Elan Wellness Service Corporation
2121 Ridge Avenue, Suite 105, Aurora, IL 60504 Tel: (630) 499-9420 / Fax: (630) 499-9450

PATIENT SUBJECTIVE PROGRESS REPORT

Name: _____ Signature (Please sign)_____ Date:____/____/____

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%, 75-100% of the time

Severity: (please circle) "No Pain" 0--1--2--3--4--5--6--7--8--9--10 "Severe Pain"

2. Is the pain (please circle) achy, burning, sharp, numb, pins & needles, stabbing, sore, dull, other_____

3. 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.

4. Please circle the percent you estimate your condition has improved **Overall Since Your First Visit** for your current condition. 0 10 20 30 40 50 60 70 80 90 100

5. 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, is the effect (Please check) Mild Moderate Severe
Please explain_____

6. Does your condition affect your **Work**, (i.e., standing, lifting, typing, bending, sitting, carrying, walking, concentration, etc.)? Please Check Yes No
If Yes, is the effect (Please Check) Mild Moderate Severe
Please explain_____

7. Does your condition affect your **Sleep**? Please Check Yes No
If Yes, is the effect (Please Check) Mild Moderate Severe

8. 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, is the effect (Please Check) Mild Moderate Severe
Please explain_____

9. 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_____

10. Tell us where you are! Facebook Twitter Instagram YouTube Pinterest Google