

# Patient Progress Report

Name \_\_\_\_\_ Date \_\_\_\_\_

## How Do You Feel Today

Please list your present symptoms for today :

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Is there any area/condition that you feel is not improving or is improving slower than you expected?

No  Yes → \_\_\_\_\_

Have you had any new complaints / conditions?

No  Yes → \_\_\_\_\_

Why is additional chiropractic care necessary for you at this point? (check all that apply)

Still have pain  My activities are still impaired  To maintain my current level of health

I don't know  Other \_\_\_\_\_

Please add anything else you would like the doctor to know about your current condition :

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Consultation Notes

## How Are You Improving?

How has your condition/pain changed **since you started care with us?**

1	2	3	4	5	6	7
great	moderate	mild	no change	mild	moderate	much
improvement	improvement	improvement		worsening	worsening	worse

Have your abilities to perform your activities of daily living or work activities improved **since you started care with us?**  Yes  No

Please circle the % that your condition has improved **since you started care with us.**

0%    10%    20%    30%    40%    50%    60%    70%    80%    90%    100%

## How Are We Doing?

Please let us know if there is any way we could improve your experience in this office. Thank you.

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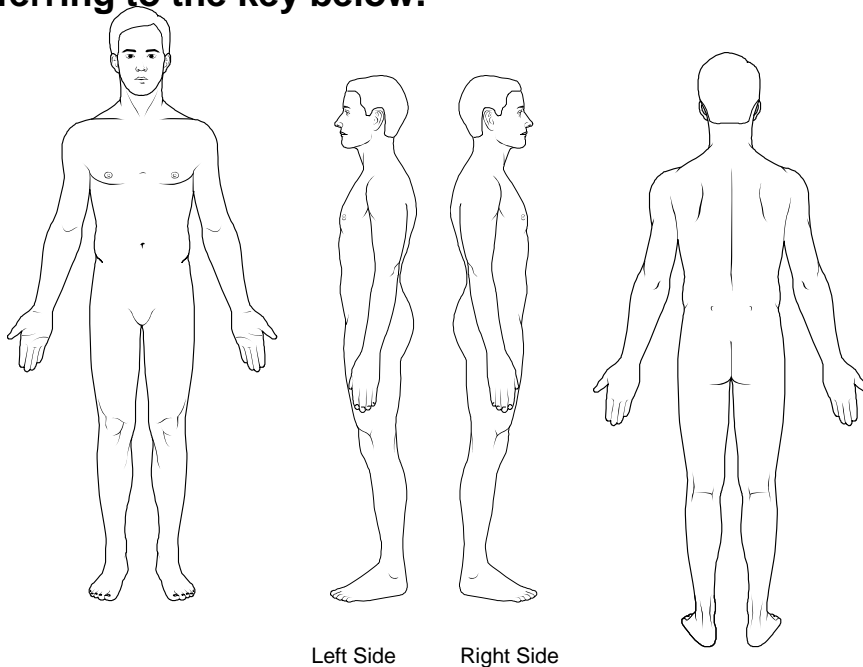
\_\_\_\_\_  
Drs Initials

# Pain Drawing & Quadruple Index

Name \_\_\_\_\_ Date \_\_\_\_\_

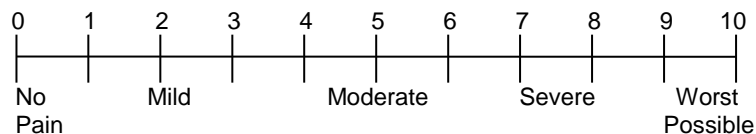
**1. Mark these drawings according to where you hurt** (If the right side of your neck hurts, mark the drawing on the right side of the neck, etc.). **Please indicate which sensations you feel by referring to the key below.**

KEY	
Stabbing	//////////
Burning	XXXXXXXX
Pins & Needles	OOOOOO
Aching	++++++
Numbness	=====

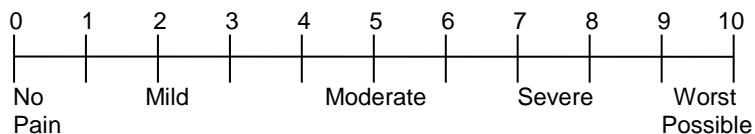


**2. On the FOUR scales below, please draw a vertical line representing your pain or discomfort.**

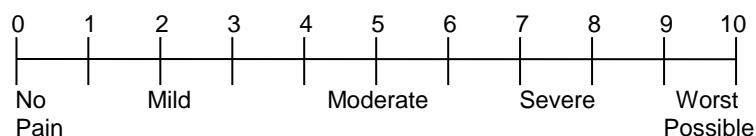
**A. Rate the pain you have RIGHT NOW:**



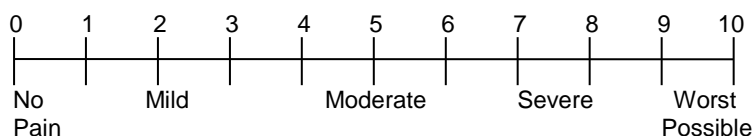
**B. Rate your AVERAGE pain in the past week:**



**C. Rate your pain at its BEST in the past week:**



**D. Rate your WORST pain in the past week:**



Consultation Notes

\_\_\_\_\_  
Drs Initials

# Activities of Daily Living

Name \_\_\_\_\_ Date \_\_\_\_\_

In order to properly assess your condition, we must understand how much your neck and/or back problems have affected your ability to manage everyday activities. For each item below, please circle the number which most closely describes your condition RIGHT NOW.

Pain Intensity

- |          |           |               |             |                     |
|----------|-----------|---------------|-------------|---------------------|
| <b>0</b> | <b>1</b>  | <b>2</b>      | <b>3</b>    | <b>4</b>            |
| No Pain  | Mild pain | Moderate pain | Severe pain | Worst possible pain |

Recreation

- |                       |                        |                        |                         |                          |
|-----------------------|------------------------|------------------------|-------------------------|--------------------------|
| <b>0</b>              | <b>1</b>               | <b>2</b>               | <b>3</b>                | <b>4</b>                 |
| Can do All Activities | Can do most activities | Can do some activities | Can do a few activities | Cannot do any activities |

Sleeping

- |               |                        |                            |                         |                         |
|---------------|------------------------|----------------------------|-------------------------|-------------------------|
| <b>0</b>      | <b>1</b>               | <b>2</b>                   | <b>3</b>                | <b>4</b>                |
| Perfect sleep | Mildly disturbed sleep | Moderately disturbed sleep | Greatly disturbed sleep | Totally disturbed sleep |

Frequency of Pain

- |          |                                 |                                   |                               |                                |
|----------|---------------------------------|-----------------------------------|-------------------------------|--------------------------------|
| <b>0</b> | <b>1</b>                        | <b>2</b>                          | <b>3</b>                      | <b>4</b>                       |
| No pain  | Occasional pain; 25% of the day | Intermittent pain; 50% of the day | Frequent pain; 75% of the day | Constant pain; 100% of the day |

Personal Care (washing, dressing, etc)

- |                          |                            |                                  |                                     |                                   |
|--------------------------|----------------------------|----------------------------------|-------------------------------------|-----------------------------------|
| <b>0</b>                 | <b>1</b>                   | <b>2</b>                         | <b>3</b>                            | <b>4</b>                          |
| No pain; no restrictions | Mild pain; no restrictions | Moderate pain; need to go slowly | Moderate pain; need some assistance | Severe pain; need 100% assistance |

Lifting

- |                           |                                  |                                     |                                  |                                |
|---------------------------|----------------------------------|-------------------------------------|----------------------------------|--------------------------------|
| <b>0</b>                  | <b>1</b>                         | <b>2</b>                            | <b>3</b>                         | <b>4</b>                       |
| No pain with heavy weight | Increased pain with heavy weight | Increased pain with moderate weight | Increased pain with light weight | Increased pain with any weight |

Travel (driving, etc.)

- |                       |                         |                             |                              |                           |
|-----------------------|-------------------------|-----------------------------|------------------------------|---------------------------|
| <b>0</b>              | <b>1</b>                | <b>2</b>                    | <b>3</b>                     | <b>4</b>                  |
| No pain on long trips | Mild pain on long trips | Moderate pain on long trips | Moderate pain on short trips | Severe pain on long trips |

Walking

- |                       |                             |                             |                             |                                 |
|-----------------------|-----------------------------|-----------------------------|-----------------------------|---------------------------------|
| <b>0</b>              | <b>1</b>                    | <b>2</b>                    | <b>3</b>                    | <b>4</b>                        |
| No pain; any distance | Increased pain after 1 mile | Increased pain after ½ mile | Increased pain after ¼ mile | Increased pain with all walking |

Work

- |   |                                  |                          |                          |             |
|---|----------------------------------|--------------------------|--------------------------|-------------|
| <b>0</b>                                    | <b>1</b>                         | <b>2</b>                 | <b>3</b>                 | <b>4</b>    |
| Can do Usual work Plus unlimited Extra work | Can do usual work; no extra work | Can do 50% of usual work | Can do 25% of usual work | Cannot work |

Standing

- |                             |                                    |                             |                             |                                  |
|-----------------------------|------------------------------------|-----------------------------|-----------------------------|----------------------------------|
| <b>0</b>                    | <b>1</b>                           | <b>2</b>                    | <b>3</b>                    | <b>4</b>                         |
| No pain after several hours | Increased pain after several hours | Increased pain after 1 hour | Increased pain after ½ hour | Increased pain with any standing |

Consultation Notes

\_\_\_\_\_ FRI Score

\_\_\_\_\_ Drs Initials