PATIENT CARE PROGRESS REPORT

NAME: _____ Date: _____

What positive/negative changes have you noticed since beginning care?
Positive:_____

Negative:_____

DAILY ACTIVITIES:

Mark the following boxes according to how your main complaint that brought you into the office affects your daily activities today. If your main complaint does not affect your daily activities, mark "no effect." If you can perform the activity only 50% of the time due to your main complaint, mark 50%.

Bending	[ ] No Effect [ ] Can do 75% [ ] 50% [ ] 25% [ ] Unable to Perform
Carrying	[ ] No Effect [ ] Can do 75% [ ] 50% [ ] 25% [ ] Unable to Perform
Climbing	[ ] No Effect [ ] Can do 75% [ ] 50% [ ] 25% [ ] Unable to Perform
Concentrating	[ ] No Effect [ ] Can do 75% [ ] 50% [ ] 25% [ ] Unable to Perform
Dancing	[ ] No Effect [ ] Can do 75% [ ] 50% [ ] 25% [ ] Unable to Perform
Doing Chores	[ ] No Effect [ ] Can do 75% [ ] 50% [ ] 25% [ ] Unable to Perform
Doing Computer Work	[ ] No Effect [ ] Can do 75% [ ] 50% [ ] 25% [ ] Unable to Perform
Dressing	[ ] No Effect [ ] Can do 75% [ ] 50% [ ] 25% [ ] Unable to Perform
Driving	[ ] No Effect [ ] Can do 75% [ ] 50% [ ] 25% [ ] Unable to Perform
Gardening	[ ] No Effect [ ] Can do 75% [ ] 50% [ ] 25% [ ] Unable to Perform
Lifting	[ ] No Effect [ ] Can do 75% [ ] 50% [ ] 25% [ ] Unable to Perform
Performing Sexual Activity	[ ] No Effect [ ] Can do 75% [ ] 50% [ ] 25% [ ] Unable to Perform
Playing Sports	[ ] No Effect [ ] Can do 75% [ ] 50% [ ] 25% [ ] Unable to Perform
Pushing	[ ] No Effect [ ] Can do 75% [ ] 50% [ ] 25% [ ] Unable to Perform
Reading	[ ] No Effect [ ] Can do 75% [ ] 50% [ ] 25% [ ] Unable to Perform
Recreating	[ ] No Effect [ ] Can do 75% [ ] 50% [ ] 25% [ ] Unable to Perform
Rolling Over	[ ] No Effect [ ] Can do 75% [ ] 50% [ ] 25% [ ] Unable to Perform
Running	[ ] No Effect [ ] Can do 75% [ ] 50% [ ] 25% [ ] Unable to Perform
Shoveling	[ ] No Effect [ ] Can do 75% [ ] 50% [ ] 25% [ ] Unable to Perform
Sitting	[ ] No Effect [ ] Can do 75% [ ] 50% [ ] 25% [ ] Unable to Perform
Sitting to Stand	[ ] No Effect [ ] Can do 75% [ ] 50% [ ] 25% [ ] Unable to Perform
Sleeping	[ ] No Effect [ ] Can do 75% [ ] 50% [ ] 25% [ ] Unable to Perform
Standing	[ ] No Effect [ ] Can do 75% [ ] 50% [ ] 25% [ ] Unable to Perform
Walking	[ ] No Effect [ ] Can do 75% [ ] 50% [ ] 25% [ ] Unable to Perform
Watching TV	[ ] No Effect [ ] Can do 75% [ ] 50% [ ] 25% [ ] Unable to Perform
Working	[ ] No Effect [ ] Can do 75% [ ] 50% [ ] 25% [ ] Unable to Perform

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On a scale of one to ten, rate your level of improvement:

No Change — Major Change

1 2 3 4 5 6 7 8 9 10

Would you say your improvement is:

[ ] Taking longer than you expected
[ ] Progressing at the speed you expected
[ ] Occurring much faster than you expected

How would you rate the concern by our staff?

Uninterested — Deeply Concerned

1 2 3 4 5 6 7 8 9 10

How would you rate the training, qualifications, and competency of our staff?

Unorganized — Efficient and Knowledgeable

1 2 3 4 5 6 7 8 9 10

What ways would you change the office or procedures we use to improve the quality of care?_____

_____

What do you like most about our office?_____

_____

_____

We strive to fully inform our patients about their care, chiropractic, and their health. How would you describe our educational efforts?

[ ] Excellent, I've learned a lot
[ ] Helpful and interesting
[ ] Still leaves some questions unanswered
[ ] Could be significantly improved

Do you foresee any issue stopping you from making your appointments? **Yes** **No**

If yes, explain: _____

_____

We greatly appreciate it when you tell others who are not healthy or want to optimize their potential about us. If you know someone who should be seeing us, but isn't, we can supply some helpful information to help you better explain today's chiropractic care.

Name: _____ [ ] Friend [ ] Relative _____ Phone: _____

Name: _____ [ ] Friend [ ] Relative _____ Phone: _____

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PROGRESS EVALUATION

NAME: _____ Date: _____

NERVE SYSTEM

Have you missed any appointments? YES NO If so, how many? _____

Have you made these up? YES NO

Have you been doing your at-home rehab as prescribed? YES NO

How many days per week? _____

NUTRITIONAL

Have you had any change in blood pressure, cholesterol, blood sugar, triglycerides, or other lab values? _____

_____

Do you eat breakfast daily for Monday thru Friday? YES NO

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 2 3 4+

How many servings of fruit do you have on a given day? 0-1 2-3 4+

How many servings of vegetables do you have on a given day? 0-1 2-3 4-5 6+

Do you regularly drink (one or more per day) any of the following?

Diet Soda Milk Coffee Soda Juice Alcohol

FITNESS

How many times per week do you exercise?

Cardiovascular? # of minutes: _____ # of days per/week: _____

Weight Training? # of minutes: _____ # of days per/week: _____

Low Impact (yoga, etc)? # of minutes: _____ # of days per/week: _____

What weight were you when you started? _____

What is your current weight? _____

What is your target weight? _____

How willing are you to change your lifestyle to reach your health goals? (scale of 1-10, 10 is most willing) _____

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TOXICITY

Have you or any members of your family had a vaccination or flu shots since starting care? YES NO

Have you been able to reduce any medications since starting care? YES NO _____

_____

Are you taking any new medications since starting care? YES NO _____

_____

Do you need more information on the usefulness and the side-effects of drugs, vaccines, and other medical treatments? YES NO _____

STRESS

Are you sleeping better since starting care? YES NO Please explain: _____

_____

Are you handling pressure and deadlines more easily since starting care? YES NO

Have you started any of the following programs in the office?

The Advanced or Core Plan Nutrition Plans Surge Training MaxT3 Daily Detox

Do you have any questions or need help with any of these programs? _____

_____

_____

Do you need help or advice with specific health issues? (diabetes, high blood pressure, high cholesterol, cancer free/super immunity, depression/anxiety, anti-aging, hormone based weight loss)_____

_____

DOCTOR SIGNATURE: _____ DATE: _____

FOR OFFICE USE ONLY

Future Appointment Schedule (Per Week): ☐ 3x ☐ 2x ☐ 1x ☐ 1/2x

Next Appointment _____/_____/_____

Please bring this paperwork to the front desk to check out after your exam. Thank you!

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