

# PROGRESS ASSESSMENT

Name \_\_\_\_\_

Date \_\_\_\_\_

1. What was the chief symptom or reason you visited our office? \_\_\_\_\_

2. Please circle the closest percentage of improvement you feel that you have made:

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

3. Please estimate how well you have followed the recommended treatment schedule:

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

4. What symptoms have improved? \_\_\_\_\_

5. What symptoms do you still have? \_\_\_\_\_

6. What changes have been made in your general feelings? Are you:

Stronger

More Relaxed

More Alert

Less Nervous

Sleeping Better

Appetite Improved

7. Do you find it easier:

Walking

Riding

Working

Bending

Standing

Sitting

Lifting

Turning

8. Is there any other condition that we have not discussed that you would like to discuss at

this time?  Yes  No If yes, please explain: \_\_\_\_\_

9. Is there any confusion about any phase of your progress? \_\_\_\_\_

10. Do you intend to continue care to avoid problems in the future?

Yes

No

Will follow my doctor's recommendations

11. Have you had the opportunity to refer anyone to our office?

Yes

No

Intend to do so

12. Your honest evaluation is always appreciated. Please comment on any areas where the

doctor(s) or staff may improve. \_\_\_\_\_