PROGRESS EVALUATION

NAME: _____ **Patient#:**_____

Date of last progress evaluation: _____ **DATE:** _____

1. For what reason did you originally see the Doctor?

   _____

2. What conditions are still bothering you?

   _____

3. How would you rate your improvement?

   ☐ No Improvement ☐ Some Improvement ☐Considerable Improvement ☐100% Improvement

4. Which medications (if any) have you decreased taking? _____

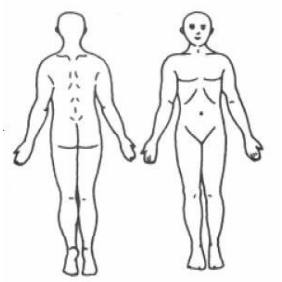
5. How would you rate the service in our office? ☐Poor ☐Fair ☐Good ☐Excellent

6. Has your family been checked for subluxation? Yes No (if no, why not?) _____

   _____

7. Why are you here? ☐to get out of pain ☐to get healthy and stay healthy for the rest of your life

   ☐ other: _____ ☐all of the above



***PLEASE MARK** the areas on the Diagram with the following **letters** to describe your symptoms:

R = Radiating **B = B**urning **D = D**ull **A =** Aching **N = N**umbness **S = S**harp/ **S**tabbing **T= T**ingling

Patient's Signature:_____ Date: _____

This section will be completed by the examiner/doctor.

Cervical ROM Flexion (50) _____ Extension (60) _____ L Lateral Flexion (45) _____ R Lateral Flexion (45) _____ L Rotation (80) _____ R Rotation (80) _____

Thoracic ROM Flexion (50) _____ L Rotation (30) _____ R Rotation (30) _____

Shoulder ROM Flexion (180) _____ Extension (60) _____ Internal Rotation (75) _____ External Rotation (90) _____ Abduction (150) _____

Lumbar ROM Flexion (90) _____ Extension (30) _____ L Lateral Flexion (30) _____ R Lateral Flexion (30) _____

Knee ROM Flexion (140) _____ Extension (10) _____

Hip ROM Flexion (125) ____ Extension (30) ____ Internal Rotation (40) ____ External Rotation (60) ____ Abduction (145) _____ Adduction (25) _____

C1
C2
C3
C4
C5
C6
C7
T1
T2
T3
T4
T5
T6
T7
T8
T9
T10
T11
T12
L1
L2
L3
L4
L5
LSI
RSI
SAC

ORTHOPEDIC TESTS

	Test	Findings				Notes
☐	SLR	+	-	R	L	☐
☐	Braggards	+	-	R	L	☐
☐	Faber-Patrick	+	-	R	L	☐
☐	Kemp's	+	-	R	L	☐
☐	Valsalva's	+	-	R	L	☐
☐	Yeoman's	+	-	R	L	☐
☐	Ely's	+	-	R	L	☐
☐	Toe Walk	+	-	R	L	☐
☐	Heal Walk	+	-	R	L	☐
☐	Sacral Apex	+	-	R	L	☐
☐	Erichsen's	+	-	R	L	☐
☐	Abduction Str	+	-	R	L	☐
☐	Adduction Str	+	-	R	L	☐
☐	Apprehension	+	-	R	L	☐
☐	Drawer Sign	+	-	R	L	☐

	Test	Findings				Notes
☐	George's	+	-	R	L	
☐	Distraction	+	-	R	L	
☐	Max. Comp.	+	-	R	L	Ipsi/Contra
☐	O'Donahue's	+	-	R	L	
☐	Soto Hall	+	-	R	L	
☐	Shoulder Dep.	+	-	R	L	
☐	Spinal Perc.	+	-	R	L	Level
☐	Finger/Nose	WNL		BNL		
☐	Adson's	+	-	R	L	
☐	Schepelmann	+	-	R	L	
☐	Bowstring's	+	-	R	L	
☐	Codman's	+	-	R	L	
☐	Dawbam's	+	-	R	L	
☐	Dugas	+	-	R	L	
☐	Impengent	+	-	R	L	
☐	Gait	WNL		Abn.		

POSTURE

Area	Findings	
F H P	+	-
Head Tilt	R	L
Head Rot	R	L
↑ Shoulder	R	L
Thor. Tilt	R	L
Thor. Trans.	R	L
↑ Hip	R	L
Hip Rot	R	L
Foot Flare	R	L

Head Weights (lbs):_____

Additional Diagnosis/Notes:_____

_____

Examiner/Doctor Signature:_____ **Date:**_____

JDD,DC 2/2012

PROGRESS EVALUATION II

NAME: _____ **Patient#:** _____

Date of last progress evaluation: _____ **DATE:** _____

1. Below you will find your pain rating at the time of your last progress evaluation on a scale of **0** to **10** with **10** being the worst pain and **zero** being no pain. In the CURRENT RATING column please rate the pain that you are currently experiencing. Under frequency and improvements, please check the box that applies.

Area	Past Rating	Current Rating	Frequency and Improvement
Head			**Pain Occurs:** ☐Constantly ☐Daily ☐Several x/week ☐Several x/month ☐Never
Neck			**Pain Occurs:** ☐Constantly ☐Daily ☐Several x/week ☐Several x/month ☐Never
Mid-Back			**Pain Occurs:** ☐Constantly ☐Daily ☐Several x/week ☐Several x/month ☐Never
Shoulder R / L			**Pain Occurs:** ☐Constantly ☐Daily ☐Several x/week ☐Several x/month ☐Never
Ribs			**Pain Occurs:** ☐Constantly ☐Daily ☐Several x/week ☐Several x/month ☐Never
Low-Back			**Pain Occurs:** ☐Constantly ☐Daily ☐Several x/week ☐Several x/month ☐Never
Other:			**Pain Occurs:** ☐Constantly ☐Daily ☐Several x/week ☐Several x/month ☐Never
Other:			**Pain Occurs:** ☐Constantly ☐Daily ☐Several x/week ☐Several x/month ☐Never
Other:			**Pain Occurs:** ☐Constantly ☐Daily ☐Several x/week ☐Several x/month ☐Never

2. Does anything you do **aggravate** your condition(s): ☐ **No** ☐ **Yes** If **yes,** what? _____
3. Does anything **relieve** your discomfort? ☐ **No** ☐ **Yes** If **yes**, what? _____
4. At the time of your last progress evaluation, you indicated a limiting ability to perform the highlighted daily activities; please identify how your current condition is affecting your ability to carry out these activities.

Bending	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Concentrating	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Doing computer Work	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Gardening	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Playing Sports	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Recreation Activities	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Shoveling	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Sleeping	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Watching TV	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Carrying	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Dancing	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Dressing	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Lifting	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Pushing	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Rolling Over	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Sitting	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Standing	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Working	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Climbing	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Doing Chores	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Driving	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Performing Sexual Activity	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Reading	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Running	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Sitting to Standing	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Walking	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform

Patient's Initials:_____