PATIENT'S REPORT OF PROGRESS

PAIN RE-ASSESSMENT #_____

IT IS IMPORTANT FOR US TO KNOW HOW YOU ARE RESPONDING. WE ASK YOUR COOPERATION IN COMPLETING THE FOLLOWING INFORMATION.

Patient Name _____ Date _____

What conditions are still bothering you? (explain) _____

_____

RATE YOUR TREATMENT PROGRESS SO FAR (PLACE AN X IN THE APPROPRIATE BOX)

	EXCELLENT	GOOD	INTERMITTENT	POOR	WORSE
Head	☐	☐	☐	☐	☐
Neck	☐	☐	☐	☐	☐
Shoulders, Arms, Hands	☐	☐	☐	☐	☐
Upper Back	☐	☐	☐	☐	☐
Mid-Back	☐	☐	☐	☐	☐
Low Back, Pelvis	☐	☐	☐	☐	☐
Hips, Legs, Knees, Feet	☐	☐	☐	☐	☐
Exhaustion, Tiredness	☐	☐	☐	☐	☐

RATE THE SEVERITY OF YOUR PAIN BY CHECKING ONE BOX ON THE SCALE TO THE RIGHT

1 = LEAST PAIN 10 = EXTREME PAIN

NO PAIN	0	1	2	3	4	5	6	7	8	9	10	EXTREME

Do you still have pain when you: (Check which one)

☐ Sit ☐ Bend ☐ Walk ☐ Lift ☐ Push ☐ Pull ☐ Other _____

If yes, explain as to what area _____

Is your disability still interfering with your ☐ Work? ☐ Sleep? ☐ Daily Routine?

If yes, explain _____

Are you now able to do physical work activities? ☐ Yes ☐ No

Are you now able to do mental work activities? ☐ Yes ☐ No

Describe the benefits you have gained from treatments in our office _____

_____

Do you feel you received a clear explanation as to the cause of your pain? ☐ Yes ☐ No

Were you told what to do to prevent future problems for your condition? ☐ Yes ☐ No

Do you feel the person treating you was understanding of your concerns? ☐ Yes ☐ No

Do you feel comfortable with our service and staff? ☐ Yes ☐ No

How do you rate the treatments you have receive so far?

☐ Excellent ☐ Good ☐ Poor ☐ Honest & objective ☐ Show you cared

List any additional comments you wish to make regarding your condition _____

_____

Patient Signature _____

#2006-N
MISSION PRINTING (209) 227-7640