SEACREST
Health & Wellness Center

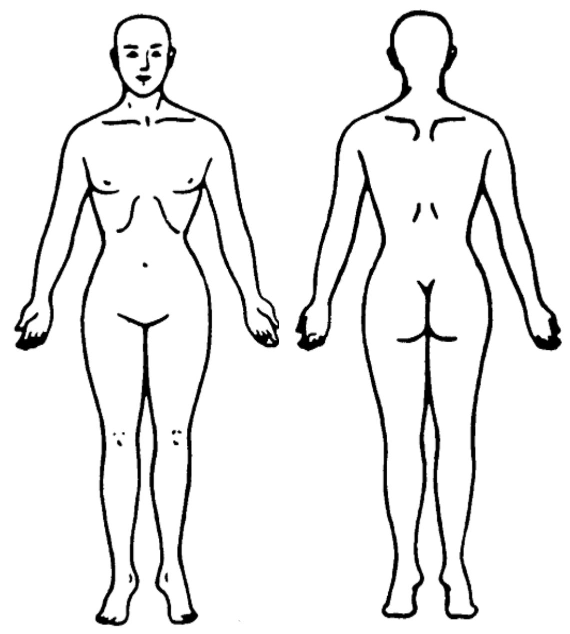
Dr. Will Rogers, DC, DACNB
Dr. Dean Peppard, DC
www.SeacrestHWC.com

10953 Meridian Dr. Ste. O
Cypress, CA 90630
714-821-4265

____ ________________________
Patient Name Date

PROGRESS EVALUATION

Use the body diagram to the right to indicate complaint areas. Please list your complaints in the space provided below in order of priority. Use the key below for frequency guidelines. Indicate severity with a # 1-10, 1 being most mild, 10 being most severe.



	Complaint	Frequency	Severity
1)	________________________	____________________	_______
2)	________________________	____________________	_______
3)	________________________	____________________	_______
4)	________________________	____________________	_______
5)	________________________	____________________	_______

FREQUENCY
(During waking hours)

0-25%	26-50%	51-75%	76-100%
Occasionally	Intermittently	Frequently	Consistently

Please circle a # 0-10 (0 being no pain, 10 being worst possible pain).

My overall pain is *generally*: [0 1 2 3 4 5 6 7 8 9 10]

My overall pain *right now*: [0 1 2 3 4 5 6 7 8 9 10]

Are you currently taking over-the-counter pain medication? ☐ **Y** ☐ **N**

Pain quality (please check any that apply):

☐ **Sharp/Stabbing** ☐ **Dull/Achy**

☐ **Tingling** ☐ **Numbness**

☐ **Burning** ☐ **Stiffness**

Please check which best describes how you currently feel overall since your initial visit to our office for this condition:

☐**Worse** ☐ **About the Same** ☐ **Somewhat Improved** ☐ **Much Improved** ☐ **No More Complaints**

Please describe any notable achievements since your last evaluation with us (e.g. activities you could not do prior to treatment):

____

If you have been off from work, have you returned to work yet? ☐ **Y** ☐ **N** If yes, date returned to work:_______________.

Please indicate any illnesses, operations, treatments or change in medications since your last evaluation with us:

____

____

Are you happy with your care in our office? ☐ **Y** ☐ **N** If no, please tell us what we can do to make it better:

____

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SYMPTOMS CHECKLIST

Please check if appropriate.

Orthopedic & Musculoskeletal

□ "Clunk" Sounds	□ Shoulder Pain	→	□ **Left** □ **Right**
□ Neck Pain	□ Upper Arm Pain	→	□ **Left** □ **Right**
□ Upper Back Pain	□ Elbow Pain	→	□ **Left** □ **Right**
□ Lower Back Pain	□ Forearm Pain	→	□ **Left** □ **Right**
□ Jaw Pain	□ Wrist Pain	→	□ **Left** □ **Right**
□ Clicking in Jaw	□ Hand Pain	→	□ **Left** □ **Right**
□ Face Pain	□ Hip Pain	→	□ **Left** □ **Right**
□ Chest Pain	□ Upper Leg Pain	→	□ **Left** □ **Right**
□ Stomach Pain	□ Knee Pain	→	□ **Left** □ **Right**
□ Range of Motion Problems	□ Lower Leg Pain	→	□ **Left** □ **Right**
□ Radiating Pain	□ Ankle Pain	→	□ **Left** □ **Right**
□ Muscle Spasms	□ Foot Pain	→	□ **Left** □ **Right**
□ Bruise/Contusion to: ______________________	□ Numb/Tingling Arm/Hand	→	□ **Left** □ **Right**
□ Abrasion/Scrape to: _______________________	□ Numb/Tingling Leg/Foot	→	□ **Left** □ **Right**
□ Other: __________________________________	□ Weakness Arm/Hand	→	□ **Left** □ **Right**
□ Other: __________________________________	□ Weakness Leg/Foot	→	□ **Left** □ **Right**

Neurological

□ Memory Problems	□ Attention Problems	□ Dizziness/Vertigo
□ Stress/ Anxiety	□ Learning Disabilities	□ Headaches/ Migraines
□ Head Trauma	□ Speech Problems	□ Movement Problems
□ Balance/Walking Issues	□ Brain Fog	□ Hyperactivity
□ Depression/Sadness	□ Abnormal Fatigue	□ Confusion/ Disorientation
□ Frustration/ Irritability	□ Reading/Writing Problems	□ Panic Attacks
□ Visual Disturbances	□ Sleep Disruption	□ Anti-Social Tendencies
□ Nausea/Vomiting	□ Mood Swings	□ Appetite Change
□ Pupils Different Sizes	□ Personality Change	□ Difficulty Making Decisions
□ Change in Sexual Function	□ Reduced Confidence	□ Feeling of Helplessness
□ Apathy (Don't Care)	□ Hearing Problems	□ Impatience

□ Other: ____
□ Other: ____