



Directions: Please print in either blue or black ink. Answer all questions as completely as possible. Please share this information with your preceptor, facilitator, and CORE staff.

Identification: (Please Print)

Last Name: _____ First Name: _____ Sex: _____

Name you prefer to be called: _____

Knowledge: I have previously encountered patients with:

- | | | |
|--|---|---------------------------------|
| <input type="checkbox"/> sore throat | <input type="checkbox"/> extremity pain | <input type="checkbox"/> other: |
| <input type="checkbox"/> ear pain | <input type="checkbox"/> back pain | |
| <input type="checkbox"/> cough | <input type="checkbox"/> anxiety/depression | |
| <input type="checkbox"/> urinary frequency | <input type="checkbox"/> hypertension | |
| <input type="checkbox"/> vomiting/diarrhea | <input type="checkbox"/> headache | |
| <input type="checkbox"/> abdominal pain | <input type="checkbox"/> dizziness | |
| <input type="checkbox"/> irregular menses | <input type="checkbox"/> syncope | |

Skills: I have observed or performed the following:

- | | | |
|--|--|---------------------------------|
| <input type="checkbox"/> patient interview (history) | <input type="checkbox"/> neurological exam | <input type="checkbox"/> other: |
| <input type="checkbox"/> ENT exam | <input type="checkbox"/> back exam | |
| <input type="checkbox"/> chest exam | <input type="checkbox"/> OMM: C-spine | |
| <input type="checkbox"/> abdominal exam | <input type="checkbox"/> OMM: T-spine | |
| <input type="checkbox"/> pelvic exam | <input type="checkbox"/> OMM: L-spine | |
| <input type="checkbox"/> extremity exam | <input type="checkbox"/> OMM: pelvis | |

Attitudes: The type of patient encounter I find most challenging is:

Goals: My learning goals for this rotation include:

Learning Style: I learn best by: