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.

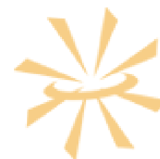
	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
A.M.						
P.M.						

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,

CEO & Co-Founder
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