

PROGRESSIVE EXAMINATION FORM

Rate the most common intensity of overall pain since being IN alignment:

0	1	2	3	4	5	6	7	8	9	10
No Pain					Moderate					Most Severe Pain

Rate the level of pain before initiating NUCCA treatment:

0	1	2	3	4	5	6	7	8	9	10
No Pain					Moderate					Most Severe Pain

In the initial phase of NUCCA care at our office, did you notice any positive changes in your body?

☐ Yes ☐ No

... if YES, to what extent were these improvements?

0	1	2	3	4	5	6	7	8	9	10
No Change										Life Altering

... if NO, please explain what you did not experience improvement in.

Regarding the changes you experienced, were they:

0	1	2	3	4	5	6	7	8	9	10
Extremely Short Term										Permanent & Long Lasting

Add additional comments if desired:

How has your condition affected your activities of daily living since you started care here?

0	1	2	3	4	5	6	7	8	9	10
More Compromised/ Less Able										Least Compromised/ Most Able

Well-Being Question (Arizona Q):

Reflect on your sense of WELL-BEING, taking into account your physical, mental, emotional, social and spiritual condition. Mark on the line, the point that summarizes your overall sense of well-being for the past month:

0	1	2	3	4	5	6	7	8	9	10
Worst I Have Ever Been										Best I Have Ever Been

**Please comment on any area of body that continues to affect you:
(worse/better, to what degree, frequency, etc.)**

- ☐ Head/headaches/migraines _____
- ☐ Jaw _____
- ☐ Neck _____
- ☐ Shoulders _____
- ☐ Arms/hands _____
- ☐ Midback/ribs _____
- ☐ Low back/buttock _____
- ☐ Legs/knees/feet _____
- ☐ Vertigo/dizziness _____
- ☐ Other _____

Additional comments:

Are there any new practitioners or treatments involved in your current care not previously indicated on the initial intake?

Lifestyle Questionnaire

Current Exercise: Please indicate typical frequency (how often) and duration (how long) of each. Leave blank if NOT applicable.

☐ Stretching _____

☐ Core Stability Training _____

☐ Resistance Training _____

☐ Aerobic Training _____

☐ Yoga _____

☐ Pilates _____

☐ Other _____

Hydration:

☐ Water per day _____

☐ Caffeinated beverages per day _____

☐ Alcohol beverages per week _____

Sleep Quality

Do you feel rested upon waking? Please select:

☐ Always ☐ Mostly ☐ Frequently ☐ Rarely ☐ Never

How many hours of sleep, on average, are you getting every night?

☐ 3-4 hours ☐ 5-7 hours ☐ 8-9 hours ☐ 9 < hours

Please include current information on the following:

☐ Supplements _____

☐ Medication _____

☐ Have you developed any new conditions: _____

☐ Are you wearing orthotics/insoles in your shoes? If so, where from? _____

☐ How often are you seeing any other practitioners? _____

Do you feel that the care you receive in this office has had a positive affect on your quality of life?

Would you like to continue care in this office to further support your journey in health and function?

- ☐ Yes, please! I feel that I am making continued progress and I'm optimistic that further changes can be reached with continued care.
- ☐ Yes, please! I am very satisfied with my progress. I have reached my original goals and would appreciate advice on how to maintain and/or optimize my function beyond pain relief.
- ☐ No thank you. I am satisfied with my progress and no longer feel the need for further corrective care.
- ☐ No thank you. I did not achieve a satisfactory improvement in the timeline anticipated and would like advice on alternative options going forward.

If yes, based on your understanding of your response to NUCCA care, how often do you feel your alignment should be assessed at this point?

Do you have any current questions, regarding your health journey, that you would like to discuss or is there any other issue(s) that you would like help or guidance with?

Communication:

Appointment Notifications and Reminders:

You can opt to receive emails to keep you informed of new bookings, changes to your bookings, and reminders for upcoming appointments.

Email

- ☐ Email 2 days prior to appointment

Text Message (SMS)

- ☐ Text Message (SMS) 2 hours prior to appointment

News and Special Promotions

- ☐ Yes, I would like to receive clinic updates and health and wellness information from the Vibe team of practitioners. This is usually sent on a monthly basis.

Progressive Exam - Consents**Privacy and Sharing of Information**

I authorize the clinic and its associated health professionals to collect my personal and medical information as documented above. In addition, I authorize the clinic and its associated health professionals to communicate with my family doctor and/or referring doctor as deemed necessary for my beneficial treatment. I also understand that my personal and medical information is confidential and will only be disclosed to third parties with my permission.

☐ I agree. - Required

Signature: _____ Date: _____