

# PROGRESS EVALUATION

Name: \_\_\_\_\_

Date: \_\_\_\_\_

**\*Always remember that an optimal functioning spine and nervous system is essential to the overall optimal health of your muscles, joints, organs, and skin.**

**1. What things are easier since starting care? ( please check )**

walking    working    sitting    standing    recreation    concentration

lifting    bending    driving    sleeping    relationships    personal care    other \_\_\_\_\_

**2. Any new concerns / complaints?** No/Yes (please describe) \_\_\_\_\_

**3. Rate you overall improvement** (0%-no change/worse, 100% -optimal): \_\_\_\_\_

**4. Are you satisfied with the care you received in our office?** Yes No

**5. Have you referred your family members to our office for a spinal check-up?** Yes No

**Are there any friends/co-workers you would like to refer to our office?** Yes No

\_\_\_\_\_  
Name

\_\_\_\_\_  
Phone

\_\_\_\_\_  
Name

\_\_\_\_\_  
Phone

**6. Do you have any comments or suggestions on how we can improve our office?**

Please describe: \_\_\_\_\_

-----*(For doctor use only below dotted line)*-----

CN 3 -12 \_\_\_\_\_

Reflexes: (UE) \_\_\_\_\_, (LE) \_\_\_\_\_

MMS: (UE) \_\_\_\_\_, (LE) \_\_\_\_\_

Ortho: \_\_\_\_\_

ROM: \_\_\_\_\_

Weight Scales: L \_\_\_\_\_, R \_\_\_\_\_

Auscultation: \_\_\_\_\_

TX. Plan: \_\_\_\_\_