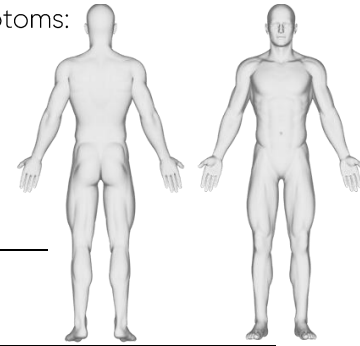


Name: _____ Date: _____



Progress Evaluation II

*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: <input type="checkbox"/> Constantly <input type="checkbox"/> Daily <input type="checkbox"/> Several x/week <input type="checkbox"/> Several x/month <input type="checkbox"/> Never
	Pain Occurs: <input type="checkbox"/> Constantly <input type="checkbox"/> Daily <input type="checkbox"/> Several x/week <input type="checkbox"/> Several x/month <input type="checkbox"/> Never
	Pain Occurs: <input type="checkbox"/> Constantly <input type="checkbox"/> Daily <input type="checkbox"/> Several x/week <input type="checkbox"/> Several x/month <input type="checkbox"/> Never
	Pain Occurs: <input type="checkbox"/> Constantly <input type="checkbox"/> Daily <input type="checkbox"/> Several x/week <input type="checkbox"/> Several x/month <input type="checkbox"/> Never
	Pain Occurs: <input type="checkbox"/> Constantly <input type="checkbox"/> Daily <input type="checkbox"/> Several x/week <input type="checkbox"/> Several x/month <input type="checkbox"/> 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

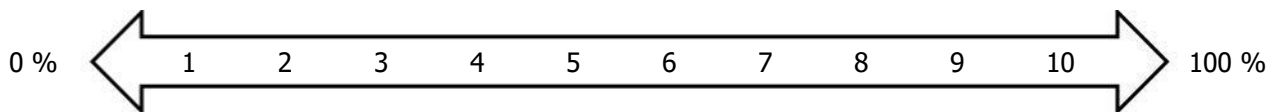
If yes, what? _____

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

7. Have you been able to reduce any medications since starting care? No Yes

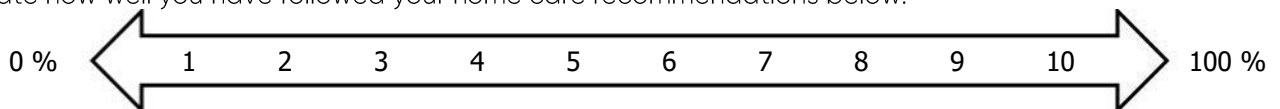
If yes, what? _____

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

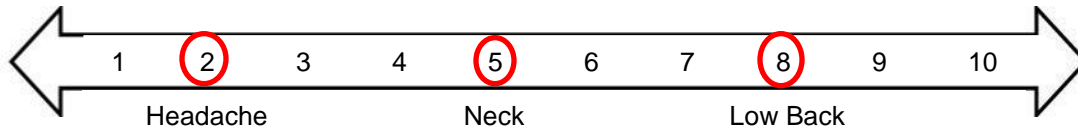
13. How would you rate the service in our office? Excellent Good Fair Poor

Comments: _____

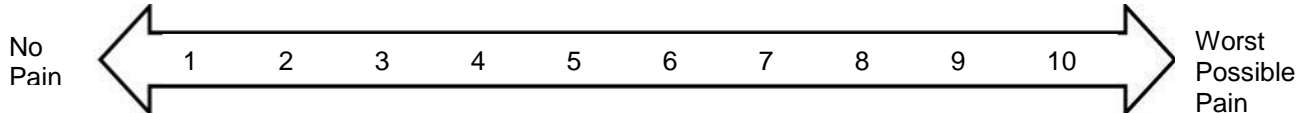
INTENSITY RATING

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

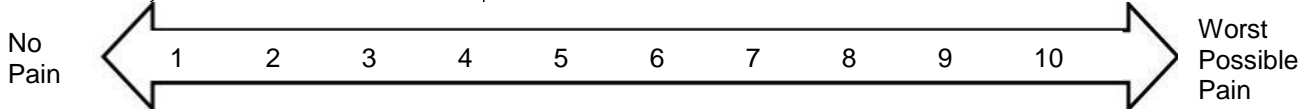
EXAMPLE:



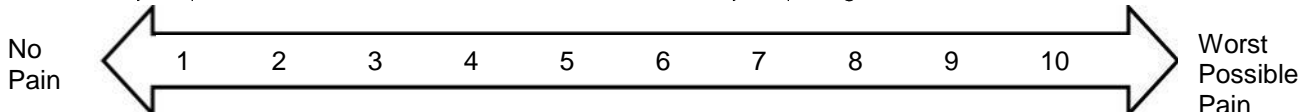
1. What is your pain RIGHT NOW?



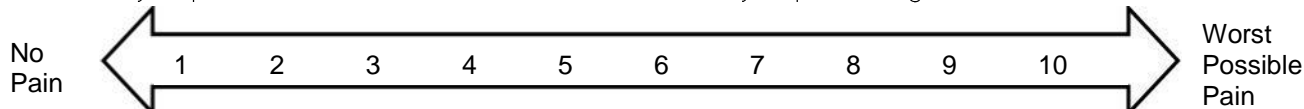
2. What is your TYPICAL or AVERAGE pain?



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:

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

Do you know what is required to maintain your spine for the rest of your life? Check all that apply.

Doing prescribed exercises everyday Getting adjusted Use Headweights Doing nothing at all

Patient Signature _____ Date _____

Doctor Signature _____ Date _____