Madison Clinic

PATIENT CARE PROGRESS REPORT

(To be completed at program re-evaluation / for a new complaint / before every 24th visit / after 1 year without treatment)

NAME: _____ DATE: _____

Our goal is to offer the very highest quality patient care possible. You can help us by responding to these questions about your progress and your experience here at our clinic.

I am coming in for an OLD or NEW health concern (PLEASE CIRCLE)

IF COMING IN FOR AN OLD CONCERN, HOW WOULD YOU RATE YOUR LEVEL OF OVERALL IMPROVEMENT?

- ☐ Poor (0-25%)
- ☐ Fair (25-50%)
- ☐ Good (50-75%)
- ☐ Excellent (75-100%)

IF COMING IN FOR AN OLD CONCERN, WOULD YOU SAY YOUR IMPROVEMENT IS:

- ☐PROGRESSING AT THE SPEED YOU EXPECTED
- ☐TAKING LONGER THAN YOU EXPECTED
- ☐OCCURING MUCH FASTER THAN YOU EXPECTED

PLEASE LIST ALL RELEVANT HEALTH CONCERNS, NEW AND OLD

Area of Concern	Progress to date (IF APPLICABLE)	Description of Pain	Pain Level (10=Worst Pain)
1) _____	- ☐Better ☐Worse ☐Same	_____	/10
2) _____	- ☐Better ☐Worse ☐Same	_____	/10
3) _____	- ☐Better ☐Worse ☐Same	_____	/10

WHAT STAGE OF CARE ARE YOU IN?

- ☐INITIAL INTENSIVE CARE (YOU ARE PAIN and NEED TO ↑ FREQUENCY OF TREATMENTS)
- ☐REHABILITATIVE STAGE (YOU ARE IN LESS PAIN, BUT NOT PAIN FREE – ↓ FREQUENCY OF TREATMENTS)
- ☐MAINTENANCE (ALMOST NO PAIN – YOU ARE MAINTAINING OPTIMAL HEALTH GAINS – FREQUENCY IS DETERMINED BY YOU AND YOUR LIFESTYLE)

HAVE YOU BEEN INSTRUCTED TO DO EXERCISES/STRETCHING AT HOME ☐YES ☐NO

IF YES HAVE, ARE YOU DOING THEM? ☐YES ☐NO

ARE YOU MORE FUNCTIONAL SINCE YOU HAVE BEGUN TREATMENT WITH US? ☐YES ☐NO

HOW WOULD YOU RATE YOUR LEVEL OF SATISFACTION WITH OUR CLINIC

☐ Poor ☐ Fair ☐ Good ☐ Excellent

IF A FRIEND WERE IN NEED OF SIMILAR HELP, WOULD YOU RECOMMEND OUR CLINIC TO THEM?

☐ No, I don't think so ☐ Yes, I think so ☐ Yes, definitely

WOULD YOU LIKE THE CLINIC TO FOLLOW UP WITH YOU PERIODICALLY?

☐YES – VIA EMAIL ☐YES – VIA PHONE ☐NO THANK YOU

WHAT ARE YOUR HEALTH GOALS FOR THIS SERIES OF TREATMENTS?

_____

DO YOU HAVE ANY COMMENTS, CONCERNS OR UNANSWERED QUESTIONS?

_____

HAS YOUR CONTACT INFORMATION CHANGED? PLEASE UPDATE:

ADDRESS: _____ APT #: _____ CITY: _____

PROVINCE: _____ POSTAL CODE: _____ EMAIL ADDRESS: _____

TELEPHONE #: (H) _____-_____ (W) _____-_____ (C) _____-_____

Below is for Office Use Only:

- ☐ ALL ORTHOPEDIC TESTS ARE THE SAME AS BEFORE – WITH THE FIXATIONS AND HYPERTONICITIES AS LISTED ON THE SOAP NOTES
- ☐ PLEASE SEE THE EXAMINATION SHEET FOR THE PHYSICAL EXAM PORTION FOR TODAY
- ►*FREQUENCY:* ☐ same as before ☐ new freq: ___ times per week for ___ weeks and re-eval