POWELL CHIROPRACTIC CLINIC, INC.
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PATIENT SUBJECTIVE PROGRESS REPORT *(please complete BOTH sides)*

Name: _____ Date of Birth: _____ Visit Date: _____
(Print Full Name)

In order for us to better serve you, we need this important confidential questionnaire answered completely by you. If you need any assistance, please do not hesitate to ask our staff for help. To comply with insurance policies, please write clearly and fill out ALL sections to the best of your ability. Thank you!

1. Please list your **Conditions/Complaints today**:

☐ Same as last visit: _____

☐ Different from last visit: _____

Frequency: ☐ **Constant** ☐ **On and Off** ☐ **25%** ☐ **25-50%** ☐ **50-75%** ☐ **75-99% of the time**

2. Have you had any of the following **Since Last Visit**? (Please Check) ☐ **Yes** ☐ **No**
☐ **New problems** ☐ **Automobile accident** ☐ **Work-related injury** ☐ **Slip and Fall**

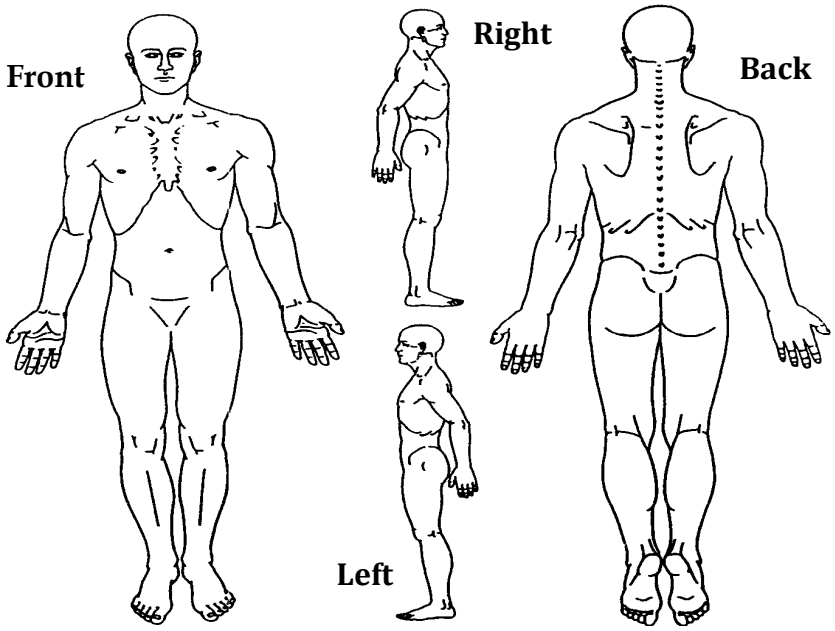
Please explain_____

If **Yes**, has this incident resulted in any increases in pain or symptoms since last visit? ☐ **Yes** ☐ **No**
Describe: _____

3. **Describe your pain:** On the diagram below, mark the areas on your body where you feel pain along with pain intensity. Include all affected areas. Use the appropriate symbol(s) listed below. If your pain travels/radiates, draw an arrow from where it starts to where it stops; please extend the arrow as far as the pain travels:

Ache A A A A	**Numbness** N N N N	**Pins and Needles** P P P P	**Burning** B B B B
Stabbing X X X X	**Throbbing** * * * *	**Tingling** T T T T	**Sharp** S S S S
Dull D D D D	**Soreness** ⊕ ⊕ ⊕ ⊕	**Shooting** → → →	**Other:** O O O O

Pain Intensity:*(please indicate on drawing below)* "No Pain" **0 – 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10** "Severe Pain"



Please list other symptoms here:

_____

_____

_____

_____

_____

PATIENT SUBJECTIVE PROGRESS REPORT *(Continued)*

4. How much time during an average day are you in pain/discomfort?
□ Less than 1 hour per day □ Between 1 and 4 hours per day □ Between 4 and 8 hours per day
□ Almost any time when not lying down □ Almost 24 hours per day □ Other_____

5. Please check the choice describing your response to the treatment **Since Last Visit:**
□ My pain/condition is rapidly getting better.
□ My pain/condition fluctuates, but overall is definitely getting better.
□ My pain/condition seems to be getting better, but improvement is slow at present time.
□ My pain/condition is neither getting better nor worse.
□ My pain/condition is gradually worsening.
□ My pain/condition is rapidly worsening.

6. Does your condition affect your normal **Activities of Daily Living**, (i.e. dressing, bathing, grooming, standing, sitting, bending stooping, walking, driving, cleaning, shopping, cooking, etc.)? □ **Yes** □ **No**
If **Yes**, please check the severity/effect: □ **Mild** □ **Moderate** □ **Severe**
Please explain/list activities: _____

7. Does your condition affect your **Work**, (i.e., standing, lifting, typing, bending, sitting, carrying, walking, concentration, etc.)? (Please Check) □ **Yes** □ **No**
If **Yes**, please check the severity/effect: □ **Mild** □ **Moderate** □ **Severe**
Please explain/list activities: _____

8. Does your condition affect your **Sleep**? (Please Check) □ **Yes** □ **No**
If **Yes**, please check the severity/effect: □ **Mild** □ **Moderate** □ **Severe**
Please explain: _____

9. Does your condition affect your **Social and Recreational Activities**, (i.e. participating in individual or group activities, social life, sporting events, hobbies, etc.)? (Please Check) □ **Yes** □ **No**
If **Yes**, please check the severity/effect: □ **Mild** □ **Moderate** □ **Severe**
Please explain/list activities: _____

10. Who is filling out this questionnaire? □ Self □ Spouse □ Parent □ Other_____

Any comments about your condition or care you have received at this office?
_____
_____
Would you be interested in sharing your story with a written and/or video Patient Testimonial? **Yes** or **No**

I certify that I have read and understand the above information. To the best of my knowledge, the above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health.

Patient's Signature_____ Date_____

Physician's Signature (upon review)_____ Date_____
Dr. Jim Powell; Dr. Walter Null; Dr. Abbey Crouse