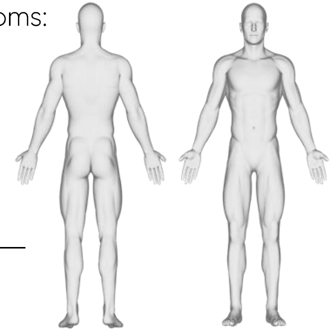
Name: ________________________________ Date: ______________________

Progress Evaluation I



***PLEASE MARK** the areas on the Diagram with the following **letters** to describe your symptoms:
R = Radiating   B = Burning   D = Dull   A = Aching   N = Numbness S = Sharp/ Stabbing
T= Tingling

1. For what reason did you originally see the Doctor? ______________________________

2. What conditions are still bothering you? Use the boxes below to describe.

Area	Frequency and Improvement
Example: Headache	Pain Occurs: ☐Constantly ☐Daily ☐Several x/week ☐Several x/month ☐Never
	Pain Occurs: ☐Constantly ☐Daily ☐Several x/week ☐Several x/month ☐Never
	Pain Occurs: ☐Constantly ☐Daily ☐Several x/week ☐Several x/month ☐Never
	Pain Occurs: ☐Constantly ☐Daily ☐Several x/week ☐Several x/month ☐Never
	Pain Occurs: ☐Constantly ☐Daily ☐Several x/week ☐Several x/month ☐Never

3. How would you rate your improvement overall?
☐ No Improvement   ☐ Some Improvement   ☐Considerable Improvement   ☐100% Improvement

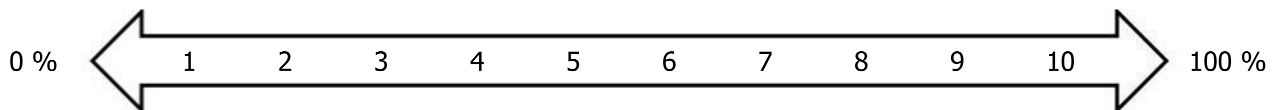
4. Does anything you do **aggravate** your condition(s): ☐ No ☐ Yes
If **yes,** what? ____

5. Does anything **relieve** your discomfort? ☐ No ☐ Yes
If **yes**, what? ____

6. Have you had any new injuries or accidents?____

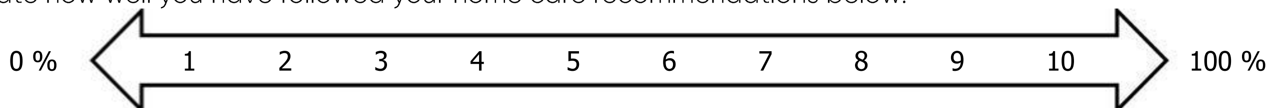
7. Have you been able to reduce any medications since starting care? ☐ No ☐ Yes
If **yes**, what? ____

8. Rate how well you have followed your prescribed visit frequency below:



How often do you make your visits? _______x/Week _______x/Month

9. Rate how well you have followed your home care recommendations below:



Name: ________________________ Date: ____________________

10. How often do you perform the following:

Wobble/Traction	_______x/Day	_______x/Week
Head weights	_______x/Day	_______x/Week
Isometrics	_______x/Day	_______x/Week
Rolls/Wedges	_______x/Day	_______x/Week

11. Has your family been checked for subluxation? ☐ No ☐ Yes

If No, why not? ____

12. What are your goals for your care?

☐ to get out of pain ☐ to get healthy & stay healthy for the rest of my life

☐ other:_____________ ☐ all of the above

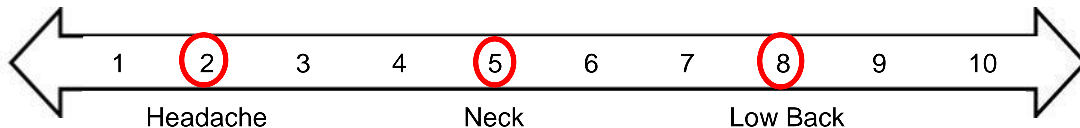
13. How would you rate the service in our office? ☐Excellent ☐Good ☐Fair ☐Poor

Comments:____

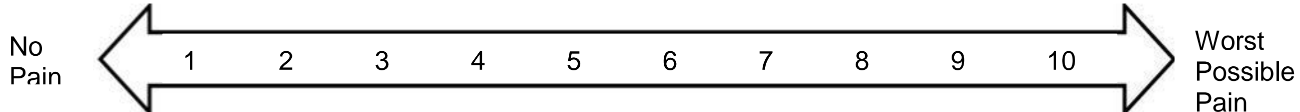
INTENSITY RATING

Instructions: Refer to question #2 on the first page and rate your pain for each condition.

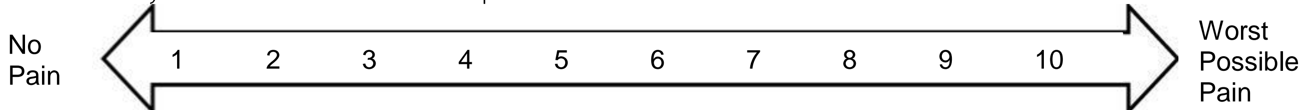
EXAMPLE:



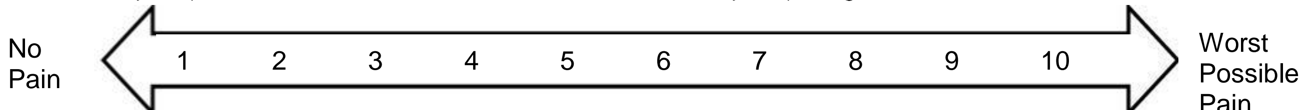
1. What is your pain RIGHT NOW?



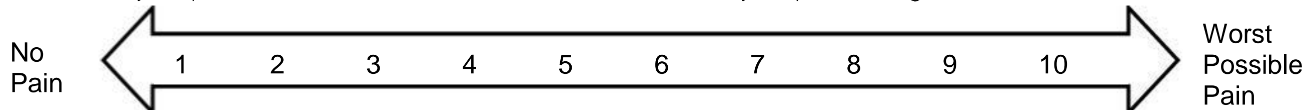
2. What is your TYPICAL or AVERAGE pain?



3. What is your pain level at AT ITS BEST (How close to "0" does your pain get at its best)?



4. What is your pain level AT ITS WORST (How close to "10" does your pain level get at its worst)?



Name: ______________________________ Date: ______________________

ACTIVITIES OF DAILY LIVING

Please identify how your current condition is affecting your ability to carry out these activities:

Activity				
Carrying Groceries	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Sit to Stand	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Climbing Stairs	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Driving	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Extended Computer Use	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Household Chores	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Lifting Children	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Reading/Concentration	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Bathing	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Dressing	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Washing/Bathing/Shaving	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Sexual Activities	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Sleep	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Sitting	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Standing	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Yard Work	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Walking	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Dishes	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Laundry	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Taking out Garbage	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Other	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Other	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform

Essential 1: Core Chiropractic

Do you perform any activities regularly that negatively affect your spine?

☐ Computer use: _____hours/day ☐ Driving: _____hours/day ☐ Texting/Phone use: ________hours/day
☐ Sustained positions:_______________ ☐ Lifting: _____hours/day ☐ Repetitive Activities: _______________
☐ Household activities: _______________ ☐ Sitting: _____hours/day ☐ Poor sleeping position: _____________
☐ Sports/Activities:_______________ ☐ Work activities:__________________ ☐ Hobbies:__________________

Name: ______________________________ Date: ____________________

Essential 2: Nutrition

Have you had any change in blood pressure, cholesterol, blood sugar, triglycerides, or other lab values? (Y / N)

If **Yes,** please explain____

Do you eat breakfast daily? (Y / N)
How many days per week do you skip one meal? (0) (1) (2) (3) (4+)
How many fast food meals do you eat per week? (0) (1-3) (4-6) (7+)
How many servings of fruit do you have per day? (0-1) (2-3) (4+)
How many servings of vegetables do you have per day? (0-1) (2-3) (4+)
Do you regularly drink (1 or more per day) any of the following? (Check all that apply)

☐Diet Soda ☐Coffee ☐Juice
☐Milk ☐Soda ☐Alcohol

Essential 3: Mindset

Are you sleeping better since starting care? (Y / N) Please explain ____________________
Are you handling pressure and deadlines more easily since starting care? (Y / N)
Have you attended a workshop in our office yet? (Y / N)

Essential 4: Oxygen & Exercise

How many times per week do you exercise? _________/week
Type:____________________ __________minutes ___________days/week
Type:____________________ __________minutes ___________days/week
Type:____________________ __________minutes ___________days/week

Have you lost weight since you began receiving care in our office? (Y / N)
Do you know your current weight? (Y / N)
Do you have a target weight you want to achieve?(Y / N) ☐ Increase_______pounds ☐ Decrease______pounds

Essential 5: Minimize Toxins

Have you or any members of your family had a vaccination or flu shot since starting care? (Y / N)
Are you taking any new medications since starting care? (Y / N) If **Yes**, please explain________________
Do you need more information on the usefulness and the side-effects of drugs, vaccines, and other medical treatments? (Y / N) If **Yes**, which ones? ______________________________

Lifestyle

On a scale of 1 to 10 with 10 being very willing, how willing are you to change your lifestyle to reach your health goals? (1) (2) (3) (4) (5) (6) (7) (8) (9) (10)

Do you need help or advice with specific health issues? i.e.: Diabetes, High Blood Pressure, High Cholesterol, Cancer, Super Immunity, Depression/Anxiety, Anti-Aging, Hormone Based Weight Loss (Y / N)
If **Yes,** which ones?____

Have you started any of the following programs to support your body's ability to heal?
☐Advanced Nutrition Plan ☐Core Nutrition Plan ☐MaxT3 ☐Daily Detox

Do you have any questions or need help with any of these programs? (Y / N)
If **Yes,** please explain:____

Patient Signature ______________________________ Date________________

Doctor Signature ______________________________ Date________________