

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

Patient Feedback and  
Functional Self-Assessment

PATIENT NAME: Cortina

Date of Birth: 1/21/74

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	Playing Sports/Exercise
Walking	Other _____
Driving	
Standing	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. I was able to do so 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 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 for any marketing, advertising, or promotional purposes they choose, on-line or off-line, in any media.

treatments I received here. Shouting loud and proud, "Blessed to be a Select Health patient!"

Patient/Guardian Signature X

SCANNED

Provider:

Chapman

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)



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  
Sit to Stand

Doing Desk/Computer Work

Getting to sleep-Staying asleep

Standing

Driving

Exercising-Playing sports

Walking

Lifting

House work-Yard work

Running

Getting Dressed

Climbing stairs

Pushing

Sexual Activity

Other \_\_\_\_\_

Rolling Over

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 tell 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:

Chapman 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)



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  
Sit to Stand

Doing Desk/Computer Work

Getting to sleep-Staying asleep

Standing

Driving

Exercising-Playing sports

Walking

Lifting

House work-Yard work

Running

Getting Dressed

Climbing stairs

Pushing

Sexual Activity  
Rolling Over

Other \_\_\_\_\_

\_\_\_\_\_

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 tell 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:

Chapman DC

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

Patient Feedback and  
Functional Self-Assessment

PATIENT NAME: Larry

Date of Birth: 7/27/55

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 Time:	5-Excellent	4-Great	3-Good	2-Okay	1-Terrible
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:

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	None of These

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

Nuropathy 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 Larry

Today's Date 4/24/25

Provider: Shawn DC

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

Patient Feedback and  
Functional Self-Assessment

PATIENT NAME: Susan L

Date of Birth: 1/1/00

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="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	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="radio"/> 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 Susan L

Today's Date 1/12/25

Provider: Shawn

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

Patient Feedback and  
Functional Self-Assessment

PATIENT NAME:

Kathy B.

Date of Birth: 

Overall, was your experience at Select Health?  Positive  Negative

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

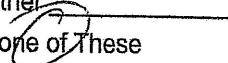


Please Tell Us About:

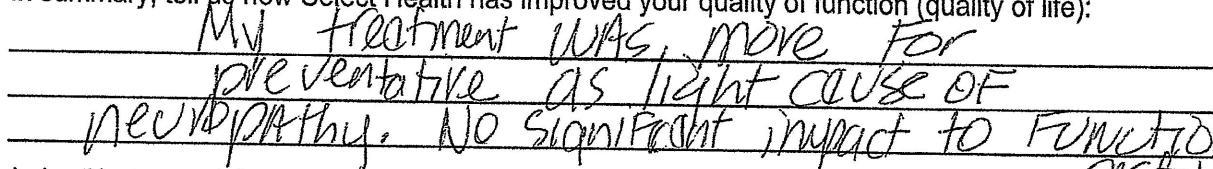
Cleanliness of the Office:	5-Excellent	4-Great	3-Good	2-Okay	1-Terrible
Check-In Process/Wait:	5-Excellent	4-Great	3-Good	2-Okay	1-Terrible
Time: Courtesy of Staff:	5-Excellent	4-Great	3-Good	2-Okay	1-Terrible
Courtesy of Physician:	5-Excellent	4-Great	3-Good	2-Okay	1-Terrible
Ease of Traveling to Office: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

  
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.

Today's Date 1/28/25

Provider:

Shawn

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: 1/1/1

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	Playing Sports/Exercise
Walking	Other _____
Driving	None of These
Standing	

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

No longer have freezing feet & nite 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

Today's Date 1-30-25

Provider:

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

Patient Feedback and  
Functional Self-Assessment

PATIENT NAME: Wendy

Date of Birth:   /  /  

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

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):

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 Wendy

Today's Date 2/2/25

Provider: Chapman

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

Patient Feedback and  
Functional Self-Assessment

PATIENT NAME: BARTON

Date of Birth: 1/1/

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
<u>Lifting</u> <small>not over 10 lbs</small>	<u>Sleeping</u>
Getting Dressed	Doing Desk/Computer
<u>Rolling Over</u>	Work Sexual Activity
<u>Housework or</u>	<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) in several areas 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

A handwritten signature that appears to read 'Barton'.

Today's Date 2/14/2025

Provider:

A handwritten signature that appears to read 'Shapiro'.

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

Patient Feedback and  
Functional Self-Assessment

PATIENT NAME: Tim C.

Date of Birth:   /  /  

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

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

NERVE damage has improved only few issues when I first standup and pain subsides 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 AC

Today's Date 2/12/2025

Provider: Shawn

PATIENT NAME: Alexander D

Date of Birth:   /  /  

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):

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.

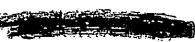
Patient/Guardian Signature X Alexander D

Today's Date 02/13/25

Provider: Shawn

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

Patient Feedback and  
Functional Self-Assessment

PATIENT NAME: Flor A 

Date of Birth:   /  /  

Overall, was your experience at Select Health?  Positive  Negative

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

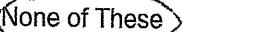


Please Tell Us About:

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):

Balance improved

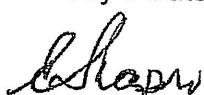
feet discomfort decreased

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 

Today's Date 02/13/2025

Provider: 

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

Patient Feedback and  
Functional Self-Assessment

PATIENT NAME: DAWN W

Date of Birth: 18/08/00

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):

IN MOST EVERY AREA THAT WAS DISCUSSED

There has SIGNIFICANT IMPROVEMENT

Dr. Shapiro ANSWERED ?'s AND true to his promises w/

EXCELLENT BEDSIDE MANNERS hol ☺  
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

Today's Date 03/04/25

Am W

Provider: Shapiro

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

Patient Feedback and  
Functional Self-Assessment

PATIENT NAME: BEN N

Date of Birth:   /  /  

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):

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 X

Today's Date 03/05/25

Provider:

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

Patient Feedback and  
Functional Self-Assessment

PATIENT NAME: Ed P.

Date of Birth:   /  /  

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

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):

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.

Today's Date 3/18/23

Provider:

Chapman

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

Patient Feedback and  
Functional Self-Assessment

PATIENT NAME: Will G

Date of Birth: 1/1/1

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 - <u>a little</u>
Sit to Stand <u>-a little</u>	Pushing
Lifting	Sleeping - <u>some</u>
Getting Dressed	Doing Desk/Computer
Rolling Over	Work Sexual Activity
Housework or	Running - <u>no more of that</u>
Yardwork Walking <u>-a little</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):

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 Will G

Today's Date 03/20/25

Provider: Chapman

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

Patient Feedback and  
Functional Self-Assessment

PATIENT NAME: Doris D Date of Birth: 7/1/20

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:	<u>5-Excellent</u>	<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 hands

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 Doris D

Today's Date 4/21/25

Provider:

Chapman

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

Patient Feedback and  
Functional Self-Assessment

PATIENT NAME: Gary C.

Date of Birth: 7/7/1975

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="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	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

*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 plus 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 X Gary C.

Today's Date 7/7/2025

Provider: Shawn

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: 2/25/19 [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 Travelling 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 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:

Chapman DC

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:

Chapman DC

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

Patient Feedback and  
Functional Self-Assessment

PATIENT NAME: MARK

Date of Birth: 1/1/1960

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

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

Today's Date 4/22/2025

Provider:

Shawn DC

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

Patient Feedback and  
Functional Self-Assessment

PATIENT NAME: Annie 

Date of Birth: 

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	<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 

Today's Date 05/13/2025

Provider: Elspaw DC

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

Patient Feedback and  
Functional Self-Assessment

PATIENT NAME: Jane

Date of Birth: 12/12/12

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	<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 down  
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

Today's Date 5/15/25

Provider: Shawn DC

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

Patient Feedback and  
Functional Self-Assessment

PATIENT NAME: Theresa

Date of Birth: 01/26/19

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:	<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 ED

Today's Date 06/12/2025

Provider: Shawn DC

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

Patient Feedback and  
Functional Self-Assessment

PATIENT NAME: Michael Date of Birth: 6/16/2023

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 M

Today's Date 6/16/2023

Provider: Elshan DC

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:	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):

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 X Rogers Gardner

Today's Date 4/18/25

Provider: Chapman DC

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

Patient Feedback and  
Functional Self-Assessment

PATIENT NAME: Mattison Date of Birth: 8/28/2000

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	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	_____

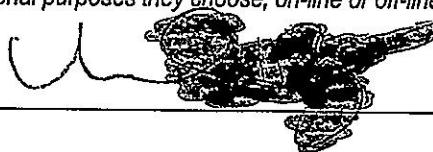
*None of these*

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

ADDED FLEXIBILITY TO MY LOWER BACK (MORE MOVED)  
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



Today's Date 07/21/25

Provider:

*Chapin DC*

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

Patient Feedback and  
Functional Self-Assessment

PATIENT NAME: JACKIE

Date of Birth: 11/03/2013

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	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):

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



Today's Date 10/15/25

Provider:

