

PROGRESS EVALUATION

Please fill out all information to the best of your ability, should you have no answer for the question please draw a line through the space or list N/A.
The more detailed information that you give us the greater the ability we have to help you.

NAME: _____ DATE: _____

EMAIL: _____ DATE OF BIRTH: _____

Health Concerns
List According to their Severity

Rate of Severity
1=Mild /10=Severe

1. _____
2. _____
3. _____

If you are experiencing pain, how would you describe it?

Sharp Dull Ache Numbness Shooting Cramping Burning Stiffness Throbbing Swollen
Does the pain travel or radiate anywhere? No Yes – Please Describe:

These symptoms interfere with my: Work Sleep Daily Routine Recreation Family School

Since the problem started, it is.... About the same Getting Better Getting Worse

What makes it worse? _____

What makes it better? _____

2. How would you describe the **health changes** that have occurred in your life since beginning care? Please circle (i.e., increased activities, better eating habits, better immune function, more energy, better sleeping patterns, less sickness, better mobility, less medication, less allergies, weight loss, less pain, better mental health, less excitability, better sports performance, etc.) Other changes: _____

3. Do you have a Home Traction Kit? Yes No

What Traction unit do you have? ___CBP ___ Door ___ Wedge ___ Posture Pro ___ Genesis

How often are you performing the traction? Daily 2x Daily Other _____

How long are you performing the traction? _____ minutes _____ repetitions

4. Do you have your Home Stretches that were prescribed to you? Yes No

How often are you performing the stretches Daily 2x Daily Other _____

How long does it take you to perform all stretches _____ minutes

5. Do you perform the recommended In-Office Therapy on each visit? Yes No

8. What Advanced Talks have you **NOT** attended since starting care (please circle)

Maximized Nutrition Maximized Detoxification Maximized Peace and Healthy Relationships Maximized Lean Muscle and Oxygen

9. Please list all current medications, and what they have been prescribed for (**even if you have given them to us before**).

10. Please list all vitamins and supplements your are currently taking (**even if you have given them to us before**).

12. If you are a Female is there any chance you may be pregnant? YES / NO

Social History

- 1. Smoking: cigars pipe cigarettes → How often? Daily Weekends Occasionally Never
- 2. Alcoholic Beverage: consumption occurs → How often? Daily Weekends Occasionally Never
- 3. Recreational Drug use: occurs → How often? Daily Weekends Occasionally Never

General Health History:

1. Please mark all symptoms you have had in the last 6 months, even if they do not seem related to your current health problems:

- Headaches
- Pins and Needles in arms
- Buzzing/Ringing in ears
- Loss of taste
- Tension/Irritability
- Constipation
- Lights bother eyes
- Dry/Cracked Skin
- Pins and Needles in Legs
- Loss of smell
- Nervousness
- Upset Stomach
- Sleeping Problems
- Fever
- Urinary Problems
- Difficulty Focusing Attention
- Fainting/Dizziness
- Back Pain
- Numbness in Fingers
- Fatigue
- Cold Feet and/or Feet
- Dry Eyes
- Heartburn/Ulcers
- Mood Swings
- Neck Pain/Stiffness
- Loss of Balance
- Numbness in toes
- Depression
- Diarrhea
- Hot Flashes/Cold Sweats
- Menstrual Pain/Irregularity
- Poor Memory

2. How much water do you drink on a daily basis (glasses or ounces)? _____

3. What other beverages do you drink on a daily basis and how much? _____

4. How many bowel movements do you have in a _____ day or a _____ week?

5. How many hours do you sleep per night? _____ Rate your Sleep quality (1=poor to 10=great)? _____

6. Have you ever had surgery?

Type _____ Date _____

Type _____ Date _____

Type _____ Date _____

7. Please list the 5 Essentials for Maximized Living

- 1. Maximized _____
- 2. Maximized _____
- 3. Maximized _____
- 4. Maximized _____
- 5. Maximized _____

8. What current activities are you currently performing that may cause damage to your spine and nervous system?

- ___ Poor nutrition
- ___ Exercising
- ___ Lack of exercise
- ___ Taking medication
- ___ Exposure to toxins
- ___ Inadequate rest
- ___ Poor posture
- ___ Incorrect working conditions
- ___ Stress
- ___ Others _____

9. Our goal is to help as many people as we possibly can become more educated about the 5 Essential of Maximized Living. Do you know of any groups, organization, or schools that you would be able to establish a presentation, talk, or screening by Dr. Harmon or our office?

10. Do you have any other concerns or question you would like the Doctor to know about your health?

11. What are you **current and long term health goals:**

- ___ prevent/reverse Cancer
- ___ Get out pain
- ___ Have abundant energy
- ___ Have healthy hormones
- ___ Save money by being healthy
- ___ prevent/reverse headaches
- ___ prevent/reverse diabetes
- ___ prevent/reverse neuropathy