

Outcome Assessment

Name		Today's Date:
<p>The patient understands and agrees to allow this chiropractic office to use their Patient Health Information for the purpose of treatment, payment, healthcare operations, and coordination of care. We want you to know how your Patient Health Information is going to be used in this office and your rights concerning those records. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your Patient Health Information we encourage you to read the HIPAA NOTICE that is available to you at the front desk before signing this consent. If there is anyone you do not want to receive your medical records, please inform our office.</p>		
Patient's Signature		
Guardian's Signature Authorizing Care:		

Outcome Assessment							
1.	Please place an "X" on the line below to indicate level of problem. No Symptoms _____ Extreme Symptoms						
2.	What was the chief symptom or reason you visited the office? (low back pain, neck pain, etc..)						
3.	How do you classify your improvement so far since beginning your care? Excellent ____ Good ____ Fair ____ Poor ____ Other ____						
4.	On a scale of 1 to 10 with 10 being the best, how would you rate your improvement?						
5.	What symptoms have improved?						
6.	What symptoms do you still have?						
7.	What changes have been made in your general feelings? Are you: (check those indicated)						
	Stronger		More Relaxed		More Alert		
	Less Nervous		Sleep Better		Appetite Improved		
8.	Do you find it easier: (check those indicated)						
	Walking		Riding		Working		Lifting
	Standing		Sitting		Bending		Same
9.	Is there any other condition you have that we have not discussed that you would like to discuss at this time?(If yes, please explain)						
10.	Is there any confusion or question about any phase of your progress?						
11.	Do you intend to continue care to avoid problems in the future (check one) Yes _____ No _____ Will follow my doctor's recommendations _____						
12.	Have you had an opportunity to refer anyone to the Doctor? (check one) Yes _____ No _____ Intend to do so _____						
13.	Your honest evaluation of the Doctor's office is always appreciated. Please comment on any areas where the Doctor may improve.						