



Progress Exam Questionnaire

To help ensure that we are on track toward achieving your health goals, please tell us what types of changes you are experiencing as your body begins the natural healing process.

Patient Name: _____ Date: _____

Your Wellness Goals

Your initial health goals for care were:	How would you rate your progress toward those goals so far?				
	Worse		No Change		Improved
1. _____	1	2	3	4	5
2. _____	1	2	3	4	5
3. _____	1	2	3	4	5

How Are You Doing?

Have you noticed any improvements in any of the following?

- Sleeping
- Walking & Running
- Flexibility & Mobility
- Sitting
- Energy Levels
- Emotional Stress
- Changing Habits
- Pain Management
- Family Life
- Work Life

Tell us about any **changes** you have noticed since beginning care:

Health Changes (ex. Fewer illnesses, Less severe symptoms, etc) _____

Physical Changes (ex. Less pain, More mobility, Feeling stronger, etc) _____

Emotional Changes (ex. Better mood regulation, Less anxious, etc) _____

Energy & Stress Levels (ex. Sleeping better, More energy, Happier, etc) _____

Tell us about any **new** health challenges or stressors in your life: _____

Your Health Progress

Your improvement so far is...

- Progressing as expected
- Occurring faster than expected

Rate the impact of these improvements on your **health**:

No Impact 1 2 3 4 5 Great Impact

Rate the impact of these improvements on your **quality of life**:

No Impact 1 2 3 4 5 Great Impact

Office Evaluation

<p>How would you rate the care and concern shown by our doctor(s)?</p> <p>Poor 1 Average 3 Excellent 5</p> <p>2 4</p>	<p>How would you rate the care and concern shown by our staff?</p> <p>Poor 1 Average 3 Excellent 5</p> <p>2 4</p>
<p>How would you rate the training and competency of our doctor(s)?</p> <p>Poor 1 Average 3 Excellent 5</p> <p>2 4</p>	<p>How would you rate the training and competency of our staff?</p> <p>Poor 1 Average 3 Excellent 5</p> <p>2 4</p>
<p>Comments about our doctor(s):</p>	<p>Comments about our staff:</p>

Practice Feedback

What did you like most about our office? _____

What would change about our office, staff, or procedures to improve your experience? _____

How would you describe our educational efforts such as workshops, events, handouts, posters, etc?

Excellent, I've learned a lot!
 Could be significantly improved
 Ineffective use of resources
 Helpful and interesting
 Not enough materials or events
 Leaves some questions unanswered

Support and Referrals

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

Have you told your family & friends about chiropractic?

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 No thanks

Our practice grows through word of mouth and referrals.

If you have loved ones experiencing health problems, please tell them about your experience, and/or list them below

Name: _____ Relationship: _____ Phone: _____ May we contact them? Yes No

Name: _____ Relationship: _____ Phone: _____ May we contact them? Yes No

Name: _____ Relationship: _____ Phone: _____ May we contact them? Yes No

Patient Signature: _____ **Date:** _____