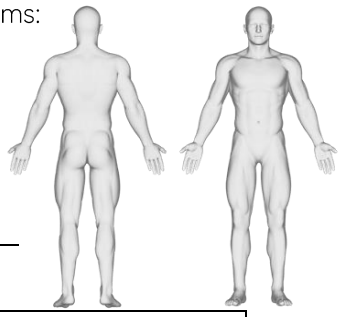
Name: _____Date:_____

# Wellness Progress Evaluation

*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. Have you had any new injuries or accidents since your last evaluation? (Y/N)?
If Yes, please explain_____

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

0 % 1 2 3 4 5 6 7 8 9 10 100 %

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

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

0 % 1 2 3 4 5 6 7 8 9 10 100 %

7. 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 |

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

If No, why not? _____

9. 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

Name: _____ Date: _____

10. Do you have any questions, concerns, or new problems that we can address? ☐ No ☐ Yes

If **Yes**, please explain: _____


## 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: _____

## Essential 2: Nutrition

Do you need help/advice with specific health issues? (i.e. Diabetes, High Blood Pressure, High Cholesterol)? ( Y / N )

If **Yes**, which ones? _____

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

Do you need help with Hormone Based Weight Loss? ( Y / N )

## Essential 3: Mindset

Are you sleeping better since starting care? ( Y / N ) Please explain _____
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

Do you need more information on non-toxic personal care or home care products? ( Y / N )
If **Yes**, which ones? _____

Are you taking any new medications since starting care? ( Y / N ) If **Yes**, please explain _____

Patient Signature _____ Date _____

Doctor Signature _____ Date _____