Harlan Chiropractic & Acupuncture
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Progress Scan Questionnaire

To help ensure that we are on track toward achieving your health goals, please tell us what types of changes you or your child are experiencing as you progress through care.

1. Patient Name: _____ Date of Birth: _____

YOUR PRIMARY HEALTH GOALS

2. Your initial health goals for care were:

How would you rate your progress toward those goals so far?

1. _____ ○ 1 - Worse ○ 2 ○ 3 - No Change ○ 4 ○ 5 - Improved

2. _____ ○ 1 - Worse ○ 2 ○ 3 - No Change ○ 4 ○ 5 - Improved

3. _____ ○ 1 - Worse ○ 2 ○ 3 - No Change ○ 4 ○ 5 - Improved

HOW ARE YOU DOING?

3. **Have you noticed improvements in any of the following areas?**

- ☐ Sleeping
- ☐ Emotional Regulation + Stress Management
- ☐ Energy Levels
- ☐ Flexibility & Mobility
- ☐ Less Pain + Tension
- ☐ Family Life (More Energy, Less Stress)
- ☐ Improved Health Habits + Lifestyle
- ☐ Work Life (Manage Stress Better)
- ☐ Improved Focus + Brain Function
- ☐ Digestive (Gut) Health + Function
- ☐ Immune Health + Function
- ☐ Happier + More Easy Going
- ☐ None at this time

4. **Tell us about any CHANGES that you have noticed since beginning care within these specific catgories:**

Physical (Motor) Changes (ex. Improved tone and coordination, less pain, more mobility, etc.)

Gut, Immune, and Hormonal Changes (ex. Improved motility, less illnesses, faster recovery, etc.)

Mental and Emotional Changes (ex. Better mood regulation, less anxious, etc.)

Energy & Stress Levels (ex. Sleeping better, more energy, happier, etc.)

5. **Tell us about any new health CHALLENGES or STRESSORS in your life (ex. illnesses, stress at work, etc.):**

YOUR HEALTH PROGRESS

6. **Your improvement so far is...**

○ Progressing as expected ○ Occuring faster than expected ○ Taking longer than expected

7. **Rate the impact of these improvements on your QUALITY OF LIFE:**

○ 1 - No Impact Yet ○ 2 - Good Impact ○ 3 - Great Impact

Please explain:

Office Evaluation

We constantly strive to make our best even better for you and your family. Your feedback is important and appreciated!

8. **DOCTOR FEEDBACK:**

How would you rate the care and concern shown by our doctor(s)?
○ 1 - Poor ○ 2 ○ 3 - Average ○ 4 ○ 5 - Excellent

How would you rate the training and competency of our doctor(s)?
○ 1 - Poor ○ 2 ○ 3 - Average ○ 4 ○ 5 - Excellent

Comments about our doctor(s):

9. **STAFF FEEDBACK:**

How would you rate the care and concern shown by our care advocates?
○ 1 - Poor ○ 2 ○ 3 - Average ○ 4 ○ 5 - Excellent

How would you rate the training and competency of our care advocates?
○ 1 - Poor ○ 2 ○ 3 - Average ○ 4 ○ 5 - Excellent

Comments about our care advocates?

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10. PRACTICE FEEDBACK:

What do you like most about our office?

What would you change about our office, team, or procedures to improve your experience?

How would you describe our educational efforts such as emails, social media, workshops, events, handouts, posters, etc.
○ Excellent, I've learned a lot! ○ Helpful & interesting ○ Could be significantly improved
○ Ineffective use of resources ○ Not enough materials or events ○ Leaves some questions unanswered

SUPPORT & REFERRALS

If you are experiencing positive results, please help spread the message!

11. 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

12. **We love nothing more than helping as many kids and families as possible live healthy, happy lives! If you know of a loved one, friend, family members, or co-worker who could use our help please list them below and stop by the front desk to let us know how we could help you, help them!**

	Name	Relationship	Phone	May we contact them?
1				
2				
3				

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

Patient Signature

Signature

Date

13.