# Bedford County Chiropractic
# Progress Report – Patient's Form
(To be completed by Patient or Guardian)

Patient Name ____________________________Chart#________ DATE ___________

As of today, Rate your *pain* **while ACTIVE**.

**Nothing** 0 1 2 3 4 5 6 7 8 9 10 **Severe**

As of today, Rate your *pain* **while at REST**.

**Nothing** 0 1 2 3 4 5 6 7 8 9 10 **Severe**

Which symptoms still exist? **Circle a level of Severity & Duration**

| | SEVERITY | DURATION |
|---|---|---|
| ______________________________ | Mild Moderate Severe | Constant Sometimes Occasional |
| ______________________________ | Mild Moderate Severe | Constant Sometimes Occasional |
| ______________________________ | Mild Moderate Severe | Constant Sometimes Occasional |

Which symptoms have improved?

_____________________________________________________________________

_____________________________________________________________________

_____________________________________________________________________

Rate your improvement (circle) 10% 20% 30% 40% 50% 60% 70% 80% 90% 100%

List any new conditions or symptoms you have noticed:

_____________________________________________________________________

_____________________________________________________________________

_____________________________________________________________________

Any questions concerning your progress? ( ) Yes ( ) No

_____________________________________________________________________

_____________________________________________________________________

_____________________________________________________________________

How old is your mattress? ___________ How old is your pillow? ____________

Are you taking a multi-vitamin? _______ Vitamin D? _____ Fish Oil (Omega 3)? _______

Would you like assistance with any of the following:

Diet / Nutrition_________ Exercise ___________Low Energy__________________

Weight Loss __________ How much would you like to loose? _________________

Sleep Issues __________Depression_______

Anything else you would like to discuss with the doctor?____________________________

PLEASE CONTINUE ON REVERSE

Answer each question from the perspective of how the current status of your condition affects your job performance and these daily activities mentioned.
(Static means: the only thing you are doing. ie:ONLY standing/sitting for an extended period of time.)

## Current Condition's Effect on Job Performance / Duties

☐ **Mildly** Painful (do with pain) ☐ **Moderately** Painful (limits ability) ☐ **Mod/Severe** Pain (limited duty)
☐ **Severe** (no limited duty *available* that I can tolerate)
☐ **Very Severe** (can't do limited duty/can't tolerate)

## Daily Activities: Effects of Current Condition on Performance

| | (*no pain*) | (*do with pain*) | (*limits ability*) | (*unable to perform task*) |
|---|---|---|---|---|
| Bending: | ☐ **No Effect** | ☐ **Mild** Pain | ☐ **Moderately** Painful | ☐ **Severely** Painful |
| Care –Infirm Family: | ☐ **No Effect** | ☐ **Mild** Pain | ☐ **Moderately** Painful | ☐ **Severely** Painful |
| Carrying Groceries: | ☐ **No Effect** | ☐ **Mild** Pain | ☐ **Moderately** Painful | ☐ **Severely** Painful |
| Move from Sit-Stand: | ☐ **No Effect** | ☐ **Mild** Pain | ☐ **Moderately** Painful | ☐ **Severely** Painful |
| Climb Stairs: | ☐ **No Effect** | ☐ **Mild** Pain | ☐ **Moderately** Painful | ☐ **Severely** Painful |
| Driving: | ☐ **No Effect** | ☐ **Mild** Pain | ☐ **Moderately** Painful | ☐ **Severely** Painful |
| Computer Use: | ☐ **No Effect** | ☐ **Mild** Pain | ☐ **Moderately** Painful | ☐ **Severely** Painful |
| Household Chores: | ☐ **No Effect** | ☐ **Mild** Pain | ☐ **Moderately** Painful | ☐ **Severely** Painful |
| Kneeling: | ☐ **No Effect** | ☐ **Mild** Pain | ☐ **Moderately** Painful | ☐ **Severely** Painful |
| Lifting: | ☐ **No Effect** | ☐ **Mild** Pain | ☐ **Moderately** Painful | ☐ **Severely** Painful |
| Pet Care: | ☐ **No Effect** | ☐ **Mild** Pain | ☐ **Moderately** Painful | ☐ **Severely** Painful |
| Concentration: | ☐ **No Effect** | ☐ **Mild** Pain | ☐ **Moderately** Painful | ☐ **Severely** Painful |
| Self Care–Bathing: | ☐ **No Effect** | ☐ **Mild** Pain | ☐ **Moderately** Painful | ☐ **Severely** Painful |
| Self Care–Dressing: | ☐ **No Effect** | ☐ **Mild** Pain | ☐ **Moderately** Painful | ☐ **Severely** Painful |
| Self Care–Shaving: | ☐ **No Effect** | ☐ **Mild** Pain | ☐ **Moderately** Painful | ☐ **Severely** Painful |
| Sexual Activities: | ☐ **No Effect** | ☐ **Mild** Pain | ☐ **Moderately** Painful | ☐ **Severely** Painful |
| Sleep: | ☐ **No Effect** | ☐ **Mild** Pain | ☐ **Moderately** Painful | ☐ **Severely** Painful |
| Static Sitting: | ☐ **No Effect** | ☐ **Mild** Pain | ☐ **Moderately** Painful | ☐ **Severely** Painful |
| Static Standing: | ☐ **No Effect** | ☐ **Mild** Pain | ☐ **Moderately** Painful | ☐ **Severely** Painful |
| Walking: | ☐ **No Effect** | ☐ **Mild** Pain | ☐ **Moderately** Painful | ☐ **Severely** Painful |
| Yard Work: | ☐ **No Effect** | ☐ **Mild** Pain | ☐ **Moderately** Painful | ☐ **Severely** Painful |

## Recreational Activities: Effects of Current Condition on Performance

(*list*)

| | | | | |
|---|---|---|---|---|
| _________________ | ☐ **No Effect** | ☐ **Mild** Pain | ☐ **Mod** Painful | ☐ **Severely** Painful |
| _________________ | ☐ **No Effect** | ☐ **Mild** Pain | ☐ **Mod** Painful | ☐ **Severely** Painful |
| _________________ | ☐ **No Effect** | ☐ **Mild** Pain | ☐ **Mod** Painful | ☐ **Severely** Painful |

Patient's Signature ___________________________________

Date _________________ chart# ____________________