CELEBRATION FAMILY CHIROPRACTIC
Scoliosis Reduction Center
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Patient Progress Review

Name_____Date_____

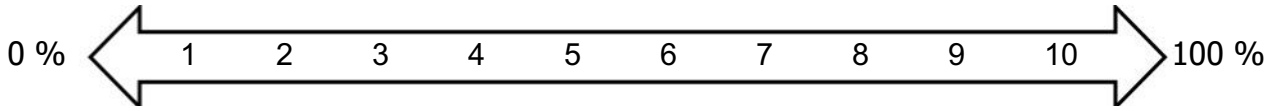
Completed By_____

1. Since your most recent intensive care, what health changes have you experienced (i.e., better posture, less pain)?_____
_____

2. Do you have any new concerns since last intensive care? (i.e stiffness, pain, discomfort)?___
_____

3. Were you recommended to purchase a Scoliosis Traction Chair for home use? Yes/No
If **Yes**, did you purchase a Scoliosis Traction Chair? Yes/No
If Purchased, how often do you use it? _____

4. Rate how well have you followed your home care recommendations below.



5. Are there any exercises you are not doing:_____

6. Do you currently see a chiropractor? Yes/No If **Yes,** how often? _____

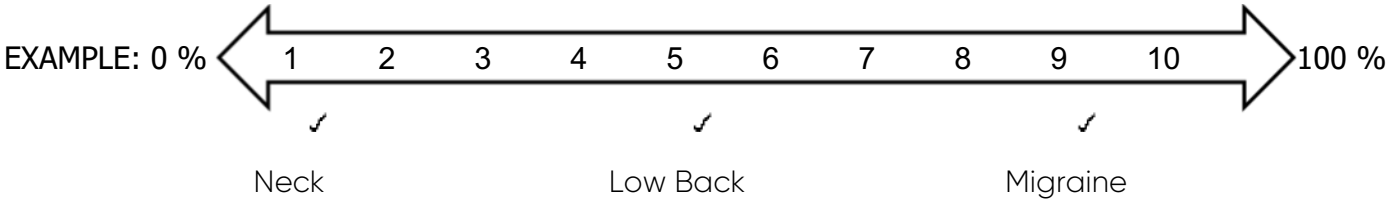
7. Have you seen any other doctors regarding you condition? Yes/No

If **Yes**, who did you see and what was the result?_____

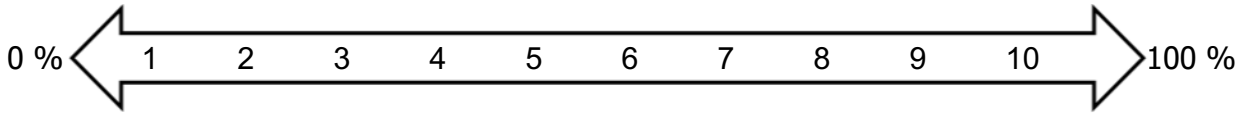
8. Were you recommended to purchase a ScoliBrace? Yes/No
If **Yes**, did you purchase a ScoliBrace? Yes/No
If **Yes**, are you in the weaning process? Yes/No
If Purchased, how many hours per day do you wear it? _____

9. What are your current goals? (i.e. continue to reduce curvature, maintain, prevent surgery)
_____
_____

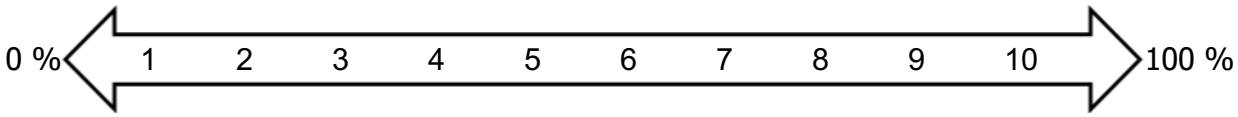
Please check/circle the number that best describes the question being asked. If you have more than one complaint, please write where your pain is located for each complaint/number circled.



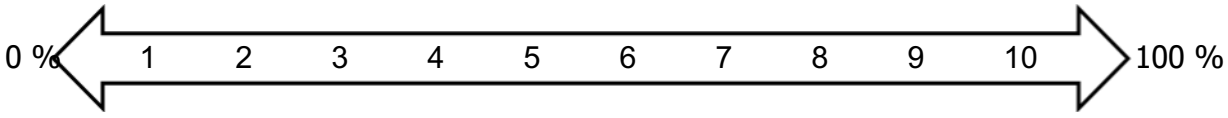
10. If you have a brace, do you have any discomfort from the brace? If you do not have a brace, write N/A



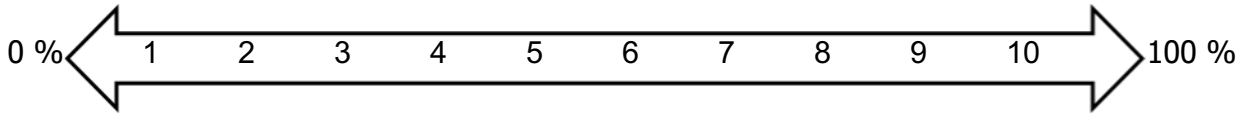
11. How is your pain RIGHT NOW? Not pertaining to the brace if you have one



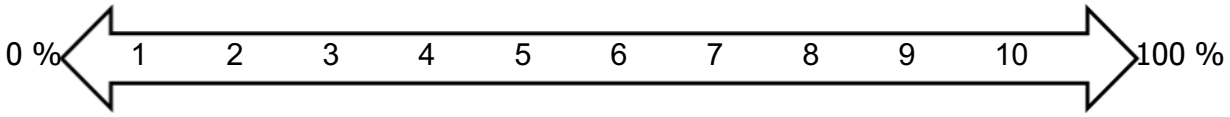
12. What is your TYPICAL or AVERAGE pain? Not pertaining to the brace if you have one



13. What is your pain level AT ITS BEST (How close to "0" does your pain get at its best)? Not pertaining to the brace if you have one



14. What is your pain level AT ITS WORST (How close to "10" does your pain get at its worst)? Not pertaining to the brace if you have one



15. Is there any additional information you feel necessary for the doctor to know?

_____

Name:_____ Date:_____

ACTIVITIES OF DAILY LIVING

Identify how your current condition is affecting your ability to carry out daily activities that are routinely part of your life:

Carrying Groceries	☐ No Effect	☐ Painful (can do)	☐Painful (Limits)	☐ Unable to Perform	
Sit to Stand	☐ No Effect	☐ Painful (can do)	☐Painful (Limits)	☐ Unable to Perform	
Climbing Stairs	☐ No Effect	☐ Painful (can do)	☐Painful (Limits)	☐ Unable to Perform	
Pet Care	☐ No Effect	☐ Painful (can do)	☐Painful (Limits)	☐ Unable to Perform	
Driving	☐ No Effect	☐ Painful (can do)	☐Painful (Limits)	☐ Unable to Perform	
Extended Computer Use	☐ No Effect	☐ Painful (can do)	☐Painful (Limits)	☐ Unable to Perform	
Household Chores	☐ No Effect	☐ Painful (can do)	☐Painful (Limits)	☐ Unable to Perform	
Lifting Children	☐ No Effect	☐ Painful (can do)	☐Painful (Limits)	☐ Unable to Perform	
Reading/Concentration	☐ No Effect	☐ Painful (can do)	☐Painful (Limits)	☐ Unable to Perform	
Bathing	☐ No Effect	☐ Painful (can do)	☐Painful (Limits)	☐ Unable to Perform	
Dressing	☐ No Effect	☐ Painful (can do)	☐Painful (Limits)	☐ Unable to Perform	
Washing/Bathing/Shaving	☐ No Effect	☐ Painful (can do)	☐Painful (Limits)	☐ Unable to Perform	
Sexual Activities	☐ No Effect	☐ Painful (can do)	☐Painful (Limits)	☐ Unable to Perform	
Sleep	☐ No Effect	☐ Painful (can do)	☐Painful (Limits)	☐ Unable to Perform	
Sitting	☐ No Effect	☐ Painful (can do)	☐Painful (Limits)	☐ Unable to Perform	
Standing	☐ No Effect	☐ Painful (can do)	☐Painful (Limits)	☐ Unable to Perform	
Yard Work	☐ No Effect	☐ Painful (can do)	☐Painful (Limits)	☐ Unable to Perform	
Walking	☐ No Effect	☐ Painful (can do)	☐Painful (Limits)	☐ Unable to Perform	
Sweeping/Vacuuming	☐ No Effect	☐ Painful (can do)	☐Painful (Limits)	☐ Unable to Perform	
Dishes	☐ No Effect	☐ Painful (can do)	☐Painful (Limits)	☐ Unable to Perform	
Laundry	☐ No Effect	☐ Painful (can do)	☐Painful (Limits)	☐ Unable to Perform	
Taking out Garbage	☐ No Effect	☐ Painful (can do)	☐Painful (Limits)	☐ Unable to Perform	
Other	☐ No Effect	☐ Painful (can do)	☐Painful (Limits)	☐ Unable to Perform	
Other	☐ No Effect	☐ Painful (can do)	☐Painful (Limits)	☐ Unable to Perform	

16. Current standing weight and height without shoes on:_____

(Take at the same time of the day every time. Take off shoes. Stand upright against a wall. Measure from the floor to the top of the patient's head.)

Signature_____Date_____