



File# \_\_\_\_\_

**Dynamic Assessment**

Name: \_\_\_\_\_ Date: \_\_\_\_\_

**Please provide any updates to your address, home and work phone numbers, and email address** \_\_\_\_\_

Our goal is to offer the very highest quality chiropractic care possible. Please help us by responding to these questions about your progress.

**Care**

What changes have you noticed since beginning care?

On a scale of one to ten, rate YOUR overall level of improvement.

No change  
1            2            3            4            5            6            7            8            Major change  
9            10

Would you say your improvement is (*Circle best answer*)

- A. Progressing at the speed you expected
- B. Taking longer than you expected
- C. Occurring much faster than you expected
- D. It's a process-certain days are better than others

In your own words what is a *subluxation* and how does it affect your health?

What is your main goal in coming here?

Why is that important to you (i.e., how will your life be better and what will you do once this is accomplished)?

**Physical Stress**

Avg. # hours of sleep per night \_\_\_\_\_ Position: \_\_Back\_\_ Stomach \_\_Side\_\_  
Good quality? [ ] Yes [ ] No If no, why not? \_\_\_\_\_

Hours in car per day \_\_\_\_\_ Do you use a support in the car? [ ] Yes [ ] No

Occupation \_\_\_\_\_ Hours per day: Sitting \_\_\_\_\_ Standing \_\_\_\_\_

Do you travel with your job? [ ] Yes [ ] No If yes, how often and for how long? \_\_\_\_\_  
Please *briefly* describe your duties.

Do you do any regular structured exercise? [ ] Yes [ ] No  
If yes, what kind and how often?

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### Chemical Stress

# Meals per day \_\_\_\_ If less than 3, which one(s) do you skip? \_\_\_\_\_

# Servings per week: Fruit \_\_\_\_ Veggies \_\_\_\_ Whole Grains \_\_\_\_ Dairy \_\_\_\_

Meats (beef, pork, poultry, seafood) \_\_\_\_ Sweets (all) \_\_\_\_

# Times per week food bought out (including cafeteria) \_\_\_\_\_

# 8 oz. glasses of **plain water** per day \_\_\_\_ Source: Bottled, Tap, Filtered, Distilled

Other beverages (list types and # per day) \_\_\_\_\_

Do you add or use artificial sweeteners? [ ] Yes [ ] No Which one(s) \_\_\_\_\_

Do you take nutritional supplements? [ ] Yes [ ] No Please list what you take:

\_\_\_\_\_  
\_\_\_\_\_

Please list any medication you take (OTC or Prescription) and what they are for:

\_\_\_\_\_

### Emotional Stress

Please rate your **overall** level of stress, 0-10 (10 high)

Currently, at work/school \_\_\_\_\_ at home \_\_\_\_\_

\_\_\_\_\_

Please rate each category for stress, 0-10 (10 high)

\_\_\_\_\_ Personal relationships (spouse, family, friends, etc.)

\_\_\_\_\_ Work/business relationships

\_\_\_\_\_ Your job itself

\_\_\_\_\_ Finances

\_\_\_\_\_ Health

\_\_\_\_\_ Uncertainty of the future

\_\_\_\_\_ Other (Please explain) \_\_\_\_\_

Do you like your present job? [ ] Yes [ ] No [ ] It's "OK"

If time, money, schooling, etc., did not matter, and you could be assured of making a good living, would you still do the job you're doing now? [ ] Yes [ ] No

If no, what would you do instead ( i.e., what is your *fantasy* job)?

\_\_\_\_\_

How happy are you 0 to 10 (10 = very happy) \_\_\_\_\_

If you could change just **one thing** in your life to raise your number just 1 higher, what would it be?

\_\_\_\_\_

Do you do any deep breathing exercises regularly? [ ] Yes [ ] No

Do you take time to pray or meditate regularly? [ ] Yes [ ] No

How often? \_\_\_\_\_ How long? \_\_\_\_\_

Do you do anything specific on a regular basis to encourage a positive mental attitude? [ ] Yes [ ] No If yes, briefly explain \_\_\_\_\_

\_\_\_\_\_

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**STAFF**

How would you rate the concern shown by our staff?

Uninterested 1 2 3 4 5 6 7 8 9 10 Deeply Concerned

If not a 10, what would need to happen for it to be a 10?

How would you rate the training, qualifications and competency of our staff?

Unorganized 1 2 3 4 5 6 7 8 9 10 Knowledgeable

If not a 10, what would it take for it to be a 10?

What do you like most about our office?

We strive to fully inform our practice members about their care and explain chiropractic as it relates to their health. How would you describe our educational efforts? (*Circle best answer*)

- A. Excellent, I've learned a lot
- B. Helpful and interesting
- C. Still leaves some questions unanswered
- D. Could be significantly improved
- E. Waste of patient's and staff's time

Are you or a family member currently subscribing to our monthly email newsletter?

Yes  No To subscribe, please provide your email address: \_\_\_\_\_

**SUPPORT**

What kind of comments have you heard from your friends and family when you've told them about seeing a chiropractor?

What has been your greatest difficulty when explaining chiropractic to others?

As with all private professionals, our practice is built upon referrals. We realize it is nearly impossible for us to REACH, TEACH and TOUCH all of the people in the valley by ourselves. That is why *we are asking for your help*. You may be the only connection a family member or friend may have to our office. Please share with them what is possible if their nerve system is free from interference. We will send them a letter with a packet of information that explains how chiropractic may be able to help them. Thank you for *caring*.

Name: \_\_\_\_\_ Address: \_\_\_\_\_

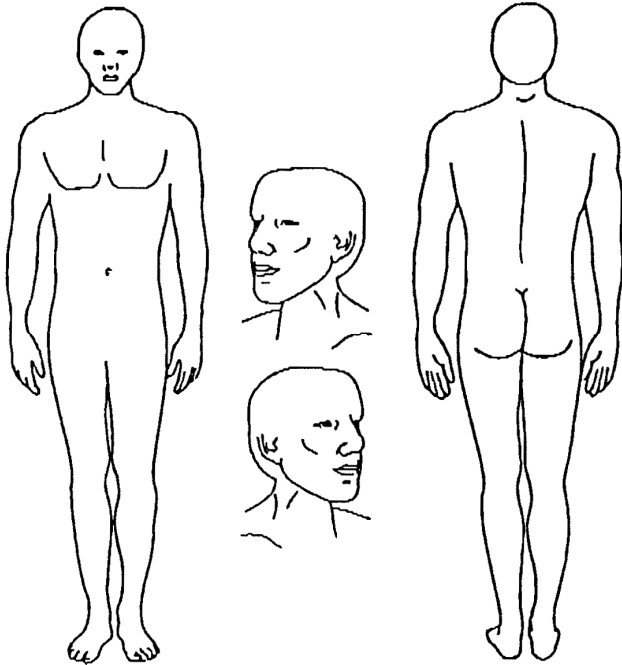
Phone: \_\_\_\_\_ Health concerns: \_\_\_\_\_

Name: \_\_\_\_\_ Address: \_\_\_\_\_

Phone: \_\_\_\_\_ Health concerns: \_\_\_\_\_

Please mention any other general comments about our office: \_\_\_\_\_

## PROGRESS REPORT



PLEASE MARK YOUR AREAS OF PAIN ON THESE FIGURES, INDICATING WHICH TYPE OF PAIN YOU ARE EXPERIENCING.

- A = SHARP PAIN
- B = DULL PAIN
- C = BURNING PAIN
- D = NUMBNESS
- E = TINGLING

Please mark the intensity of pain you are experiencing on the pain scale.

|          |      |               |   |   |             |   |          |   |              |           |
|----------|------|---------------|---|---|-------------|---|----------|---|--------------|-----------|
| <b>0</b> | 1    | 2             | 3 | 4 | 5           | 6 | 7        | 8 | 9            | <b>10</b> |
| No Pain  | Mild | Discomforting |   |   | Distressing |   | Horrible |   | Excruciating |           |

**Daily Activities:** Effects of Current Condition on Performance

- |                              |                                    |  |  |  |
|------------------------------|------------------------------------|--|--|--|
| 1. Bending:                  | <input type="checkbox"/> No Effect | <input type="checkbox"/> Mild Painful (Can do) | <input type="checkbox"/> Mod Painful (Limited) | <input type="checkbox"/> Sev Unable to Perform |
| 2. Carrying Groceries:       | <input type="checkbox"/> No Effect | <input type="checkbox"/> Mild Painful (Can do) | <input type="checkbox"/> Mod Painful (Limited) | <input type="checkbox"/> Sev Unable to Perform |
| 3. Change Posn–Sit–Stand:    | <input type="checkbox"/> No Effect | <input type="checkbox"/> Mild Painful (Can do) | <input type="checkbox"/> Mod Painful (Limited) | <input type="checkbox"/> Sev Unable to Perform |
| 4. Climb Stairs:             | <input type="checkbox"/> No Effect | <input type="checkbox"/> Mild Painful (Can do) | <input type="checkbox"/> Mod Painful (Limited) | <input type="checkbox"/> Sev Unable to Perform |
| 5. Driving:                  | <input type="checkbox"/> No Effect | <input type="checkbox"/> Mild Painful (Can do) | <input type="checkbox"/> Mod Painful (Limited) | <input type="checkbox"/> Sev Unable to Perform |
| 6. Ext Computer Use:         | <input type="checkbox"/> No Effect | <input type="checkbox"/> Mild Painful (Can do) | <input type="checkbox"/> Mod Painful (Limited) | <input type="checkbox"/> Sev Unable to Perform |
| 7. Household Chores:         | <input type="checkbox"/> No Effect | <input type="checkbox"/> Mild Painful (Can do) | <input type="checkbox"/> Mod Painful (Limited) | <input type="checkbox"/> Sev Unable to Perform |
| 8. Kneeling:                 | <input type="checkbox"/> No Effect | <input type="checkbox"/> Mild Painful (Can do) | <input type="checkbox"/> Mod Painful (Limited) | <input type="checkbox"/> Sev Unable to Perform |
| 9. Lift Children:            | <input type="checkbox"/> No Effect | <input type="checkbox"/> Mild Painful (Can do) | <input type="checkbox"/> Mod Painful (Limited) | <input type="checkbox"/> Sev Unable to Perform |
| 10. Lifting:                 | <input type="checkbox"/> No Effect | <input type="checkbox"/> Mild Painful (Can do) | <input type="checkbox"/> Mod Painful (Limited) | <input type="checkbox"/> Sev Unable to Perform |
| 11. Reading (Concentration): | <input type="checkbox"/> No Effect | <input type="checkbox"/> Mild Painful (Can do) | <input type="checkbox"/> Mod Painful (Limited) | <input type="checkbox"/> Sev Unable to Perform |
| 12. Self Care–Bathing:       | <input type="checkbox"/> No Effect | <input type="checkbox"/> Mild Painful (Can do) | <input type="checkbox"/> Mod Painful (Limited) | <input type="checkbox"/> Sev Unable to Perform |
| 13. Self Care–Dressing:      | <input type="checkbox"/> No Effect | <input type="checkbox"/> Mild Painful (Can do) | <input type="checkbox"/> Mod Painful (Limited) | <input type="checkbox"/> Sev Unable to Perform |
| 14. Self Care–Shaving:       | <input type="checkbox"/> No Effect | <input type="checkbox"/> Mild Painful (Can do) | <input type="checkbox"/> Mod Painful (Limited) | <input type="checkbox"/> Sev Unable to Perform |
| 15. Sexual Activities:       | <input type="checkbox"/> No Effect | <input type="checkbox"/> Mild Painful (Can do) | <input type="checkbox"/> Mod Painful (Limited) | <input type="checkbox"/> Sev Unable to Perform |
| 16. Sleep:                   | <input type="checkbox"/> No Effect | <input type="checkbox"/> Mild Painful (Can do) | <input type="checkbox"/> Mod Painful (Limited) | <input type="checkbox"/> Sev Unable to Perform |
| 17. Sitting:                 | <input type="checkbox"/> No Effect | <input type="checkbox"/> Mild Painful (Can do) | <input type="checkbox"/> Mod Painful (Limited) | <input type="checkbox"/> Sev Unable to Perform |
| 18. Standing:                | <input type="checkbox"/> No Effect | <input type="checkbox"/> Mild Painful (Can do) | <input type="checkbox"/> Mod Painful (Limited) | <input type="checkbox"/> Sev Unable to Perform |
| 19. Walking:                 | <input type="checkbox"/> No Effect | <input type="checkbox"/> Mild Painful (Can do) | <input type="checkbox"/> Mod Painful (Limited) | <input type="checkbox"/> Sev Unable to Perform |
| 20. Yard Work:               | <input type="checkbox"/> No Effect | <input type="checkbox"/> Mild Painful (Can do) | <input type="checkbox"/> Mod Painful (Limited) | <input type="checkbox"/> Sev Unable to Perform |
| 21. Other _____              | <input type="checkbox"/> No Effect | <input type="checkbox"/> Mild Painful (Can do) | <input type="checkbox"/> Mod Painful (Limited) | <input type="checkbox"/> Sev Unable to Perform |
| 22. Other _____              | <input type="checkbox"/> No Effect | <input type="checkbox"/> Mild Painful (Can do) | <input type="checkbox"/> Mod Painful (Limited) | <input type="checkbox"/> Sev Unable to Perform |

Date: \_\_\_\_\_ Name (Printed) \_\_\_\_\_ Signature \_\_\_\_\_