

Progress Exam Questionnaire

To help ensure that we are on track toward achieving your health goals, please tell us what types of changes you are experiencing as your body begins the natural healing process.

Patient Name: _____

Date: _____

Your Wellness Goals

Your initial health goals for care were:

1. _____
2. _____
3. _____

How would you rate your **progress** toward those goals so far?

- | Worse | | No change | | Improved |
|-------|---|-----------|---|----------|
| ① | ② | ③ | ④ | ⑤ |
| ① | ② | ③ | ④ | ⑤ |
| ① | ② | ③ | ④ | ⑤ |

How are You Doing?

Have you noticed any **improvements** in any of the following?

- | | | | | |
|--|---|--|-----------------------------------|-------------------------------------|
| <input type="radio"/> Sleeping | <input type="radio"/> Walking & Running | <input type="radio"/> Flexibility & Mobility | <input type="radio"/> Sitting | <input type="radio"/> Energy Levels |
| <input type="radio"/> Emotional Stress | <input type="radio"/> Changing Habits | <input type="radio"/> Pain Management | <input type="radio"/> Family Life | <input type="radio"/> Work Life |

Tell us about any **changes** that you have noticed since beginning care:

– Physical changes (ex. *Less pain, more mobility, feeling stronger, etc.*)

– Health changes (ex. *Fewer illnesses, less severe symptoms, etc.*)

– Emotional changes (ex. *Better mood regulation, less anxious, etc.*)

– Energy & stress levels (ex. *Sleeping better, more energy, happier, etc.*)

Tell us about any **new** health challenges or stressors in your life:

Your Health Progress

Your **improvement** so far is...

- Taking longer than expected Progressing as expected Occurring faster than expected

Rate the impact of these improvements on your **health**:

- No impact ① ② ③ ④ ⑤ Great impact

Rate the impact of these improvements on your **quality of life**:

- No impact ① ② ③ ④ ⑤ Great impact

Office Evaluation

We constantly strive to make our best even better for you and your family. Your feedback is important and appreciated!

How are we doing?

How would you rate our doctor(s) on the following?					How would you rate our staff on the following?						
	Poor		Average	Excellent		Poor		Average	Excellent		
Care and Concern	①	②	③	④	⑤	Care and Concern	①	②	③	④	⑤
Training & Competency	①	②	③	④	⑤	Training & Competency	①	②	③	④	⑤
Comments about our doctor(s):					Comments about our staff:						

Practice Feedback

What do you like most about our office?

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

How would you describe our educational efforts such as workshops, events, handouts, posters, etc.?

Excellent, I've learned a lot! Could be significantly improved Ineffective use of resources
 Helpful & interesting Not enough materials or events Leaves some questions unanswered

Support & Referrals

If you are experiencing positive results, please help spread the message!

Have you told your family & friends about chiropractic? Yes No

What feedback and comments have you heard from others since beginning care?

Would you be willing to share how chiropractic has impacted your health? Yes, I'll share my story Not at this time

Our practice grows through word of mouth and referrals.
If you have loved ones experiencing health problems, please tell them about your experience and/or list them below.

Name: _____ Relationship: _____ Phone: _____ May we contact them? Yes No

Name: _____ Relationship: _____ Phone: _____ May we contact them? Yes No

Name: _____ Relationship: _____ Phone: _____ May we contact them? Yes No

Thank you for helping us make a positive impact on our community!

Patient Signature: _____

Date: _____

All Star Family Chiropractic

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