Progress Check

To help ensure that we are on track toward achieving your health goals, please tell us what types of changes you are experiencing as your body begins the natural healing process.

Patient Name: ______________________________ Date: ______________

YOUR WELLNESS GOALS

Your initial health goals for care were:	How would you rate your **progress** toward those goals so far?				
	Worse		*No change*		*Improved*
1. ______________	①	②	③	④	⑤
2. ______________	①	②	③	④	⑤
3. ______________	①	②	③	④	⑤

HOW ARE YOU DOING?

Have you noticed any **improvements** in any of the following?

- ○ Sleeping
- ○ Walking & Running
- ○ Flexibility & Mobility
- ○ Sitting/Standing
- ○ Energy Levels
- ○ Emotional Stress
- ○ Changing Habits
- ○ Pain Management
- ○ Family/Work Life
- ○ Decreased heartburn

Tell us about any **changes** that you have noticed since beginning care:

· Physical Changes *(ex. Less pain, more mobility, feeling stronger, etc.)*

· Health Changes *(ex. Fewer illnesses, less severe symptoms, etc.)*

· Emotional Changes *(ex. Better mood regulation, less anxious, etc.)*

· Energy & Stress Levels *(ex. Sleeping better, more energy, happier, etc.)*

Tell us about any **new** health challenges or stressors in your life-fill out attached struggle survey.

YOUR HEALTH PROGRESS

Your improvement so far is...

○ Taking longer than expected ○ Progressing as expected ○ Occurring faster than expected

Rate the impact of these improvements on your **health**:

No impact ① ② ③ ④ ⑤ *Great impact*

Rate the impact of these improvements on your **quality of life**:

No impact ① ② ③ ④ ⑤ *Great impact*

Office Evaluation

We constantly strive to make our best even better for you and your family. Your feedback is important and appreciated!

HOW ARE WE DOING?

How would you rate the care and concern shown by our doctor(s)?	How would you rate the care and concern shown by our staff?
Poor ① ② *Average* ③ ④ *Excellent* ⑤	*Poor* ① ② *Average* ③ ④ *Excellent* ⑤
How would you rate the training and competency of our doctor(s)?	**How would you rate the training and competency of our staff?**
Poor ① ② *Average* ③ ④ *Excellent* ⑤	*Poor* ① ② *Average* ③ ④ *Excellent* ⑤
Comments about our doctor(s):	Comments about our staff:

PRACTICE FEEDBACK

What do you like most about our office?

What would you change about our office, staff, or procedures to improve your experience?

How would you describe our educational efforts such as workshops, events, handouts, posters, etc.

- ○ Excellent, I've learned a lot!
- ○ Could be significantly improved
- ○ Ineffective use of resources
- ○ Helpful & interesting
- ○ Not enough materials or events
- ○ Leaves some questions unanswered

SUPPORT & REFERRALS & CONTINUED CARE

Our practice grows through word of mouth and referrals. If you are experiencing positive results, please help spread the message!

Have you told your family & friends about chiropractic? ○ Yes ○ No

What feedback and comments have you heard from others since beginning care?

Would you be willing to share how chiropractic has impacted your health? ○ Yes, I'll share my story ○ Not at this time

**Please write your story below.

Do you plan to continue care? ○ Yes ○ No ○ Will follow my doctors recommendation

Thank you for helping us make a positive impact on our community!

Patient Signature: ______________________________ Date: ____________

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Struggle Survey

Tell us about your struggles, whether they be pain related (headaches, back pain, neck pain, wrist/ankle pain, etc.) or functional (digestion, energy, ADD/ADHD, vertigo, sleep, etc.) you have been experiencing.
If you are truly here for wellness and haven't had any struggles in the last month please check this box. ☐

Struggle 1: ____
Severity:(no issue) 0 1 2 3 4 5 6 7 8 9 10 (big issue) **Progression**: same better worse
Impact on life: mild mod severe **Frequency:** < 25% 25-50% 50-75% >75%
When did you notice the problem? ____________ How did it start?____________________
Better with: rest motion ice heat meds topicals massage chiropractic other: ____________
Worse with: bending movement lifting walking sit stand lying stress other: ____________
Feels like? sharp shooting dull ache burning stiff stabbing throbbing numb sore
Does it travel? (to arms, legs, etc.) Yes No **If yes, where?** ______________________
What time of day is it worst? morning afternoon evening falling asleep while sleeping
What treatment(s) have you received? PT surgery injection chiropractic acupuncture **Helpful?** Yes No

Struggle 2: ____
Severity:(no issue) 0 1 2 3 4 5 6 7 8 9 10 (big issue) **Progression**: same better worse
Impact on life: mild mod severe **Frequency:** < 25% 25-50% 50-75% >75%
When did you notice the problem? ____________ How did it start?____________________
Better with: rest motion ice heat meds topicals massage chiropractic other: ____________
Worse with: bending movement lifting walking sit stand lying stress other: ____________
Feels like? sharp shooting dull ache burning stiff stabbing throbbing numb sore
Does it travel? (to arms, legs, etc.) Yes No **If yes, where?** ______________________
What time of day is it worst? morning afternoon evening falling asleep while sleeping
What treatment(s) have you received? PT surgery injection chiropractic acupuncture **Helpful?** Yes No

Struggle 3: ____
Severity:(no issue) 0 1 2 3 4 5 6 7 8 9 10 (big issue) **Progression**: same better worse
Impact on life: mild mod severe **Frequency:** < 25% 25-50% 50-75% >75%
When did you notice the problem? ____________ How did it start?____________________
Better with: rest motion ice heat meds topicals massage chiropractic other: ____________
Worse with: bending movement lifting walking sit stand lying stress other: ____________
Feels like? sharp shooting dull ache burning stiff stabbing throbbing numb sore
Does it travel? (to arms, legs, etc.) Yes No **If yes, where?** ______________________
What time of day is it worst? morning afternoon evening falling asleep while sleeping
What treatment(s) have you received? PT surgery injection chiropractic acupuncture **Helpful?** Yes No

**For additional struggles, please fill out another "Struggle Survey" form to submit or write on the back of this page.

Contact Information Changes

If any of your contact information has changed please provide the new information below.

Address: ____
Phone Number: ______________________ E-mail Address: ______________________
Contact Preference: Phone E-mail Text Form delivery: E-mail Mail In person
Any changes to your insurance information? Yes No If yes, please supply us with your new insurance card.