Progress Evaluation

maxliving

Child's Name: _____ **Patient#:**_____

Date: _____

1. For what reason did you originally see the Doctor?

   _____

2. What conditions are still bothering you?

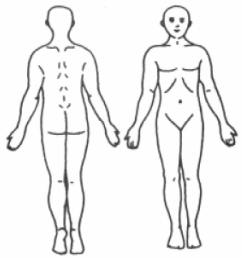
   _____

3. How would you rate your improvement?

☐ No Improvement ☐ Some Improvement ☐Considerable Improvement ☐100% Improvement

4. Which medications (if any) have you decreased taking? _____
5. How would you rate the service in our office? ☐Poor ☐Fair ☐Good ☐Excellent
6. Has your family been checked for subluxation? Yes No (if no, why not?) _____
7. Why are you here? ☐to get out of pain ☐to get healthy and stay healthy for the rest of your life
   ☐ other: _____ ☐all of the above

***PLEASE MARK** the areas on the Diagram with the following **letters** to describe your symptoms:
R = Radiating **B = B**urning **D = D**ull **A =** Aching **N = N**umbness **S = S**harp/ **S**tabbing
T= Tingling



Patient's Signature:_____ **Date:** _____

This section will be completed by the examiner/doctor.

Cervical ROM Flexion (50) _____ L Lateral Flexion (45) _____ L Rotation (80) _____
(60) _____ R Lateral Flexion (45) _____ R Rotation (80) _____

Thoracic ROM Flexion (50) _____ L Rotation (30) _____ R Rotation (30) _____

Shoulder ROM Flexion (180) _____ Internal Rotation (75) _____ Abduction (150) _____
Extension (60) _____ External Rotation (90) _____

Lumbar ROM Flexion (90) _____ L Lateral Flexion (30) _____
Extension (30) _____ R Lateral Flexion (30) _____

Knee ROM Flexion (140) _____ Extension (10) _____

Hip ROM Flexion (125) ____ Internal Rotation (40) ____ Abduction (145) _____
Extension (30) ____ External Rotation (60) ____ Adduction (25) _____

Exten

CO
C1
C2
C3
C4
C5
C6
C7
T1
T2
T3
T4
T5
T6
T7
T8
T9
T10
T11
T12
L1
L2
L3
L4
L5
LSI
RSI
SAC

ORTHOPEDIC TESTS

	Test	Findings				Notes
•	SLR	+	-	R	L	€
•	Braggards	+	-	R	L	€
•	Faber-Patrick	+	-	R	L	€
•	Kemp's	+	-	R	L	€
•	Valsalva's	+	-	R	L	€
•	Yeoman's	+	-	R	L	€
•	Ely's	+	-	R	L	€
•	Toe Walk	+	-	R	L	€
•	Heal Walk	+	-	R	L	€
•	Sacral Apex	+	-	R	L	€
•	Erichsen's	+	-	R	L	€
•	Abduction Str	+	-	R	L	€
•	Adduction Str	+	-	R	L	€
•	Apprehension	+	-	R	L	€
•	Drawer Sign	+	-	R	L	€

	Test	Findings				Notes
•	George's	+	-	R	L	
•	Distraction	+	-	R	L	
•	Max. Comp.	+	-	R	L	Ipsi/Contra
•	O'Donahue's	+	-	R	L	
•	Soto Hall	+	-	R	L	
•	Shoulder Dep.	+	-	R	L	
•	Spinal Perc.	+	-	R	L	Level
•	Finger/Nose	WNL		BNL		
•	Adson's	+	-	R	L	
•	Schepelmann	+	-	R	L	
•	Bowstring's	+	-	R	L	
•	Codman's	+	-	R	L	
•	Dawbam's	+	-	R	L	
•	Dugas	+	-	R	L	
•	Impengent	+	-	R	L	
•	Gait	WNL		Abn.		

POSTURE

Area	Findings	
F H P	+	-
Head Tilt	R	L
Head Rot	R	L
↑ Shoulder	R	L
Thor. Tilt	R	L
Thor. Trans.	R	L
↑ Hip	R	L
Hip Rot	R	L
Foot Flare	R	L

Head Weights (lbs):_____

Additional Notes:

Examiner/Doctor Signature:_____ **Date:**_____

JDD,DC 2/2012

PEDIATRIC WELLNESS EVALUATION

Child's Name: _____
Date of last x-rays: _____ **Today's Date:** _____

Health Conditions

1. What health conditions were present upon starting care?	2. What improvements have happened along the way?	3. Are there any health conditions persisting ***or*** that have just started? If yes, please rate on a scale of 1-10 (10 being worst):

Does your child get adjusted for (check all that apply)
____ Wellness & Prevention
____ Birth Trauma
____ Existing Health Condition
____ Sports Performance
____ Other (please specify): _____

Do you have any questions, concerns or comments regarding your child's adjustments or spine? _____
_____
_____
_____

Nutrition & Toxicity

1. What does your child eat for breakfast normally: _____ 2. What does your child eat for lunch normally: _____ 3. What's your biggest concern about your child's nutrition?_____ _____	2. What supplements is your child currently taking? _____ MaxKids Multi-Vitamin _____ MaxKids Probiotics _____ Other (specify): _____ _____ _____	3. Vaccinations a) Does your child get the flu shot? ___ Yes ____ No b) Is your child on (check one): ____the regular vaccine schedule ____delayed vaccine schedule ____unvaccinated c) Would you like information on current vaccine safety & education? ____ Y _____ N

Lifestyle & Exercise

1. Backpack Safety: a) Does your child carry a backpack daily? _____ b) Weight in it (circle): Light Medium Heavy <5lbs 5-10lbs >10lbs	**2. Technology:** a) How many hours a day does your child spend using iPad, phone, tablet, laptop, etc?_____ b) Are they doing wobble exercises every 30 minutes?	**3. Physical Activities:** a) What is your child's #1 physical activity? _____ b) How many hours a day, do they spend doing it? __hrs/day, __days/week

Parent/Guardian's Name: _____ **Date:** _____

Parent/Guardian's Signature: _____
Reviewing Doctor's Signature: _____ Date: _____