ACTION CHIROPRACTIC CLINIC & THERAPY, PLC
UPDATE/PROGRESS EVALUATION

Name_____ **Date**_____

Please be thorough when completing this form. Thank you.

Your 1st complaint was:_____

Rate your pain **NOW** (0 = no pain; 10=extreme pain): 0 1 2 3 4 5 6 7 8 9 10

Is the pain constant or does it come and go?_____

Is the pain worse during the day or at night?_____

Since treatment, what still aggravates your condition?_____

(Driving, sitting, bending, laying down, coughing, working, normal daily activities.)

Since treatment, what relieves your condition?_____

Your 2nd complaint was:_____

Rate your pain **NOW** (0 = no pain; 10=extreme pain): 0 1 2 3 4 5 6 7 8 9 10

Is the pain constant or does it come and go?_____

Is the pain worse during the day or at night?_____

Since treatment, what still aggravates your condition?_____

(Driving, sitting, bending, laying down, coughing, working, normal daily activities.)

Since treatment, what relieves your condition?_____

Your 3rd complaint was:_____

Rate your pain **NOW** (0 = no pain; 10=extreme pain): 0 1 2 3 4 5 6 7 8 9 10

Is the pain constant or does it come and go?_____

Is the pain worse during the day or at night?_____

Since treatment, what still aggravates your condition?_____

(Driving, sitting, bending, laying down, coughing, working, normal daily activities.)

Since treatment, what relieves your condition?_____

Your 4th complaint was:_____

Rate your pain **NOW** (0 = no pain; 10=extreme pain): 0 1 2 3 4 5 6 7 8 9 10

Is the pain constant or does it come and go?_____

Is the pain worse during the day or at night?_____

Since treatment, what still aggravates your condition?_____

(Driving, sitting, bending, laying down, coughing, working, normal daily activities.)

Since treatment, what relieves your condition?_____

Your 5th complaint was:_____

Rate your pain **NOW** (0 = no pain; 10=extreme pain): 0 1 2 3 4 5 6 7 8 9 10

Is the pain constant or does it come and go?_____

Is the pain worse during the day or at night?_____

Since treatment, what still aggravates your condition?_____

(Driving, sitting, bending, laying down, coughing, working, normal daily activities.)

Since treatment, what relieves your condition?_____

Do you have any new symptoms? If yes, please list._____

_____

If you were given exercises, are you doing them? _____ Yes _____ No

Are you using any supports? _____ Orthotics _____ Neck Pillow _____ Wrist Support _____ Low Back Belt

Have you seen your family physician since starting care at this office? _____ Yes _____ No

If yes, please state the reason for seeing your physician._____

_____

Do you have any questions regarding your health that we have not answered? _____Yes _____ No

If yes, please list._____

_____

Please list any concerns you have with any part of your care at this office (i.e., treatment, frequency of visits, insurance coverage)._____

_____

Do you have any complaints regarding our office?_____

_____

Are you interested in any other services we provide, such as:

_____ Nutrition Analysis
_____ Specific Exercises
_____ Supports/Orthotics
_____ Payment Plan
_____ Massage Therapy
_____ Family Referral Opportunity
_____ Bed Recommendations

Would you like a referral to another practitioner? ____ Yes ____ No If so, to whom?_____

Signature_____ **Date**_____

Your choices for future care at this office are:

1. Follow Dr. Bell's recommended schedule of _____
2. Establish your own schedule of _____
3. Discontinue chiropractic care._____