



www.TLC4Superteams.com

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Practice Breakthrough Assessment

Thank you for taking the time to engage in this assessment process. I value how precious time is and that your engagement with us is a choice. My intention upon reviewing what you share on this assessment is to thoroughly provide as insightful and beneficial an exchange as possible for you during our telephone conversation.

Please Print

Practice name: _____

Doctor name: _____ **Date of Birth:** _____

Spouse name: _____ **Date of Birth:** _____

Is Spouse a Chiropractor? _____

Practice Address: _____

City _____ **State** _____ **Zip** _____

Practice #: _____ **Fax #:** _____

Cell #: _____ **Home #:** _____

Home Address: _____

City: _____ **State:** _____ **Zip:** _____

Email: _____

What Chiropractic College did you attend? _____ **Year Grad:** _____

Who can we thank for referring you? _____

Please name any additional TLC members you know: _____

Years in your present practice _____ **Did you open this practice?** _____

If no, please explain your “story in practice”:

Please list names of all Associate Doctors.

Team Members:

Name

Zone

What are your present practice statistics?

NPs/mo: _____ OV's/mo _____ Services _____ Collections _____

What are your goals for these practice statistics (within the next 6 months)?

NPs/mo: _____ OV's/mo _____ Services _____ Collections _____

1. What personal strengths do you see yourself bringing to your life?

Personally: _____

Professionally: _____

2. Does your practice life spill over into your personal life on evenings or weekends?

If so how often and explain; _____

3. Do you provide weekly Spinal Workshops? (separate & distinct from patient orientation) Yes ___ No ___ Other? _____

4. Do you provide weekly team trainings (45-60 minutes)? Yes ___ No ___

5. Do you do 1 on 1 weekly accountability meetings? Yes ___ No ___

6. Have you been a part of any other coaching/management company?

Company Name _____ **# of years** _____

Company Name _____ **# of years** _____

7. Please write your exact daily practice hours.

	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
A.M.						
P.M.						

8. Gross outstanding debts (please be as accurate as possible):

PERSONAL

PROFESSIONAL

9. On a scale of 0-10, 10 being your best score, please assess how you believe you are performing in the following 12 areas of practice and personal life:

_____ Promotions and Marketing	_____ Science & Philosophy	_____ Business Planning
_____ New Patient Process	_____ Patient Financials	_____ Leadership
_____ Team Driven Practice	_____ Belief and Mindedness	_____ Capacity
_____ Balance	_____ Patient Care and Outcomes	_____ Retention



10. What is your greatest challenge you are currently experiencing in your practice?

11. What do you experience as any other challenges you would wish to share with me?

12. If your dreams were to become true, over the next several years, what would they look like in your life?

Personal

Professional

Thank you for your time, I look forward to speaking with you.



Your Heart Coach,

Samuel S. S. S.

CEO & Co-Founder

TLC4Superteams

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