Wellness Progress Evaluation

Name: _____ **Patient#:**_____

Date of last progress evaluation: _____ **Date:** _____

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

   _____

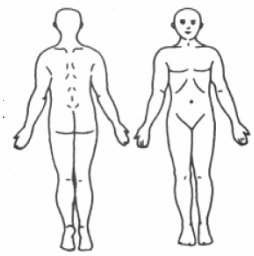
2. What conditions are still bothering you?

   _____

3. How would you rate your improvement?

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

4. How would you rate the service in our office? ☐Poor ☐Fair ☐Good ☐Excellent
5. Has your family been checked for subluxation? Yes No (if no, why not?) _____
6. Do you know of anyone else who is struggling with their health?_____
7. Would you be interested in setting up a lunch and learn for you and your coworkers or small group?_____
8. Why are you here? ☐to get out of pain ☐to get healthy and stay healthy for the rest of your life
   ☐all of the above ☐ other: _____



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= T**ingling

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

This section will be completed by the examiner/doctor.

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

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

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/Diagnosis:

_____

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

Goals: **Met?**

1. _____ ☐
2. _____ ☐
3. _____ ☐

Updated Goals

1. _____ ☐
2. _____ ☐
3. _____ ☐

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

JDD,DC 2/2012

Wellness Progress Evaluation

Name: _____ **Date:** _____

1. How frequently are you currently getting adjusted?
   - □ 1x/week
   - □ 2x/week
   - □ 3x/week
   - □ 1x/month
   - □ 2x/month
   - □ other: _____

   How do you feel your frequency is working for you?
   - □ Too much □ Just right □ Not enough

   Why?_____

2. How often are you doing your home rehab exercises?
   - □ 2x's per Day
   - □ 1x per Day
   - □ Sometimes (3-4x's per week)
   - □ Rarely (before and after my adjustments in the office)

   Are there any exercises you do not like or have questions about? _____

   _____

   □ I would like to review my home rehab prescription with Dr. Jake.

3. How would you describe the **health changes** that have occurred in your life? (i.e., increased activities, better immune function, more energy, better sleeping patterns, less sickness, better mobility, improved golf score, etc.)

   _____

   _____

   _____

3. You may have attended our workshops on the 5 Essentials. Please check those below which you have learned about.
   - □ Maximized Mind
   - □ Maximized Nutrition
   - □ Maximized Oxygen & Lean Muscle
   - □ Minimized Toxins
   - □ I've attended a workshop on each of the 5 Essentials.

   Do you have any suggestions for workshop topics you would like to learn more about: _____

   _____

4. Please list any questions or concerns you may have which have not been addressed.

_____

_____

_____

5. Which of the following are you currently doing to improve the function of your body?

□Advanced Nutrition Plan □Core Nutrition Plan □Other: _____

□Surge Training □MaxT3 □Other: _____

6. Which of the following supplements are you currently taking?

□Vitamin D3 Complex □Detox System □Men's/Women's Multi □Optimal Omega

□B-Complex □Magnesium □Protein □Other:_____

7. Have you been able to reduce any medications? (Y / N) If yes, please state which medications. Any new medications?

_____

_____

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

Doctor's Signature: _____ **Date:** _____

JDD, DC, 2/2012