PROGRESS ASSESSMENT

To help us better determine the progress of your recovery please complete the following form as accurately and completely as possible. **Please complete one form for EACH significant symptom that you are being treated for at this office.** If an item does not apply, please write "N/A" for Not Applicable. Thank you for your assistance.

Patient Name: _____

Injury Date: _____

1. Subjective Complaints (please explain symptoms that are still persistent):_____
   _____
   _____
   _____
2. On a "0-100%" scale, where "0%" represents "no improvement" and "100%" represents "total recovery" how do you rate your recovery for the above complaint?

   0% 10% 20% 30% 40% 50% 60% 70% 80% 90% 100%
   No improvement *Complete Recovery*

3. Overall, has our treatment been helpful for this problem? □Yes □No
4. Do you currently take medication for this problem? □Yes □No
5. If yes, please identify medication and how often you take it:_____

6. Please CHECK-MARK any of the following activities that make this problem worse and CROSS-MARK those you are unable to do because of this problem:

   □Repeated Bending □Quick Motions □Changing Positions
   □Bending □Sneezing □Applied Pressure
   □Twisting □Coughing □Walking more than: _____
   □Pushing/Pulling □Sleeping □Sitting longer than: _____
   □Quick Motions □Straining □Standing longer than: _____

7. Pain Scale: *please rate by circling the appropriate response*

   0 1 2 3 4 5 6 7 8 9 10
   No Pain *Unbearable*

8. Frequency: □Constant (75-100% of the time) □Frequent (50-75% of the time)
   □Intermittent (25-50% of the time) □Occasional (<25% of the time)

9. Comments:
   _____
   _____
   _____
   _____

Signature:_____ Today's Date:
_____