

PATIENT PROGRESS ANALYSIS

Patient Name: _____

Today's Date: _____

Number of visits completed: _____

Number of weeks in program: _____

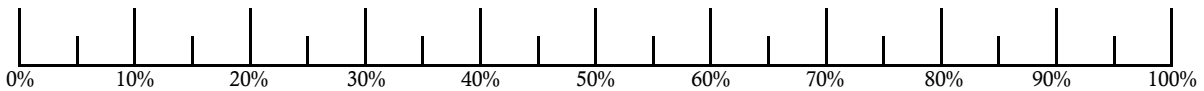
1. Overall, do you feel your condition is responding to the care you are receiving in our office? Yes _____ No _____

If your answer is No, please explain: _____

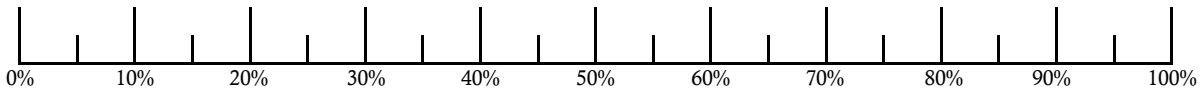
2. Would you like to continue your care in our office? Yes _____ No _____

If No, do you feel your condition is stable and you can now transfer to an independent program? Yes _____ No _____

3. What percent of improvement have you noticed in your condition since you started treatment with us? _____%. Mark the percentage on the following scale.



4. What percent of the time is your pain present? _____%. If your pain is there all the time, in varying degrees, that would indicate 100%. Mark the percentage on the following scale.



5. Please rate the average intensity level of your pain on the scale below as well as on a good and a bad day. Refer to the color chart we have provided to rate your pain intensity.

Intensity (Circle one)
Good Day: ____/10 0 1 2 3 4 5 6 7 8 9 10
Bad Day: ____/10 None Mild Moderate Severe

6. Please rate the average level of functional deficit you experience due to your pain, as well as on a good and a bad day. A rating of 10/10 would indicate severe disability where you cannot perform, enjoy, or complete your work, social, or recreational activities.

Functional deficit (Circle one)
Good Day: ____/10 0 1 2 3 4 5 6 7 8 9 10
Bad Day: ____/10 None Mild Moderate Severe

- 7. Current work status: (Please circle one)
- a) Working full-time without restrictions
- b) Working part-time without restrictions
- c) Working full-time with restrictions
- d) Working part-time with restrictions
- e) Not working due to accident
- f) Not working due to age
- g) Not working
- h) Retired

SIGNATURE: _____

DATE: _____

Please use the back of this form to record any notes or comments your have about your treatment or condition.

Patient Name: _____

Today's Date: _____

Date injury occurred or symptoms began: _____

SYMPTOM ASSESSMENT CHART

Please complete the following chart according to the instructions. This chart is intended to assess your present symptoms which resulted from your injuries. Use the following definitions as a guide in completing the chart.

Symptom Description

Describe the symptom as clearly as possible.

Frequency

Enter the amount of time, on percentage basis, that the symptom is present during your waking hours.

Intensity

Using a scale of 1-10, where 10 is the worst pain imaginable, circle the pain intensity level for each symptom.

| No. | Symptom Description | Frequency | Intensity (circle one) |
|-----|---------------------|-----------|------------------------|
| 1 | | _____% | 1 2 3 4 5 6 7 8 9 10 |
| 2 | | _____% | 1 2 3 4 5 6 7 8 9 10 |
| 3 | | _____% | 1 2 3 4 5 6 7 8 9 10 |
| 4 | | _____% | 1 2 3 4 5 6 7 8 9 10 |
| 5 | | _____% | 1 2 3 4 5 6 7 8 9 10 |