☐ Dr Reviewed ☐ File
☐ Recorded by staff

PROGRESS REPORT Name: _____ Date _____

A. What changes in medication/ activity have you made? Any Injuries or New symptoms since last exam?
Or circle NONE _____
_____

B. How have you been doing with your home therapy or other exercise? (We will mark exercises taught.)

☐ Gluteal/"rear" (TPT) – *tennis ball* ……..... ___ days per week ___ times per day
☐ Upper back / Shoulder *tennis ball* (circle one)...___ days per week ___ times per day
☐ Foam Roll…….___ days per week ___ times per day
☐ Mirror Posture Therapy(*laying on the side*)... ___ days per week ___ times per day
☐ Posture Pump® Neck Therapy……..……...___ days per week ___ times per day
☐ Cross Crawl (*on hands & knees – opp. arm-leg*) ___ days per week
☐ Dead Bug(*laying on your back*).. ……..… ___ days per week
☐ SI Belt…… ___ days per week
☐ Vitamins and other supplements…….___days per week ___ times per day
Other Exercise_____ ___days per week
_____ …… ___ days per week

Remember: *bring any applicable fill-in-the-blank check-list sheets/cards to your re-exam.* Inflammation Questionnaire Posture Pump Record

C. What symptoms improved, compared to before treatment. Circle How Much it has improved ***on average***?

1. _____ 10 20 30 40 50 60 70 80 90 100%
2. _____ 10 20 30 40 50 60 70 80 90 100%
3. _____ 10 20 30 40 50 60 70 80 90 100%
4. _____ 10 20 30 40 50 60 70 80 90 100%

D. What symptoms still exist?

	Frequency	**Severity, on average** (0=None, 10= worst imaginable)
1. _____	1 2 3 4 _ All x Daily / Wkly / Mnthly	**0 1 2 3 4 5 6 7 8 9 10**
2. _____	1 2 3 4 _ All x Daily / Wkly / Mnthly	**0 1 2 3 4 5 6 7 8 9 10**
3. _____	1 2 3 4 _ All x Daily / Wkly / Mnthly	**0 1 2 3 4 5 6 7 8 9 10**

E. Have you had any other changes in your general health picture?
1. Pain _____
2. Energy and General Strength _____
3. Mental Outlook or Other _____

This section is for patients under regular care in our office, not patients who have been gone for months or more.

F. On average, **circle** the **% of overall improvement** you feel you have received since before treatment or taking our advice.
10% 20% 30% 40% 50% 60% 70% 80% 90% 100% OR New Injury

G. On average, **circle** the **% of overall level of health** you have compared to ideal health for your age.
10% 20% 30% 40% 50% 60% 70% 80% 90% 100%

H. Why do you suppose your body has responded this well or poorly?
_____

I. Classify your overall *satisfaction* of treatment and the service (Circle one): Excellent Good Fair

J. Do you have a question about any phase of your progress? ( )No ( )Yes
_____

K. Is there any Information, Service, etc. that you expect or want that you have not received? ( )No ( )Yes
_____

L. Has anyone (outside our office) asked you about your progress? ( ) Yes ( ) No
Remarks: _____

M. Have you tried to refer anyone to this **Office**, **Website** (VisaliaSynergy.com), or **Health Workshop**? ( )Yes ( )No

N. Would you like us to mail (or give you) information concerning our office for anyone? ( )Yes ( )No
(…like an introductory video) Who? _____