☐ Dr Reviewed ☐ Dr finished
☐ Report sent

PROGRESS REPORT Name: _____ Date _____

A. Since the last exam, what changes in medication/ activity have you made; or any Chemical, Structural, or Mental strains or New symptoms? Or circle NONE _____
_____

B. Have you had any other changes in your general health picture?
- Energy and General Strength _____
- Mental Outlook or Other _____

C. **Adjustments, in Rhythm:** Have you made spinal adjustment / treatments as recommended? **Yes / No**

D. Grade yourself on how you have done **at Breaking Bad Habits** or influence of Eating, Drinking, Breathing, Thinking, Sleeping, and Moving (Posture, being Sedentary or Overstraining)? **A B C D F**

E. **Good Habits:** How have you been doing with **Adding Good Habits**? (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
- ☐ Neck/Back Massager and/ or Foam Roll……. ___ days per week ___ times per day
- ☐ Cross Crawl (*on hands & knees – opp. arm-leg*).. ___ days per week
- ☐ Core stability exercise ……. ___ days per week
- ☐ SI Belt……... ___ days per week
- ☐ Vitamins / Supplements _____ ___ days per week
- ☐ Mirror Posture Therapy(*laying on the side*) or Posture Pump.... ___ days d/wk ___ x per day
- ☑ Other Exercise/Relaxation/Nutrition_____ ___ days per week
  _____ ___ 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

F. Symptom	How Severe, on average (0=None, 10= worst imaginable)	How much better do you feel? compared to **before** treatment
	0 1 2 3 4 5 6 7 8 9 10	10 20 30 40 50 60 70 80 90 100%
	0 1 2 3 4 5 6 7 8 9 10	10 20 30 40 50 60 70 80 90 100%
	0 1 2 3 4 5 6 7 8 9 10	10 20 30 40 50 60 70 80 90 100%
	0 1 2 3 4 5 6 7 8 9 10	10 20 30 40 50 60 70 80 90 100%
	0 1 2 3 4 5 6 7 8 9 10	10 20 30 40 50 60 70 80 90 100%

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

H. On average, **how good do you feel &function** compared to **ideal health,** based on your age**? (circle)**

10% 20% 30% 40% 50% 60% 70% 80% 90% 100% and are you Worsening / Steady / Improving

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

I. Classify your overall *satisfaction* of our service (Circle one): (terrible)**0 1 2 3 4 5(fair) 6 7 8 9 10(super)**

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

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