

**Patient Name:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**FOR OFFICE USE ONLY:**  Progress Exam  Re-Exam  InBody  Heel Lift \_\_\_\_\_mm \_\_\_\_\_%  
 Patient ID: \_\_\_\_\_  X-Rays | CER - AP LAT | TH - AP LAT | LUM - AP LAT

**SECTION 1 Initial Assessment Questions (check one for each question)**

**1. In general, how would you rate your overall health?**

- Excellent  Very Good  Good  Fair  Poor

**2. How often do you exercise for at least 20 mins in a day?**

- Every day  3-6 days/wk  1-2 days/wk  0 days

**3. How often do you do chiropractic exercises/therapies?**

- Every day  3-6 days/wk  1-2 days/wk  0 days

**Questions about chiropractic exercises/therapies?**

- I would like a copy of my exercises  
 I would like to review my exercises in person  
 No questions

**4. Are you interested in a Fitness and/or Nutrition program to help you make changes to improve your health?**

- Yes, I want to learn more about nutrition  
 Yes, I want to learn more about fitness  
 No, I am not interested at this time

**5. Are there any new stressors in your life?**

**PHYSICAL**

- More exercise  Accidents  
 Less exercise  Falls  
 Other \_\_\_\_\_

**CHEMICAL**

- Medications  Change in Diet  
 Other \_\_\_\_\_

**EMOTIONAL**

- School / Work  Relationships  
 Other \_\_\_\_\_

OFFICE NOTES:

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

**SECTION 2 HFC Assessment Questions (check one for each question)**

**1. What are you most pleased about your experience here at HFC?** \_\_\_\_\_

**2. What are your motivating reasons/goals for maintaining care at HFC?**

- Pain Relief  Corrective Care  Overall Health  Other: \_\_\_\_\_

**3. Have you given HFC a thumbs up on Facebook?**

- Yes  Not Yet  Not on Facebook  Use other social media platforms

**4. Is there a reason your entire family has not had a spinal check-up at HFC?**

- Family Already Receiving Care  Lack of Time  Financial  Other: \_\_\_\_\_

Patient Signature: \_\_\_\_\_

OFFICE USE ONLY: \_\_\_\_\_

\_\_\_\_\_

**SECTION 3 Health Concerns / Symptoms Assessment Questions**

**How have your previous health concerns / symptoms changed?**

1. \_\_\_\_\_  
 No Longer Exists  Improved  No Change  Worsened

**Movement/activity that help or hurt the above symptom?**

\_\_\_\_\_

2. \_\_\_\_\_  
 No Longer Exists  Improved  No Change  Worsened

**Movement/activity that help or hurt the above symptom?**

\_\_\_\_\_

3. \_\_\_\_\_  
 No Longer Exists  Improved  No Change  Worsened

**Movement/activity that help or hurt the above symptom?**

\_\_\_\_\_

4. \_\_\_\_\_  
 No Longer Exists  Improved  No Change  Worsened

**Movement/activity that help or hurt the above symptom?**

\_\_\_\_\_

5. \_\_\_\_\_  
 No Longer Exists  Improved  No Change  Worsened

**Movement/activity that help or hurt the above symptom?**

\_\_\_\_\_

**Do you have NEW PAINS / SYMPTOMS?**  
 Yes  No  
Please describe your pain(s) or symptom(s):  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Are you DISCOURAGED about anything?**  
 Yes  No  
Please tell us why you are discouraged:  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

OFFICE NOTES:  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**OFFICE USE ONLY**

**SECTION 4 Health Goals Assessment**  
**CA:** Questions to ask depending on patient's response to each health goal.  
**ACHIEVED GOAL:** How did you achieve your goal?      **NEED SUPPORT:** How can HFC support you?  
**STILL WORKING:** Steps taking to achieve goal?      **GOAL CHANGED:** What is your new goal?

**Current Immediate Health Goal:**  
\_\_\_\_\_  
\_\_\_\_\_

Achieved Goal  Need Support  
 Still Working  Goal Changed

**New Immediate Health Goal:**  
\_\_\_\_\_  
\_\_\_\_\_

**Current Short Term Health Goal:**  
\_\_\_\_\_  
\_\_\_\_\_

Achieved Goal  Need Support  
 Still Working  Goal Changed

**New Short Term Health Goal:**  
\_\_\_\_\_  
\_\_\_\_\_

**Current Long Term Health Goal:**  
\_\_\_\_\_  
\_\_\_\_\_

Achieved Goal  Need Support  
 Still Working  Goal Changed

**New Long Term Health Goal:**  
\_\_\_\_\_  
\_\_\_\_\_