Progress Exam Questionnaire

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 ① ② ③ ④ ⑤ *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	◯ Energy Levels
◯ Emotional Stress	◯ Changing Habits	◯ Pain Management	◯ Family Life	◯ Work Life

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:

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

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

Our practice grows through word of mouth and referrals.
If you have loved ones experiencing health problems, please tell them about your experience, and/or list them below.

Name: _____ Relationship: _____ Phone: _____ May we contact them? ○ Yes ○ No

Name: _____ Relationship: _____ Phone: _____ May we contact them? ○ Yes ○ No

Name: _____ Relationship: _____ Phone: _____ May we contact them? ○ Yes ○ No

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

Patient Signature: _____ Date: ____/____/____

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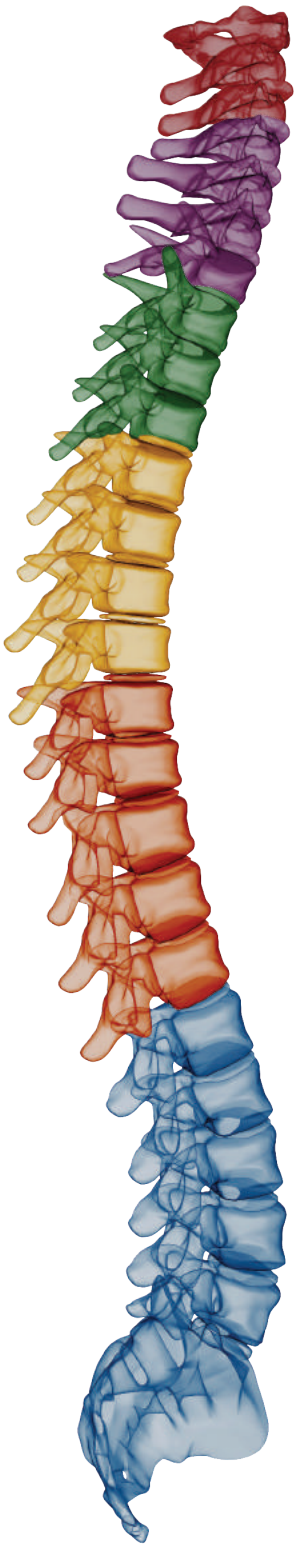
Patient Review of Systems

THE NERVOUS SYSTEM CONTROLS AND COORDINATES ALL ORGANS AND STRUCTURES OF THE HUMAN BODY

Please check the corresponding boxes for each symptom or condition you have experienced – including both past and present.



REGIONS	FUNCTIONS	SYMPTOMS (PAST / PRESENT)	
Cervical	• Autonomic Nervous System • ENT System • Vision, Balance & Coordination • Speech • Immune System • Digestive System • Nerve Supply to Shoulders, Arms & Hands • Sympathetic Nucleus • Metabolism	☐☐ Colic & Excessive Crying ☐☐ Ear & Sinus Infections ☐☐ Allergies & Congestion ☐☐ Immune Deficiency ☐☐ Headaches & Migraines ☐☐ Vertigo & Dizziness ☐☐ Sore Throat & Strep ☐☐ Swollen Tonsils & Adenoids ☐☐ Vision & Hearing Issues ☐☐ Low Energy & Fatigue ☐☐ Difficulty Sleeping ☐☐ Pain, Numbness & Tingling in Arms to Hands	☐☐ Epilepsy & Seizures ☐☐ Sensory & Spectrum ☐☐ ADD / ADHD ☐☐ Focus & Memory Issues ☐☐ Anxiety & Stress ☐☐ Balance & Coordination ☐☐ Speech Issues ☐☐ TMJ / Jaw Pain ☐☐ Stiff Neck & Shoulders ☐☐ Depression ☐☐ High Blood Pressure ☐☐ Poor Metabolism & Weight Control
Upper Thoracic	• Upper G.I. • Respiratory System • Cardiac Function	☐☐ Reflux / GERD ☐☐ Chronic Colds & Cough ☐☐ Asthma	☐☐ Bronchitis & Pneumonia ☐☐ Functional Heart Conditions
Mid Thoracic	• Major Digestive Center • Detox & Immunity	☐☐ Gallbladder Pain / Issues ☐☐ Jaundice ☐☐ Fever	☐☐ Indigestion & Heartburn ☐☐ Stomach Pains & Ulcers ☐☐ Blood Sugar Problems
Lower Thoracic	• Stress Response • Filtration & Elimination • Gut & Digestion • Hormonal Control	☐☐ Behavior Issues ☐☐ Hyperactivity ☐☐ Chronic Fatigue ☐☐ Chronic Stress	☐☐ Allergies & Eczema ☐☐ Skin Conditions / Rash ☐☐ Kidney Problems ☐☐ Gas Pain & Bloating
Lumbar, Sacrum & Pelvis	• Lower G.I. (Absorption & Motility) • Gut-Immune System • Major Hormonal Control	☐☐ Constipation ☐☐ Chrohn's, Colitis & IBS ☐☐ Diarrhea ☐☐ Bed-wetting ☐☐ Bladder & Urination Issues ☐☐ Cramps & Menstrual Issues ☐☐ Cysts & Endometriosis ☐☐ Infertility ☐☐ Impotency ☐☐ Hemorrhoids	☐☐ Sciatica & Radiating Pain ☐☐ Lumbopelvic / SI Joint Pain ☐☐ Hamstring Tightness ☐☐ Disc Degeneration ☐☐ Leg Weakness & Cramps ☐☐ Poor Circulation & Cold Feet ☐☐ Knee, Ankle & Foot Pain ☐☐ Weak Ankles & Arches ☐☐ Lower Back Pain ☐☐ Gluten & Casein Intolerance

Patient Name: _____ Date: __/__/__

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