Progress Examination Questionnaire

Patient Name: _____ Date: _____

1. Please comment on the progression of your major complaints:

☐ **Complaint #1**: _____

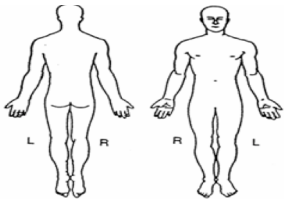
Please check the appropriate box: The pain is ☐ constant ☐ it comes and goes

From a scale from 1-10 with 10 being the worst circle the level of pain 0 1 2 3 4 5 6 7 8 9 10

Type of Pain: ☐ Sharp ☐ Burning ☐ Dull ☐ Tingling ☐ Numbness Other _____

Since your last visit how long did you feel relief? <1 Day 1 Day 2 Days 3 Days >3 Days

++ Sharp/Stabbing
Burning
XX Tingling/Numb 00 Dull



☐ **Complaint #2**: _____

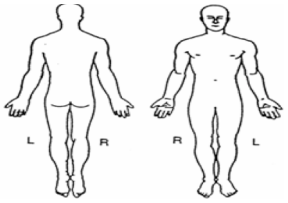
Please check the appropriate box: The pain is ☐ constant ☐ it comes and goes

From a scale from 1-10 with 10 being the worst circle the level of pain 0 1 2 3 4 5 6 7 8 9 10

Type of Pain: ☐ Sharp ☐ Burning ☐ Dull ☐ Tingling ☐ Numbness Other _____

Since your last visit how long did you feel relief? <1 Day 1 Day 2 Days 3 Days >3 Days

++ Sharp/Stabbing
Burning
XX Tingling/Numb 00 Dull



☐ **Additional /Info:** _____

2. How would you rate your overall improvement?

☐ No Improvement ☐ Some Improvement ☐ Considerable Improvement ☐ 100% Improvement

3. Please list any additional lifestyle changes you have made since your last examination. (ie. Exercise, Diet, Sleep, Stress, etc)

_____

4. What medications have you stopped (or started) since your last examination?

_____

5. How are you doing with keeping your scheduled appointments? Keeping your rhythm?
Grade yourself: ☐ A ☐ B ☐ C ☐ D ☐ F

6. What bad habits to you currently have that are affecting your spinal health

__Eating inflammatory diet	__Poor ergonomics at work	__Being sedentary all day / no exercise	__Sleeping with a feather pillow
__Not drinking enough water	__Looking down at a screen	__One-sided exercises (golf/tennis)	__Sleeping on your stomach
__Not taking Foundation Nutrition	__Using non-ergonomic chair	__Not doing rehab exercises	__Sleeping on a soft mattress
__Excessive daily stress at work	__Excessive stress at home	__Not able to lose weight	__Not getting enough sleep
__ Excessive intake of alcohol	__ Excessive intake of caffeine	__Excessive intake of pain meds	__Excessive intake of fast

7. How are you doing with breaking your bad habits?
Grade yourself: ☐ A ☐ B ☐ C ☐ D ☐ F

8. Do you know the 3 “Keys to Obtain Results and/or Correction”?
☐Specific Exercises ☐ Sleep Patterns ☐ Adjustments ☐ Laughter ☐Breaking Bad Habits

9. Do you know what exercises you should be doing to support your adjustments?
☐Yes ☐ No

10. How are you doing with your exercises?
Grade yourself: ☐ A ☐ B ☐ C ☐ D ☐ F

11. Have you been implementing what you have been learning at the clinic?
☐Yes ☐ No

12. What determines how often you should be adjusted?
Pick 2: ☐Your goals ☐The weather ☐How well you hold your adjustments ☐Random chance ☐No idea

13. What influences how well you hold your adjustments?
Pick all that apply: ☐ Your commitment to keeping your appointments (Rhythm)
☐ Breaking the bad habits that cause subluxation
☐ Adding specific exercises that strengthen the spine

14. How do you feel your care is going? Are your expectations being met?

_____

15. What could you do to get even better results and reach your goals?

_____

16. What can we do to help you get better results and reach your goals?

_____

17. Please circle the changes you have noticed in the box below.

More Relaxed	Improved Hearing	Improved Immunity	Bending Is Easier
More Rested	Improved Balance	Improved Allergies	Sitting Is Easier
Stronger	Improved Sleep	Fewer Colds/flu	Increase Overall Comfort
More Alert	Improved Vision	Walking is Easier	Increase neck Comfort
Better Memory	Improved Breathing	Standing Is Easier	Increased Back Comfort

Women	**Men**	**Children**
More Regular Cycles	Reduced Prostate Irritation	Improvement with colic
More comfortable cycles	Improved Sexual Function	Improvement with earaches
Improved Sexual Function		Improved behavior

Patient's Signature: _____

For Office Use Only:

☐ FR ☐Rev ☐ Dx ☐Plan/Goal ☐ FmHx ☐ Test ☐ MD Update Schedule: _____