check-In Process/Wait	<u>5-Excellent</u>	4-Great	3-Good	2-Okay	1-Terrible
Time: Courtesy of Staff:	<u>5-Excellent</u>	4-Great	3-Good	2-Okay	1-Terrible
Courtesy of Physician:	<u>5-Excellent</u>	4-Great	3-Good	2-Okay	1-Terrible
Ease of Traveling to Office:	<u>5-Excellent</u>	4-Great	3-Good	2-Okay	1-Terrible

Functional Self-Assessment:

Thinking **ONLY** about the symptoms for **which you treated in OUR office...**
Please circle any of the functions below that you struggle to perform:

- | | |
|---------------------|-------------------------|
| <u>Sitting</u> | Climbing Stairs |
| <u>Sit to Stand</u> | Pushing |
| Lifting | Sleeping |
| Getting Dressed | Doing Desk/Computer |
| Rolling Over | Work Sexual Activity |
| Housework or | Running |
| Yardwork Walking | Playing Sports/Exercise |
| Driving | Other _____ |
| Standing | None of These |

In summary, tell us how Select Health has improved your quality of function (quality of life):

NERVE DAMAGE HAS IMPROVED ONLY FEEL ISSUE WHEN
I FIRST STANDUP AND PAIN SUBSIDIES AFTER MOVING AROUND.

By signing this document, I certify that the above statements are true, and accurately reflect my opinions of Select Health and my functional self-assessment. I hereby authorize Select Health to publish this document, or any portion of my protected health information, in any media, website, venue, court, or publication necessary to defend the treatment plan and/or my reputation of Select Health and the integrity of the Doctor. I also give Select Health permission to use the statements I made on this document for any marketing, advertising, or promotional purposes they choose, on-line or off-line, in any media.

Patient/Guardian Signature X [Signature] Today's Date 2/12/2025

Provider: [Signature]

Select Health
15720 Brixham Hill Ave.,
#130 Charlotte, NC 28277
704-541-5555

Patient Feedback and
Functional Self-Assessment

PATIENT NAME: Alexander D. [REDACTED]

Date of Birth: [REDACTED] / [REDACTED] / [REDACTED]

Overall, was your experience at Select Health? Positive Negative

How would you rate Select Health? (please circle one)



Please Tell Us About:

Cleanliness of the Office:	<u>5-Excellent</u>	4-Great	3-Good	2-Okay	1-Terrible
Check-In Process/Wait	<u>5-Excellent</u>	4-Great	3-Good	2-Okay	1-Terrible
Time: Courtesy of Staff:	<u>5-Excellent</u>	4-Great	3-Good	2-Okay	1-Terrible
Courtesy of Physician:	<u>5-Excellent</u>	4-Great	3-Good	2-Okay	1-Terrible
Ease of Traveling to Office:	5-Excellent	<u>4-Great</u>	3-Good	2-Okay	1-Terrible

Functional Self-Assessment:

Thinking **ONLY** about the symptoms for which you treated in OUR office...
Please circle any of the functions below that you struggle to perform:

- | | |
|------------------|---------------------------------------------------|
| Sitting | Climbing Stairs |
| Sit to Stand | Pushing |
| Lifting | Sleeping |
| Getting Dressed | Doing Desk/Computer |
| Rolling Over | Work Sexual Activity |
| Housework or | Running |
| Yardwork Walking | Playing Sports/Exercise |
| Driving | Other _____ |
| Standing | <input checked="" type="checkbox"/> None of These |

In summary, tell us how Select Health has improved your quality of function (quality of life):

Select Health help me to be painless. I started out with
a lot of pain the end result is great

By signing this document, I certify that the above statements are true, and accurately reflect my opinions of Select Health and my functional self-assessment. I hereby authorize Select Health to publish this document, or any portion of my protected health information, in any media, website, venue, court, or publication necessary to defend the treatment plan and/or my reputation of Select Health and the integrity of the Doctor. I also give Select Health permission to use the statements I made on this document for any marketing, advertising, or promotional purposes they choose, on-line or off-line, in any media.

Patient/Guardian Signature Xc Alexander D. [REDACTED]

Today's Date 02/13/25

Provider: [Signature]

Select Health
15720 Brixham Hill Ave.,
#130 Charlotte, NC 28277
704-541-5555






Patient Feedback and Functional Self-Assessment

PATIENT NAME: Flor A [REDACTED]

Date of Birth: [REDACTED] / [REDACTED] / [REDACTED]

Overall, was your experience at Select Health? Positive Negative

How would you rate Select Health? (please circle one)

				
TERRIBLE	OK	GOOD	GREAT	EXCELLENT

Please Tell Us About:

Cleanliness of the Office:	5-Excellent	4-Great	3-Good	2-Okay	1-Terrible
Check-In Process/Wait	5-Excellent	4-Great	3-Good	2-Okay	1-Terrible
Time: Courtesy of Staff:	5-Excellent	4-Great	3-Good	2-Okay	1-Terrible
Courtesy of Physician:	5-Excellent	4-Great	3-Good	2-Okay	1-Terrible
Ease of Traveling to Office:	5-Excellent	4-Great	3-Good	2-Okay	1-Terrible

Functional Self-Assessment:

Thinking **ONLY** about the symptoms for which you treated in OUR office...
Please circle any of the functions below that you struggle to perform:

- | | |
|------------------|-------------------------|
| Sitting | Climbing Stairs |
| Sit to Stand | Pushing |
| Lifting | Sleeping |
| Getting Dressed | Doing Desk/Computer |
| Rolling Over | Work Sexual Activity |
| Housework or | Running |
| Yardwork Walking | Playing Sports/Exercise |
| Driving | Other |
| Standing | <u>None of These</u> |

In summary, tell us how Select Health has improved your quality of function (quality of life):

Balance Improved
feet discomfort decreased
More positive to feel better/improve

By signing this document, I certify that the above statements are true, and accurately reflect my opinions of Select Health and my functional self-assessment. I hereby authorize Select Health to publish this document, or any portion of my protected health information, in any media, website, venue, court, or publication necessary to defend the treatment plan and/or my reputation of Select Health and the integrity of the Doctor. I also give Select Health permission to use the statements I made on this document for any marketing, advertising, or promotional purposes they choose, on-line or off-line, in any media.

Patient/Guardian Signature X [REDACTED]

Today's Date 02, 13, 2025

Provider: [Signature]

Select Health
15720 Brixham Hill Ave.,
#130 Charlotte, NC 28277
704-541-5555

Patient Feedback and Functional Self-Assessment

PATIENT NAME: Dawn W [redacted]

Date of Birth: [redacted]

Overall, was your experience at Select Health? Positive Negative

How would you rate Select Health? (please circle one)

1 2 3 4 5

TERRIBLE OK GOOD GREAT EXCELLENT

Please Tell Us About:

Cleanliness of the Office:	<u>5-Excellent</u>	4-Great	3-Good	2-Okay	1-Terrible
Check-In Process/Wait	<u>5-Excellent</u>	4-Great	3-Good	2-Okay	1-Terrible
Time: Courtesy of Staff:	<u>5-Excellent</u>	4-Great	3-Good	2-Okay	1-Terrible
Courtesy of Physician:	<u>5-Excellent</u>	4-Great	3-Good	<u>2-Okay</u>	1-Terrible
Ease of Traveling to Office:	5-Excellent	4-Great	3-Good	<u>2-Okay</u>	1-Terrible

Functional Self-Assessment:

Thinking **ONLY** about the symptoms for which you **treated in OUR office...**
Please circle any of the functions below that you **struggle** to perform:

- | | |
|------------------|--------------------------------|
| Sitting | Climbing Stairs |
| Sit to Stand | Pushing |
| Lifting | Sleeping |
| Getting Dressed | Doing Desk/Computer |
| Rolling Over | Work Sexual Activity |
| Housework or | <u>Running</u> |
| Yardwork Walking | <u>Playing Sports/Exercise</u> |
| Driving | Other |
| Standing | <u>(None of These)</u> |

In summary, tell us how Select Health has improved your quality of function (quality of life):

IN MOST EVERY AREA THAT WAS DISCUSSED
THERE HAS SIGNIFICANT IMPROVEMENT
DR. SHAPIRO ANSWERED ?'S AND TRUE TO HIS PROMISES W/
EXCELLENT BEDSIDE MANNERS LOL 😊

By signing this document, I certify that the above statements are true, and accurately reflect my opinions of Select Health and my functional self-assessment. I hereby authorize Select Health to publish this document, or any portion of my protected health information, in any media, website, venue, court, or publication necessary to defend the treatment plan and/or my reputation of Select Health and the integrity of the Doctor. I also give Select Health permission to use the statements I made on this document for any marketing, advertising, or promotional purposes they choose, on-line or off-line, in any media.

Patient/Guardian Signature [Signature]

Today's Date 03/04/25

[Signature]

Provider:

[Signature]

Select Health
15720 Brixham Hill Ave.,
#130 Charlotte, NC 28277
704-541-5555

Patient Feedback and Functional Self-Assessment

PATIENT NAME: BEN N [REDACTED]

Date of Birth: [REDACTED] / [REDACTED] / [REDACTED]

Overall, was your experience at Select Health? Positive Negative

How would you rate Select Health? (please circle one)

1 TERRIBLE 2 OK 3 GOOD 4 GREAT 5 EXCELLENT

Please Tell Us About:

Cleanliness of the Office:	<u>5-Excellent</u>	4-Great	3-Good	2-Okay	1-Terrible
Check-In Process/Wait	<u>5-Excellent</u>	4-Great	3-Good	2-Okay	1-Terrible
Time: Courtesy of Staff:	<u>5-Excellent</u>	4-Great	3-Good	2-Okay	1-Terrible
Courtesy of Physician:	<u>5-Excellent</u>	4-Great	3-Good	2-Okay	1-Terrible
Ease of Traveling to Office:	<u>5-Excellent</u>	4-Great	3-Good	2-Okay	1-Terrible

Functional Self-Assessment:

Thinking **ONLY** about the symptoms for which you treated in OUR office...
Please circle any of the functions below that you struggle to perform:

- | | |
|---------------------|--------------------------------|
| <u>Sitting</u> | Climbing Stairs |
| Sit to Stand | <u>Pushing</u> |
| Lifting | <u>Sleeping</u> |
| Getting Dressed | Doing Desk/Computer |
| <u>Rolling Over</u> | Work Sexual Activity |
| Housework or | <u>Running</u> |
| Yardwork Walking | <u>Playing Sports/Exercise</u> |
| <u>Driving</u> | Other _____ |
| Standing | None of These |

In summary, tell us how Select Health has improved your quality of function (quality of life):

FEET HAVE FEELING

BETTER BALANCE CONTROL

By signing this document, I certify that the above statements are true, and accurately reflect my opinions of Select Health and my functional self-assessment. I hereby authorize Select Health to publish this document, or any portion of my protected health information, in any media, website, venue, court, or publication necessary to defend the treatment plan and/or my reputation of Select Health and the integrity of the Doctor. I also give Select Health permission to use the statements I made on this document for any marketing, advertising, or promotional purposes they choose, on-line or off-line, in any media.

Patient/Guardian Signature [Signature]

Today's Date 03/05/25

Provider: [Signature]


Select Health
15720 Brixham Hill Ave.,
#130 Charlotte, NC 28277
704-541-5555

Patient Feedback and Functional Self-Assessment

PATIENT NAME: Ed P. [Redacted]

Date of Birth: [Redacted]

Overall, was your experience at Select Health? Positive Negative

How would you rate Select Health? (please circle one) 
TERRIBLE OK GOOD GREAT EXCELLENT

Please Tell Us About:

Cleanliness of the Office:	<u>5</u> -Excellent	4-Great	3-Good	2-Okay	1-Terrible
Check-In Process/Wait	<u>5</u> -Excellent	4-Great	3-Good	2-Okay	1-Terrible
Time: Courtesy of Staff:	<u>5</u> -Excellent	4-Great	3-Good	2-Okay	1-Terrible
Courtesy of Physician:	<u>5</u> -Excellent	4-Great	3-Good	2-Okay	1-Terrible
Ease of Traveling to Office:	<u>5</u> -Excellent	4-Great	3-Good	2-Okay	1-Terrible

Functional Self-Assessment:

Thinking **ONLY** about the symptoms for which you treated in OUR office...
Please circle any of the functions below that you struggle to perform:

Sitting	<u>Climbing Stairs</u>
Sit to Stand	Pushing
Lifting	Sleeping
Getting Dressed	Doing Desk/Computer
Rolling Over	<u>Work Sexual Activity</u>
Housework or	<u>Running</u>
<u>Yardwork Walking</u>	<u>Playing Sports/Exercise</u>
Driving	Other _____
Standing	None of These

In summary, tell us how Select Health has improved your quality of function (quality of life):
Back Pain is better - Foot pain much better

By signing this document, I certify that the above statements are true, and accurately reflect my opinions of Select Health and my functional self-assessment. I hereby authorize Select Health to publish this document, or any portion of my protected health information, in any media, website, venue, court, or publication necessary to defend the treatment plan and/or my reputation of Select Health and the integrity of the Doctor. I also give Select Health permission to use the statements I made on this document for any marketing, advertising, or promotional purposes they choose, on-line or off-line, in any media.

Patient/Guardian Signature X Ed P. [Redacted]

Today's Date 3/18/25

Provider: [Signature]


Select Health
15720 Brixham Hill Ave.,
#130 Charlotte, NC 28277
704-541-5555

Patient Feedback and Functional Self-Assessment

PATIENT NAME: WILLIAMS

Date of Birth: 03/20/25

Overall, was your experience at Select Health? Positive Negative

How would you rate Select Health? (please circle one) 

Please Tell Us About:

Cleanliness of the Office:	5-Excellent	4-Great	3-Good	2-Okay	1-Terrible
Check-In Process/Wait	5-Excellent	4-Great	3-Good	2-Okay	1-Terrible
Time: Courtesy of Staff:	5-Excellent	4-Great	3-Good	2-Okay	1-Terrible
Courtesy of Physician:	5-Excellent	4-Great	3-Good	2-Okay	1-Terrible
Ease of Traveling to Office:	5-Excellent	4-Great	3-Good	2-Okay	1-Terrible

Functional Self-Assessment:

Thinking **ONLY** about the symptoms for which you treated in OUR office...
Please circle any of the functions below that you struggle to perform:

Sitting	Climbing Stairs - a little
Sit to Stand - a little	Pushing
Lifting	Sleeping - some
Getting Dressed	Doing Desk/Computer
Rolling Over	Work Sexual Activity
Housework or	Running - no more of that
Yardwork Walking - a little	Playing Sports/Exercise
Driving	Other _____
Standing	None of These

In summary, tell us how Select Health has improved your quality of function (quality of life):
much less leg pain during the day

By signing this document, I certify that the above statements are true, and accurately reflect my opinions of Select Health and my functional self-assessment. I hereby authorize Select Health to publish this document, or any portion of my protected health information, in any media, website, venue, court, or publication necessary to defend the treatment plan and/or my reputation of Select Health and the integrity of the Doctor. I also give Select Health permission to use the statements I made on this document for any marketing, advertising, or promotional purposes they choose, on-line or off-line, in any media.

Patient/Guardian Signature X Williams, B.

Today's Date 03/20/25

Provider: Shaw

Select Health
15720 Brixham Hill Ave.,
#130 Charlotte, NC 28277
704-541-5555

Patient Feedback and
Functional Self-Assessment

PATIENT NAME: Dois D [REDACTED]

Date of Birth: [REDACTED] / [REDACTED] / [REDACTED]

Overall, was your experience at Select Health? Positive Negative

How would you rate Select Health? (please circle one)



Please Tell Us About:

Cleanliness of the Office:	<u>5-Excellent</u>	4-Great	3-Good	2-Okay	1-Terrible
Check-In Process/Wait Time:	<u>5-Excellent</u>	4-Great	3-Good	2-Okay	1-Terrible
Courtesy of Staff:	<u>5-Excellent</u>	4-Great	3-Good	2-Okay	1-Terrible
Courtesy of Physician:	<u>5-Excellent</u>	4-Great	3-Good	2-Okay	1-Terrible
Ease of Traveling to Office:	5-Excellent	<u>4-Great</u>	3-Good	2-Okay	1-Terrible

Functional Self-Assessment:

Circle any of the functions below that you struggle to perform:

Sitting	Climbing Stairs
Sit to Stand	Pushing
Lifting	Sleeping
Getting Dressed	Doing Desk/Computer Work
Rolling Over	Sexual Activity
Housework or Yardwork	Running
Walking	Playing Sports/Exercise
Driving	Other _____
Standing	<u>None of These</u>

In summary, tell us how Select Health has improved your quality of function (quality of life):

I have better balance and feeling in my feet and sh, do

By signing this document, I certify that the above statements are true, and accurately reflect my opinions of Select Health and my functional self-assessment. I hereby authorize Select Health to publish this document, or any portion of my protected health information, in any media, website, venue, court, or publication necessary to defend the treatment plan and/or my reputation of Select Health and the integrity of the Doctor. I also give Select Health permission to use the statements I made on this document for any marketing, advertising, or promotional purposes they choose, on-line or off-line, in any media.

Patient/Guardian Signature X Dois D [REDACTED]

Today's Date 4/2/25

Provider: [Signature]

Select Health
15720 Brixham Hill Ave.,
#130 Charlotte, NC 28277
704-541-5555






Patient Feedback and
Functional Self-Assessment

PATIENT NAME: GARY C [REDACTED]

Date of Birth: [REDACTED] / [REDACTED] / [REDACTED]

Overall, was your experience at Select Health? Positive Negative

How would you rate Select Health? (please circle one)

				
TERRIBLE	OK	GOOD	GREAT	EXCELLENT

Please Tell Us About:

Cleanliness of the Office:	<u>5</u> -Excellent	4-Great	3-Good	2-Okay	1-Terrible
Check-In Process/Wait	<u>5</u> -Excellent	4-Great	3-Good	2-Okay	1-Terrible
Time: Courtesy of Staff:	<u>5</u> -Excellent	4-Great	3-Good	2-Okay	1-Terrible
Courtesy of Physician:	<u>5</u> -Excellent	4-Great	3-Good	2-Okay	1-Terrible
Ease of Traveling to Office:	5-Excellent	4-Great	3-Good	2-Okay	<u>1</u> -Terrible

Functional Self-Assessment:

Thinking **ONLY** about the symptoms for which you **treated in OUR office...**
Please circle any of the functions below that you struggle to perform:

- | | |
|------------------|-------------------------|
| Sitting | Climbing Stairs |
| Sit to Stand | Pushing |
| Lifting | Sleeping |
| Getting Dressed | Doing Desk/Computer |
| Rolling Over | Work Sexual Activity |
| Housework or | Running |
| Yardwork Walking | Playing Sports/Exercise |
| Driving | Other _____ |
| <u>Standing</u> | None of These |

While ASSISTING AT THE Church I AM STANDING OVER 3 HOURS AT A TIME

In summary, tell us how Select Health has improved your quality of function (quality of life):

YOU HAVE ELIMINATED THE PAIN + NEEDLE EFFECT FOR MY FEET - THANK YOU VERY MUCH.

By signing this document, I certify that the above statements are true, and accurately reflect my opinions of Select Health and my functional self-assessment. I hereby authorize Select Health to publish this document, or any portion of my protected health information, in any media, website, venue, court, or publication necessary to defend the treatment plan and/or my reputation of Select Health and the integrity of the Doctor. I also give Select Health permission to use the statements I made on this document for any marketing, advertising, or promotional purposes they choose, on-line or off-line, in any media.

Patient/Guardian Signature Gary C [REDACTED]

Today's Date 4 / 7 / 2025

Provider: [Signature]

Select Health
15720 Brixham Hill Ave.,
#130 Charlotte, NC 28277
704-541-5555






Patient Feedback and Functional Self-Assessment

PATIENT NAME: Jean [REDACTED]

Date of Birth: [REDACTED]

Overall, was your experience at Select Health? Positive Negative

How would you rate Select Health? (please circle one)

				
TERRIBLE	OK	GOOD	GREAT	EXCELLENT

Please Tell Us About:

Cleanliness of the Office:	<u>5-Excellent</u>	4-Great	3-Good	2-Okay	1-Terrible
Check-In Process/Wait	<u>5-Excellent</u>	4-Great	3-Good	2-Okay	1-Terrible
Time: Courtesy of Staff:	<u>5-Excellent</u>	4-Great	3-Good	2-Okay	1-Terrible
Courtesy of Physician:	<u>5-Excellent</u>	4-Great	3-Good	2-Okay	1-Terrible
Ease of Traveling to Office:	<u>5-Excellent</u>	4-Great	3-Good	2-Okay	1-Terrible

Functional Self-Assessment:

Thinking **ONLY** about the symptoms for which you treated in **OUR** office...
Please circle any of the functions below that you struggle to perform:

- | | |
|------------------|-------------------------|
| Sitting | Climbing Stairs |
| Sit to Stand | Pushing |
| Lifting | Sleeping |
| Getting Dressed | Doing Desk/Computer |
| Rolling Over | Work Sexual Activity |
| Housework or | Running |
| Yardwork Walking | Playing Sports/Exercise |
| Driving | Other _____ |
| Standing | <u>None of These</u> |

In summary, tell us how Select Health has improved your quality of function (quality of life):
I have much less pain in my feet
at night

By signing this document, I certify that the above statements are true, and accurately reflect my opinions of Select Health and my functional self-assessment. I hereby authorize Select Health to publish this document, or any portion of my protected health information, in any media, website, venue, court, or publication necessary to defend the treatment plan and/or my reputation of Select Health and the integrity of the Doctor. I also give Select Health permission to use the statements I made on this document for any marketing, advertising, or promotional purposes they choose, on-line or off-line, in any media.

Patient/Guardian Signature X Jean [REDACTED]

Today's Date 4/10/25

Provider: [Signature]

Select Health
15720 Brixham Hill Ave.,
#130 Charlotte, NC 28277
704-541-5555

Patient Feedback and
Functional Self-Assessment

PATIENT NAME: Betty [redacted]

Date of Birth: [redacted] / [redacted] / [redacted]

Overall, was your experience at Select Health? Positive Negative

How would you rate Select Health? (please circle one)



Please Tell Us About:

Cleanliness of the Office:	<u>5-Excellent</u>	4-Great	3-Good	2-Okay	1-Terrible
Check-In Process/Wait Time:	<u>5-Excellent</u>	4-Great	3-Good	2-Okay	1-Terrible
Courtesy of Staff:	<u>5-Excellent</u>	4-Great	3-Good	2-Okay	1-Terrible
Courtesy of Physician:	<u>5-Excellent</u>	4-Great	3-Good	2-Okay	1-Terrible
Ease of Traveling to Office:	5-Excellent	4-Great	<u>3-Good</u>	2-Okay	1-Terrible

Functional Self-Assessment:

Circle any of the functions below that you struggle to perform:

Sitting	Climbing Stairs
Sit to Stand	Pushing
Lifting	<u>Sleeping</u>
<u>Getting Dressed</u>	Doing Desk/Computer Work
<u>Rolling Over</u>	Sexual Activity
<u>Housework or Yardwork</u>	<u>Running</u>
<u>Walking</u>	Playing Sports/Exercise
Driving	Other _____
Standing	None of These

In summary, tell us how Select Health has improved your quality of function (quality of life):

By signing this document, I certify that the above statements are true, and accurately reflect my opinions of Select Health and my functional self-assessment. I hereby authorize Select Health to publish this document, or any portion of my protected health information, in any media, website, venue, court, or publication necessary to defend the treatment plan and/or my reputation of Select Health and the integrity of the Doctor. I also give Select Health permission to use the statements I made on this document for any marketing, advertising, or promotional purposes they choose, on-line or off-line, in any media.

Patient/Guardian Signature X Betty [redacted]

Today's Date 7 / 10 / 25

Provider:

[Signature]

Select Health
15720 Brixham Hill Ave.,
#130 Charlotte, NC 28277
704-541-5555


Patient Feedback and Functional Self-Assessment

PATIENT NAME: MARK M [REDACTED]

Date of Birth: [REDACTED]

Overall, was your experience at Select Health? Positive Negative

How would you rate Select Health? (please circle one)



Please Tell Us About:

- Cleanliness of the Office: 5-Excellent 4-Great 3-Good 2-Okay 1-Terrible
- Check-In Process/Wait: 5-Excellent 4-Great 3-Good 2-Okay 1-Terrible
- Time: Courtesy of Staff: 5-Excellent 4-Great 3-Good 2-Okay 1-Terrible
- Courtesy of Physician: 5-Excellent 4-Great 3-Good 2-Okay 1-Terrible
- Ease of Traveling to Office: 5-Excellent 4-Great 3-Good 2-Okay 1-Terrible

Functional Self-Assessment:

Thinking **ONLY** about the symptoms for **which you treated in OUR office...**
Please circle any of the functions below that you struggle to perform:

- | | |
|-------------------------|---------------------------------|
| Sitting | Climbing Stairs |
| Sit to Stand | Pushing |
| Lifting | Sleeping |
| Getting Dressed | Doing Desk/Computer |
| Rolling Over | Work/Sexual Activity |
| Housework or | Running |
| <u>Yardwork</u> Walking | Playing Sports/ <u>Exercise</u> |
| Driving | Other _____ |
| Standing | None of These |

In summary, tell us how Select Health has improved your quality of function (quality of life):

My feet are both much better.
My hands are getting better - slower process.
Overall condition has helped all the above.

By signing this document, I certify that the above statements are true, and accurately reflect my opinions of Select Health and my functional self-assessment. I hereby authorize Select Health to publish this document, or any portion of my protected health information, in any media, website, venue, court, or publication necessary to defend the treatment plan and/or my reputation of Select Health and the integrity of the Doctor. I also give Select Health permission to use the statements I made on this document for any marketing, advertising, or promotional purposes they choose, on-line or off-line, in any media.

Patient/Guardian Signature X Mark [REDACTED]

Today's Date 4/22/2025

Provider: [Signature]

Select Health
15720 Brixham Hill Ave.,
#130 Charlotte, NC 28277
704-541-5555

Patient Feedback and Functional Self-Assessment

PATIENT NAME: Annie [Redacted]

Date of Birth: 1/19/30

Overall, was your experience at Select Health? Positive Negative

How would you rate Select Health? (please circle one)

TERRIBLE OK GOOD GREAT EXCELLENT

Please Tell Us About:

Cleanliness of the Office:	<u>5</u> -Excellent	4-Great	3-Good	2-Okay	1-Terrible
Check-In Process/Wait	<u>5</u> -Excellent	4-Great	3-Good	2-Okay	1-Terrible
Time: Courtesy of Staff:	<u>5</u> -Excellent	4-Great	3-Good	2-Okay	1-Terrible
Courtesy of Physician:	<u>5</u> -Excellent	4-Great	3-Good	2-Okay	1-Terrible
Ease of Traveling to Office:	<u>5</u> -Excellent	4-Great	3-Good	2-Okay	1-Terrible

Functional Self-Assessment:

Thinking **ONLY** about the symptoms for which you **treated in OUR office...** →
Please circle any of the functions below that you **struggle** to perform:

- | | |
|------------------|-------------------------|
| Sitting | <u>Climbing Stairs</u> |
| Sit to Stand | Pushing |
| <u>Lifting</u> | Sleeping |
| Getting Dressed | Doing Desk/Computer |
| Rolling Over | Work Sexual Activity |
| Housework or | <u>Running</u> |
| Yardwork Walking | Playing Sports/Exercise |
| Driving | Other _____ |
| <u>Standing</u> | None of These |

In summary, tell us how Select Health has improved your quality of function (quality of life):

I CAN sleep better
I CAN do my house work
I feel better

By signing this document, I certify that the above statements are true, and accurately reflect my opinions of Select Health and my functional self-assessment. I hereby authorize Select Health to publish this document, or any portion of my protected health information, in any media, website, venue, court, or publication necessary to defend the treatment plan and/or my reputation of Select Health and the integrity of the Doctor. I also give Select Health permission to use the statements I made on this document for any marketing, advertising, or promotional purposes they choose, on-line or off-line, in any media.

Patient/Guardian Signature X Annie [Redacted]

Today's Date 05/13/2025

Provider: [Signature]

Select Health
15720 Brixham Hill Ave.,
#130 Charlotte, NC 28277
704-541-5555

Patient Feedback and Functional Self-Assessment

PATIENT NAME: Jane [redacted]

Date of Birth: [redacted]

Overall, was your experience at Select Health? Positive Negative

How would you rate Select Health? (please circle one)

1 2 3 4 5

TERRIBLE OK GOOD GREAT EXCELLENT

Please Tell Us About:

Cleanliness of the Office:	<input checked="" type="checkbox"/> 5-Excellent	4-Great	3-Good	2-Okay	1-Terrible
Check-In Process/Wait	<input checked="" type="checkbox"/> 5-Excellent	4-Great	3-Good	2-Okay	1-Terrible
Time: Courtesy of Staff:	<input checked="" type="checkbox"/> 5-Excellent	4-Great	3-Good	2-Okay	1-Terrible
Courtesy of Physician:	<input checked="" type="checkbox"/> 5-Excellent	4-Great	3-Good	2-Okay	1-Terrible
Ease of Traveling to Office:	<input checked="" type="checkbox"/> 5-Excellent	4-Great	3-Good	2-Okay	1-Terrible

Functional Self-Assessment:

Thinking **ONLY** about the symptoms for which you treated in OUR office...
Please circle any of the functions below that you struggle to perform:

- | | |
|------------------|-------------------------------------------------------------|
| Sitting | Climbing Stairs |
| Sit to Stand | Pushing |
| Lifting | Sleeping |
| Getting Dressed | Doing Desk/Computer |
| Rolling Over | Work Sexual Activity |
| Housework or | <input checked="" type="checkbox"/> Running |
| Yardwork Walking | <input checked="" type="checkbox"/> Playing Sports/Exercise |
| Driving | Other _____ |
| Standing | None of These |

In summary, tell us how Select Health has improved your quality of function (quality of life):

my feet + legs do not feel as numb
leg cramps at night have less
warmth in ft + legs improved

By signing this document, I certify that the above statements are true, and accurately reflect my opinions of Select Health and my functional self-assessment. I hereby authorize Select Health to publish this document, or any portion of my protected health information, in any media, website, venue, court, or publication necessary to defend the treatment plan and/or my reputation of Select Health and the integrity of the Doctor. I also give Select Health permission to use the statements I made on this document for any marketing, advertising, or promotional purposes they choose, on-line or off-line, in any media.

Patient/Guardian Signature X Jane [redacted]

Today's Date 5/15/25


Provider: [Signature]

Select Health
15720 Brixham Hill Ave.,
#130 Charlotte, NC 28277
704-541-5555

**Patient Feedback and
Functional Self-Assessment**

PATIENT NAME: Ahena [REDACTED] Date of Birth: 01/26/1961

Overall, was your experience at Select Health? Positive Negative

How would you rate Select Health? (please circle one) 

Please Tell Us About:

Cleanliness of the Office:	<input checked="" type="checkbox"/> 5-Excellent	4-Great	3-Good	2-Okay	1-Terrible
Check-In Process/Wait	<input checked="" type="checkbox"/> 5-Excellent	4-Great	3-Good	2-Okay	1-Terrible
Time: Courtesy of Staff:	<input checked="" type="checkbox"/> 5-Excellent	4-Great	3-Good	2-Okay	1-Terrible
Courtesy of Physician:	<input checked="" type="checkbox"/> 5-Excellent	4-Great	3-Good	2-Okay	1-Terrible
Ease of Traveling to Office:	<input checked="" type="checkbox"/> 5-Excellent	4-Great	3-Good	2-Okay	1-Terrible

Functional Self-Assessment:

Thinking **ONLY** about the symptoms for which you **treated in OUR office...**
Please circle any of the functions below that you struggle to perform:

- | | |
|------------------|-------------------------|
| Sitting | Climbing Stairs |
| Sit to Stand | Pushing |
| Lifting | Sleeping |
| Getting Dressed | Doing Desk/Computer |
| Rolling Over | Work Sexual Activity |
| Housework or | Running |
| Yardwork Walking | Playing Sports/Exercise |
| Driving | Other _____ |
| Standing | <u>None of These</u> |

In summary, tell us how Select Health has improved your quality of function (quality of life):

I can walk! NO pain

By signing this document, I certify that the above statements are true, and accurately reflect my opinions of Select Health and my functional self-assessment. I hereby authorize Select Health to publish this document, or any portion of my protected health information, in any media, website, venue, court, or publication necessary to defend the treatment plan and/or my reputation of Select Health and the integrity of the Doctor. I also give Select Health permission to use the statements I made on this document for any marketing, advertising, or promotional purposes they choose, on-line or off-line, in any media.

Patient/Guardian Signature X [Signature]

Today's Date 06/12/2025

Provider: [Signature]

Select Health
15720 Brixham Hill Ave.,
#130 Charlotte, NC 28277
704-541-5555


Patient Feedback and Functional Self-Assessment

PATIENT NAME: Michael [Signature]

Date of Birth: 6/16/2025

Overall, was your experience at Select Health? Positive Negative

How would you rate Select Health? (please circle one)



Please Tell Us About:

Cleanliness of the Office:	<u>5-Excellent</u>	4-Great	3-Good	2-Okay	1-Terrible
Check-In Process/Wait	<u>5-Excellent</u>	4-Great	3-Good	2-Okay	1-Terrible
Time: Courtesy of Staff:	<u>5-Excellent</u>	4-Great	3-Good	2-Okay	1-Terrible
Courtesy of Physician:	<u>5-Excellent</u>	4-Great	3-Good	2-Okay	1-Terrible
Ease of Traveling to Office:	<u>5-Excellent</u>	4-Great	3-Good	2-Okay	1-Terrible

Functional Self-Assessment:

Thinking **ONLY** about the symptoms for which you **treated in OUR office...**
Please circle any of the functions below that you **struggle** to perform:

Sitting	Climbing Stairs
Sit to Stand	Pushing
Lifting	Sleeping
Getting Dressed	Doing Desk/Computer
Rolling Over	Work Sexual Activity
Housework or	<u>Running</u>
Yardwork Walking	<u>Playing Sports/Exercise</u>
Driving	Other _____
Standing	None of These

In summary, tell us how Select Health has improved your quality of function (quality of life):

Helped neuropathy - either stopped it from getting worse or improved my functionality

By signing this document, I certify that the above statements are true, and accurately reflect my opinions of Select Health and my functional self-assessment. I hereby authorize Select Health to publish this document, or any portion of my protected health information, in any media, website, venue, court, or publication necessary to defend the treatment plan and/or my reputation of Select Health and the integrity of the Doctor. I also give Select Health permission to use the statements I made on this document for any marketing, advertising, or promotional purposes they choose, on-line or off-line, in any media.

Patient/Guardian Signature X [Signature]

Today's Date 6/16/2025

Provider: [Signature]

Select Health
15720 Brixham Hill Ave.,
#130 Charlotte, NC 28277
704-541-5555

Patient Feedback and Functional Self-Assessment

PATIENT NAME: Rogers Gardner

Date of Birth: 11, 17, 1973

Overall, was your experience at Select Health? Positive Negative

How would you rate Select Health? (please circle one)



Please Tell Us About:

Cleanliness of the Office:	<u>5-Excellent</u>	4-Great	3-Good	2-Okay	1-Terrible
Check-In Process/Wait	<u>5-Excellent</u>	4-Great	3-Good	2-Okay	1-Terrible
Time: Courtesy of Staff:	<u>5-Excellent</u>	4-Great	3-Good	2-Okay	1-Terrible
Courtesy of Physician:	<u>5-Excellent</u>	4-Great	3-Good	2-Okay	1-Terrible
Ease of Traveling to Office:	<u>5-Excellent</u>	4-Great	3-Good	2-Okay	1-Terrible

Functional Self-Assessment:

Thinking **ONLY** about the symptoms for which you treated in OUR office...
Please circle any of the functions below that you struggle to perform:

Sitting	Climbing Stairs
Sit to Stand	Pushing
Lifting	Sleeping
Getting Dressed	Doing Desk/Computer
Rolling Over	Work Sexual Activity
Housework or	<u>Running</u>
Yardwork Walking	Playing Sports/Exercise
Driving	Other _____
Standing	None of These

In summary, tell us how Select Health has improved your quality of function (quality of life):

Sessions have improved low back "shock" absorption while walking. Bending seems more stable during non flare up times. This helps with daily activity & workouts.

By signing this document, I certify that the above statements are true, and accurately reflect my opinions of Select Health and my functional self-assessment. I hereby authorize Select Health to publish this document, or any portion of my protected health information, in any media, website, venue, court, or publication necessary to defend the treatment plan and/or my reputation of Select Health and the integrity of the Doctor. I also give Select Health permission to use the statements I made on this document for any marketing, advertising, or promotional purposes they choose, on-line or off-line, in any media.

Patient/Guardian Signature Rogers Gardner

Today's Date 6/18/25

Provider:

Shap DC

Select Health
15720 Brixham Hill Ave.,
#130 Charlotte, NC 28277
704-541-5555






Patient Feedback and Functional Self-Assessment

PATIENT NAME: MATTSON [Signature]

Date of Birth: [Signature] / [Signature] / [Signature]

Overall, was your experience at Select Health? Positive Negative

How would you rate Select Health? (please circle one)

				
TERRIBLE	OK	GOOD	GREAT	EXCELLENT

Please Tell Us About:

Cleanliness of the Office:	<u>5</u> -Excellent	4-Great	3-Good	2-Okay	1-Terrible
Check-In Process/Wait	<u>5</u> -Excellent	4-Great	3-Good	2-Okay	1-Terrible
Time: Courtesy of Staff:	<u>5</u> -Excellent	4-Great	3-Good	2-Okay	1-Terrible
Courtesy of Physician:	<u>5</u> -Excellent	4-Great	3-Good	2-Okay	1-Terrible
Ease of Traveling to Office:	5-Excellent	4-Great	<u>3</u> -Good	2-Okay	1-Terrible

Functional Self-Assessment:

Thinking **ONLY** about the symptoms for which you **treated in OUR office...**
Please circle any of the functions below that you **struggle** to perform:

- | | | |
|--------------|--------------------------|---------------------------------|
| Sitting | Doing Desk/Computer Work | Getting to sleep-Staying asleep |
| Sit to Stand | Driving | Exercising-Playing sports |
| Standing | Lifting | House work-Yard work |
| Walking | Getting Dressed | Climbing stairs |
| Running | Sexual Activity | Other _____ |
| Pushing | Rolling Over | _____ |

None of these

In summary, tell us how Select Health has improved your quality of function (quality of life):

ADDED FLEXIBILITY TO MY LOWER BACK IMPROVED MY PHYSICAL STAMINA FOR MANUAL LABOR, SITTING FOR LONG PERIODS (LESS STIFFNESS)

By signing this document, I certify that the above statements are true, and accurately reflect my opinions of Select Health and my functional self-assessment. I hereby authorize Select Health to publish this document, or any portion of my protected health information, in any media, website, venue, court, or publication necessary to defend the treatment plan and/or my reputation of Select Health and the integrity of the Doctor. I also give Select Health permission to use the statements I made on this document for any marketing, advertising, or promotional purposes they choose, on-line or off-line, in any media.

Patient/Guardian Signature X [Signature]

Today's Date 07/21/25

Provider: [Signature]

Select Health
15720 Brixham Hill Ave.,
#130 Charlotte, NC 28277
704-541-5555






Patient Feedback and Functional Self-Assessment

PATIENT NAME: Jackie [REDACTED]

Date of Birth: 11 / [REDACTED] / [REDACTED]

Overall, was your experience at Select Health? Positive Negative

How would you rate Select Health? (please circle one)

				
TERRIBLE	OK	GOOD	GREAT	EXCELLENT

Please Tell Us About:

Cleanliness of the Office:	<u>5-Excellent</u>	4-Great	3-Good	2-Okay	1-Terrible
Check-In Process/Wait	<u>5-Excellent</u>	4-Great	3-Good	2-Okay	1-Terrible
Time: Courtesy of Staff:	<u>5-Excellent</u>	4-Great	3-Good	2-Okay	1-Terrible
Courtesy of Physician:	<u>5-Excellent</u>	4-Great	3-Good	2-Okay	1-Terrible
Ease of Traveling to Office:	<u>5-Excellent</u>	4-Great	3-Good	2-Okay	1-Terrible

Functional Self-Assessment:

Thinking **ONLY** about the symptoms for which you **treated in OUR office...**
Please circle any of the functions below that you struggle to perform:

- | | | |
|--------------|--------------------------|---------------------------------|
| Sitting | Doing Desk/Computer Work | Getting to sleep-Staying asleep |
| Sit to Stand | Driving | Exercising-Playing sports |
| Standing | <u>Lifting</u> | House work-Yard work |
| Walking | Getting Dressed | Climbing stairs |
| Running | Sexual Activity | Other _____ |
| Pushing | Rolling Over | _____ |

In summary, tell us how Select Health has improved your quality of function (quality of life):

I am able to get back to normal with everyday activities.

By signing this document, I certify that the above statements are true, and accurately reflect my opinions of Select Health and my functional self-assessment. I hereby authorize Select Health to publish this document, or any portion of my protected health information, in any media, website, venue, court, or publication necessary to defend the treatment plan and/or my reputation of Select Health and the integrity of the Doctor. I also give Select Health permission to use the statements I made on this document for any marketing, advertising, or promotional purposes they choose, on-line or off-line, in any media.

Patient/Guardian Signature X [REDACTED]

Today's Date 10/15/25


Provider: [Signature]

Select Health
15720 Brixham Hill Ave.,
#130 Charlotte, NC 28277
704-541-5555

Patient Feedback and
Functional Self-Assessment

PATIENT NAME: Emily D. [Signature] Date of Birth: 6/17/1971 [Signature]

Overall, was your experience at Select Health? Positive Negative

How would you rate Select Health? (please circle one) 

Please Tell Us About:

Cleanliness of the Office:	<u>5-Excellent</u>	4-Great	3-Good	2-Okay	1-Terrible
Check-In Process/Wait	<u>5-Excellent</u>	4-Great	3-Good	2-Okay	1-Terrible
Time: Courtesy of Staff:	<u>5-Excellent</u>	4-Great	3-Good	2-Okay	1-Terrible
Courtesy of Physician:	<u>5-Excellent</u>	4-Great	3-Good	2-Okay	1-Terrible
Ease of Traveling to Office:	<u>5-Excellent</u>	4-Great	3-Good	2-Okay	1-Terrible

Functional Self-Assessment:

Thinking **ONLY** about the symptoms for which you treated in OUR office...
Please circle any of the functions below that you struggle to perform:

- | | | |
|--------------|--------------------------|---------------------------------|
| Sitting | Doing Desk/Computer Work | Getting to sleep-Staying asleep |
| Sit to Stand | Driving | Exercising-Playing sports |
| Standing | Lifting | House work-Yard work |
| Walking | Getting Dressed | Climbing stairs |
| Running | Sexual Activity | Other _____ |
| Pushing | Rolling Over | _____ |

In summary, tell us how Select Health has improved your quality of function (quality of life):

My symptoms have dramatically reduced

By signing this document, I certify that the above statements are true, and accurately reflect my opinions of Select Health and my functional self-assessment. I hereby authorize Select Health to publish this document, or any portion of my protected health information, in any media, website, venue, court, or publication necessary to defend the treatment plan and/or my reputation of Select Health and the integrity of the Doctor. I also give Select Health permission to use the statements I made on this document for any marketing, advertising, or promotional purposes they choose, on-line or off-line, in any media.

Patient/Guardian Signature X Emily D. [Signature] Today's Date 4/17/2026

Provider: [Signature]