

# A Renaissance Health Center for Natural Medicine

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## 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.

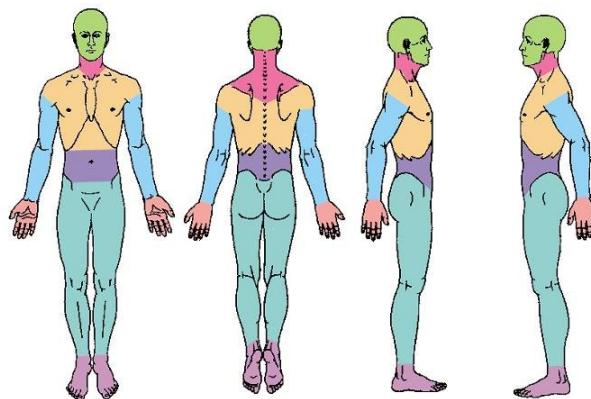
NOW	0	1	2	3	4	5	6	7	8	9	10
BEST	0	1	2	3	4	5	6	7	8	9	10
WORST	0	1	2	3	4	5	6	7	8	9	10
SEVERITY OF PAIN	NO PAIN		MILD		MOD.		SEVERE		VERY SEVERE		WORST PAIN POSSIBLE

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** \_\_\_\_\_