Progressive Exam Questionnaire

ChiropracticWellness

This questionnaire is designed to track your health and wellness goals to make sure that they continue to progress optimally. Please be sure to let us know of any changes you're experiencing during your course of care with us.

Patient Name: _____ Date: _____

Your Wellness Goals

What conditions are you seeking treatment for? (i.e. headaches, lower back pain, neck pain, constipation, etc.)

Condition #1: _____

- This condition is...(circle all that apply) Left Right Bilateral
  New *Better* *Same* *Worse* *Comes&Goes* *Constant*
  Sharp *Shooting* *Aching* *Throbbing* *Burning* *Numbness* *Weak*
- If you have symptoms, what percentage of the time are the symptoms present? 0% 25% 50% 75% 100%
- What is your level of discomfort on a scale of 0-10 (0=No Pain, 10= Extreme Pain) _____/10
- What makes this condition better? _____
- What makes it worse? _____

Condition #2: _____

- This condition is...(circle all that apply) Left Right Bilateral
  New *Better* *Same* *Worse* *Comes&Goes* *Constant*
  Sharp *Shooting* *Aching* *Throbbing* *Burning* *Numbness* *Weak*
- If you have symptoms, what percentage of the time are the symptoms present? 0% 25% 50% 75% 100%
- What is your level of discomfort on a scale of 0-10 (0=No Pain, 10= Extreme Pain) _____/10
- What makes this condition better? _____
- What makes it worse? _____

Condition #3: _____

- This condition is...(circle all that apply) Left Right Bilateral
  New *Better* *Same* *Worse* *Comes&Goes* *Constant*
  Sharp *Shooting* *Aching* *Throbbing* *Burning* *Numbness* *Weak*
- If you have symptoms, what percentage of the time are the symptoms present? 0% 25% 50% 75% 100%
- What is your level of discomfort on a scale of 0-10 (0=No Pain, 10= Extreme Pain) _____/10
- What makes this condition better? _____
- What makes it worse? _____

Your Progress

- Have you noticed any improvements in the following? (Please circle all that apply)

  More Energy *Better Digestion* *Decreased Headaches* *Better Breathing* *Better Sleep* *Less Medication*
  No Medication *Less Pain* *No Pain* *Overall Better Health* *More Strength* *Better Motion* *Fewer Illnesses*
  No Illness *Improved Flexibility* *Less Emotional Stress* *Improved Daily Activity* *Work Life*

- Your improvement is: taking longer than expected progressing as expected faster than expected symptoms gone
- Any accidents, injuries, surgeries/hospitalizations since your last exam (Y/N) if yes, explain:

  _____

  _____

- Current Activities (hobbies, sports, yard work etc…):

  _____

  _____

- Repetitive Motions and positions of the spine (bending, twisting, looking up and down, computer work, phone usage etc…): _____

  _____

- List all current medications/supplements If none please list none: _____

  _____

  _____

- Current stressors in life? _____

Office Evaluation

We are constantly striving to make your care the best it can be. We appreciate all and any feedback from you!

What do you like most about our office?

What would you change about our office, staff, or procedures to improve your experience?

Would you be willing to share how chiropractic has impacted your health?

Please circle all that apply: Yes, I'll share my story via video

Yes, I'll share my story via written and photographic testimonial

Consent to Examination and Treatment

I, the undersigned, do hereby authorize Dr. Jennifer C. Daniel-Price, D.C. and/or any other licensed chiropractic physicians and assistants employed by Chiropractic Wellness Connection to perform any examination, diagnostic tests, diagnosis and render necessary treatment as deemed necessary by the doctor to myself or minor child.

Patient Signature: _____ Date: _____

Parent Signature (If Patient is Minor): _____ Date: _____

Review of Systems

Name:_____ Date:_____

At Chiropractic Wellness Connection, we strive to find the CAUSE of your concerns. This questionnaire will help us to identify what is going on specifically for you. Please rate each of the following symptoms based what you have experienced in the **last 60 days.**

Point Scale: **leave blank** = *never* have the symptom, **1** = *occasionally* have symptom, **2** = *regularly* have symptom, **3** = *frequently* have symptom, **4** = *constantly* have symptom

Eyes, Ears, Nose, Throat:
__chronic ear infections
__ringing in the ears
__blurred or tunnel vision
__eye pain
__itchy or watery eyes
__nasal congestion
__nose bleeds
__loss of smell
__sore throat
__sores in mouth
__difficulty swallowing/gagging
__white patches on throat/tongue
__need to repetitively clear throat

Musculoskeletal:
__joint pain
__joint stiffness
__pain in muscles
__abnormal muscle movements
__muscle weakness

General:
__unexplained weight loss
__unexplained weight gain
__severe fatigue
__fever
__excessive thirst
__frequent illnesses
__difficulty sleeping

Urinary:
__difficulty urinating
__blood in urine
__chronic UTIs
__frequent urination

Neurological:
__tremors/tics
__difficulty walking
__difficulty with balance
__headaches
__numbness or tingling
__bruises easily
__ seizures

Digestive:
__nausea or vomiting
__diarrhea
__constipation
__bloated belly
__heart burn
__abdominal pain
__blood in stool

Mental/Emotional:
__memory loss
__depression
__anxiety/social anxiety
__confusion
__inability to focus
__hyperactivity
__loss of interest/motivation
__homicidal/suicidal thoughts

Respiratory:
__short of breath
__wheezing
__asthma
__coughing

Integumentary:
__itchy skin
__rashes
__jaundice
__swollen lymph nodes
__hair loss

Cardiovascular:
__chest pain
__heart palpitations
__irregular heartbeat
__fainting
__swelling in hands/feet
__difficulty with speech
__dizziness
__restless legs
__slurred speech

Female Reproductive Only:
__abnormal periods
__excessive bleeding/clots
__period irregularity
__loss of pregnancy
__slurred speech

Total:_____