Progress Assessment

Name: _____ Today's date: _____

To help us better determine the progress of your recovery, please complete the following form as accurately and completely as possible. There is one form for EACH significant symptom that you are being treated for at this office. If an item does not apply, please write "N/A" (Not Applicable). Thank you for your assistance.

CURRENT COMPLAINT: _____

1. On a "0 - 100%" scale, where "0%" represents "no improvement" and "100%" represents "total recovery," how do you rate your recovery for the above complaint?

   0% 10% 20% 30% 40% 50% 60% 70% 80% 90% 100%
   No improvement Total recovery

2. Overall, is our treatment helpful for this particular problem? Yes ( ) No ( )

3. Does the recommended exercise program help this particular problem? Yes ( ) No ( )

4. Do you currently take any medication for this particular problem? Yes ( ) No ( )

5. If yes, please identify the medication, dosage, and how often you take it: _____

   _____

6. Please CIRCLE any of the following activities that make this particular problem worse?

Repeated bending	Quick motions	Changing positions	Sexual activity
Lifting	Sneezing	Prolonged sitting	Home chores
Bending	Coughing	Applied pressure	Rest
Twisting	Straining	Weather changes	Sleeping

   Other: _____

7. What is the AVERAGE level of pain that you ***currently*** experience in a typical day?

   0 1 2 3 4 5 6 7 8 9 10
   No pain Worst possible pain

8. What is the LOWEST level of pain that you ***currently*** experience in a typical day?

   0 1 2 3 4 5 6 7 8 9 10
   No pain Worst possible pain

9. What is the HIGHEST level of pain that you ***currently*** experience in a typical day?

   0 1 2 3 4 5 6 7 8 9 10
   No pain Worst possible pain

10. When you have the problem, what percent of the day is the problem present?

    0% 10% 20% 30% 40% 50% 60% 70% 80% 90% 100%

11. How many days a week do you have the problem? 0 1 2 3 4 5 6 7

12. Comments: _____

    _____

    _____

Signature _____