

A Renaissance Health Center for Natural Medicine

130 NW Miller Ave., Gresham, OR 97030 PH: 503.665.2344 FAX: 503.66.2337

PATIENT PROGRESS SELF-ASSESSMENT

(PLEASE FILL OUT EACH VISIT TO HELP ASSESS YOUR IMPROVEMENT)

TX # _____

DATE: _____ Practitioner: _____

PT. NAME: _____ DOB _____

ADDRESS _____

CITY _____ STATE _____ ZIP _____ PH _____

My main health concern(s) today are _____

Specific areas of pain in my body include the following today:

1. _____	2. _____	3. _____
4. _____	5. _____	6. _____

Since your last visit/treatment, you notice that your main health concern/pain level is:

- The same as the last time you were here
- Slightly Improved
- Moderately Improved
- Worse

Please rate your pain below in terms of severity as you are now experiencing it.

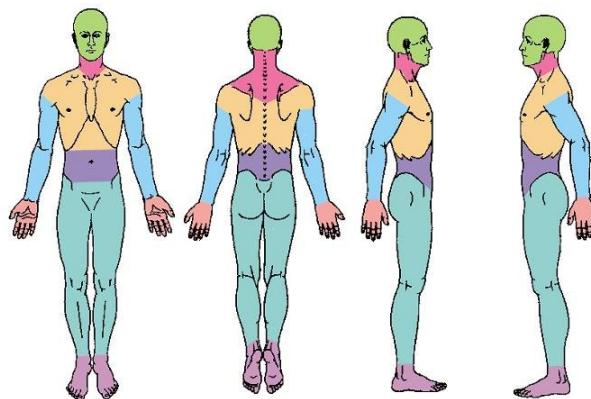
NOW	0	1	2	3	4	5	6	7	8	9	10
BEST	0	1	2	3	4	5	6	7	8	9	10
WORST	0	1	2	3	4	5	6	7	8	9	10
SEVERITY OF PAIN	NO PAIN		MILD		MOD.		SEVERE		VERY SEVERE		WORST PAIN POSSIBLE

I notice my range of motion in area of concern is: Better Same Worse

Changes in Pain Medications Since Beginning Treatment?

None Using Less Using More DOSAGE OF MEDS PER DAY? _____

Circle areas that match pain on your body.



- ACHEY
- BURNING
- THROBBING
- NUMBNESS
- TINGLING
- PAIN

CHECK ALL THAT APPLY

PATIENT SIGNATURE _____

Date _____