

# Practice Member Progress Report 1

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

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

*Our goal is to offer the very highest quality of care possible. Please help us by responding to the following questions about your progress in our office.*

Aside from the complaint that brought you to our office, what are other benefits you have noticed since beginning your care? (Many of our practice members remark that they have had increased energy, better digestion, and other things that they didn't know would be improved with Chiropractic care.)

**Please mark with an X in one box on the continuum where you think you are.**

## Comfort Zone

**DISEASE**           **WELLNESS**

Multiple medications  
Poor quality of life  
Limited function & potential

**POOR HEALTH**  
Symptoms  
Drug therapy & surgery  
Losing normal function

**MAINTAINING HEALTH**  
No symptoms  
Inconsistent nutrition & exercise

**GOOD HEALTH**  
Regular exercise  
Good nutrition  
Minimal nerve interference

**100% FUNCTION**  
Continuous development  
Wellness lifestyle

Please indicate which direction you think you are heading:

**Towards Disease**

**Towards Wellness**

What actions have you taken to move in this direction?

---

Since beginning chiropractic care (please check yes or no):

Yes    No

1) *My ability to cope with/handle stress has improved:*

  

2) *I exercise more:*

  

3) *I drink more water:*

  

4) *My perception of my own health has increased:*

  

5) *Others perceive my general level of health to have increased:*

Y N

6) My sense of well-being has increased:

7) I have followed the Doctor's recommendations for my adjusting schedule and home care:

8) Are you satisfied with your care?

9) What is the major stress affecting your health today?

---

10) How are you responding to and coping with that major stress?

---

11) What other lifestyle changes have you made that may also be contributing to your health?

---

12) Please check the following areas you would like to work on to reach your health goals:

Stress management

Sleep

Exercise

Posture training

Weight Loss

Hold adjustments better

Nutrition

Positive mental attitude

Please take a moment to provide us with your feedback on your experience at CHASE Clinic by marking an X along the continuum for the most appropriate number.

How would you rate the concern shown by our staff?

Uninterested 0 5 10 Deeply Concerned

How would you rate the training, qualifications and competency of our staff?

Unorganized/Unprepared 0 5 10 Efficient/Knowledgeable

Is there anyone who has been especially helpful?

---

If you were in charge of this office tomorrow, what would be the first thing you would do differently?

---

What do you like most about our office?

---

On a scale of 0 out of 10 (0 being no pain and 10 being the most pain possibly imaginable) rate your pain:

- \_\_\_\_\_ At Rest
- \_\_\_\_\_ With Activity

On a scale of 1 out of 3 (1 = minor 2 = can perform with difficulty 3 = can't perform) rate how this injury affects your daily life

- \_\_\_ Bending
- \_\_\_ Carrying Groceries
- \_\_\_ Sitting to Standing
- \_\_\_ Climbing Stairs
- \_\_\_ Lifting
- \_\_\_ Household Chores
- \_\_\_ Sleep
- \_\_\_ Prolonged Sitting
- \_\_\_ Prolonged Standing
- \_\_\_ Walking
- \_\_\_ Yard Work
- \_\_\_ Recreational Activities (list) \_\_\_\_\_, \_\_\_\_\_, \_\_\_\_\_
- \_\_\_ Extended Computer use
- \_\_\_ Reading