SUBJECTIVE PROGRESS REPORT

Name _____ Date _____

1. Do you have any questions regarding your care? Yes___ No___ Comments _____

_____

_____

2. What body signals have improved since your last exam? And how has this impacted your life? _____

_____

_____

_____

3. What body signals remain? And what areas are still limited? _____

_____

_____

4. Please rate your progress so far: 10% 20% 30% 40% 50% 60% 70% 80% 90% 100%
Very Poor Excellent

5. Daily Activities: Effects of Current Condition on Performance:

Carrying Groceries	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Changing Positions	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Sit or Stand	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Climbing Stairs	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Pet Care	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Driving	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Extended Computer Use	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Household Chores	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Lifting Children	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Reading/Concentration	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Self Care - Bathing	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Self Care - Dressing	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Self Care - Shaving	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Sexual Activities	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Sleep	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Sitting Still	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Standing Still	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Yard Work	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Walking	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform

Please list any effects that this may have on any Recreational Activities:_____

_____

6. Please note if you have noticed any improvement in the following:

____ Digestion ____ Energy Level ____ Elimination ____ Sleeping

____ Breathing ____ Strength ____ Composure ____ Stamina

7. Have we been attentive to your specific concerns? Yes___ No___

8. Is there anything you think the doctor should know concerning your condition? _____

_____

9. How often are you doing prescribed exercises? Are they helping? _____

_____

10. Would you tell one person about the benefits of chiropractic? Yes___ No___

If yes, then who do you wish was coming here? _____

121. Given your current understanding of chiropractic care and the results you have achieved, what are your goals through chiropractic care?

____ Just pain relief ____ Being pain free, plus improved Spinal structural ability & wellness

____ Pain relief, improved stability, plus long term increased vitality

12. Do you understand why chiropractic is so important for children? Yes___ No___

Why? _____

_____

13. Have your children been checked? Yes___ No___