



Progress Report:

Patient Name _____ Date _____

A. What symptoms have improved?

1. _____
2. _____
3. _____

B. What symptoms still exist?

Circle one

Circle one

1. _____ Severe/moderate/slight---Constant/Sometimes/Infrequent
2. _____ Severe/moderate/slight---Constant/Sometimes/Infrequent
3. _____ Severe/moderate/slight---Constant/Sometimes/Infrequent

C. As of today, circle the percentage of relief you have received.

10% 20% 30% 40% 50% 60% 70% 80% 90% 100%

D. Have you had any changes in your general health picture?

1. Nerves _____
2. Pain _____
3. Energy _____
4. General strength _____
5. Mental Outlook _____

E. List any new conditions or symptoms you have notice _____

F. Classify your improvement. () Excellent () Good () Fair

G. Are you confused about any phase of your progress? () Yes () No. Remarks _____

H. Has anyone asked you about your progress? () Yes () No.

I. Have you tried to refer anyone to this office for care? () Yes () No.

J. Would you like us to contact anyone with information on becoming a patient in our office?

() Yes () No. If YES, Whom? Name _____ Phone _____

Address _____

City, State, Zip _____

K. Any question concerning your progress? () Yes () No _____

Patient/Guardian Signature _____ Date _____