

Progress Mid-Therapy Questionnaire Review

Name of Patient: _____ Chart # _____
Date of Birth: ____/____/____ Exam Date: _____
Name of person completing this form: _____

Please let us know if there have been any changes with patient's demographic information since your last visit:
(please check if no changes)

1) List your initial goals when entering the therapy program.

2) List any areas where you feel progress has been made towards achieving your initial goals.

3) List any areas of continuing concern.

4) Please use the following scale to rate each symptom: None Mild Moderate Severe
0 1 2 3 4 5 6

__ Headache	__ Dizziness	__ Sleeping more than usual	__ Attention difficulty	__ Motion sensitivity
__ Nausea	__ Lightheadedness	__ Sleeping less than usual	__ Feeling slowed down	__ Ruminating thoughts
__ Vomiting	__ Balance problems	__ Drowsiness	__ Sadness/hopelessness	__ Difficulty in Math
__ Sensitivity to light	__ Numbness/tingling	__ Difficulty concentrating	__ Nervous/anxious	__ Difficulty reading
__ Sensitivity to noise	__ Fatigue	__ Feeling mentally foggy	__ Irritability	__ Symptoms worse
__ Visual Problems	__ Trouble falling asleep	__ Difficulty remembering	__ More emotional	at end of day

5) Please list any changes in your general health since your last visit.

6) Please list all current medications and dosages. (please check if no changes)

7) Have there been any illnesses /injuries, operations or hospitalizations since your last visit. Yes No (If yes, please list details.)

8) List any additional concerns you need to share with Dr. Mackowsky today. _____

Signature (please circle: patient/parent/spouse/caretaker)

Date

Dr. Mackowsky's Signature

Date