PATIENT FOLLOW-UP/ RE-EVALUATION

To monitor your progress, please answer the questions below. These correspond to questions asked on your first visit to this office.

Patient Name: _____ Date: _____

Describe the status of your original complaints: _____

_____

Since your treatment began, your symptoms are: Decreasing Not Changing/ Staying the Same Increasing
Since your treatment began, your overall function is: Improving Not Changing/ Staying the Same Worsening

Please rate your overall improvement from 0 – 100% since beginning/ continuing treatment so far: _____% improved.
(No Improvement: 0%) (Mild Improvement: 1-30%) (Moderate Improvement: 31-60%) (Significant Improvement: 61-100%)
Please indicate and rate your individual areas of complaint: Area:_____/___% Area:_____/___%
Area:_____/___% Area:_____/___%

Have you, during your course of treatment, done anything to make your complaints worse? NO YES
If YES, please explain:

_____

Any new complaints? NO YES Describe: _____

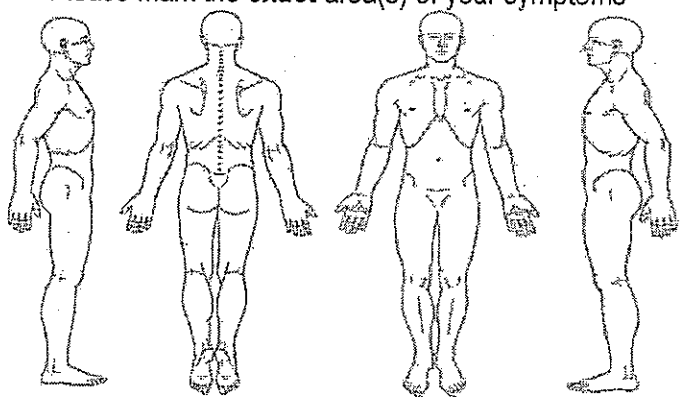
_____

Please describe the character of your current symptoms (You may choose one or more of the answers):
Dull Sore/Ache Sharp Stabbing Burning Tingling Numbness Shooting/Radiating
Weak Tension Spasm Throbbing Restricted Movement

Indicate the average intensity of your symptom(s).

None										**Unbearable**
0	1	2	3	4	5	6	7	8	9	10

Please mark the ***exact*** area(s) of your symptoms



Symptoms are **better** in: Morning Afternoon Evening No Change with Time of Day

Symptoms are **worse** in: Morning Afternoon Evening No Change with Time of Day

How often are the symptoms present?
Constant (76-100%) Frequent (51-75%) Occasional (26-50%) Intermittent (25% or less)

What makes your problem **better**?
Nothing Lying Down Sitting Standing Walking Lifting Carrying Pushing Pulling
Movement Exercise Inactivity Sleep Stretching Hot Water Weather Other _____

What makes your problem **worse**?

Nothing Lying Down Sitting Standing Walking Lifting Carrying Pushing Pulling
Movement Exercise Inactivity Sleep Stretching Hot Water Weather Other _____

Are you currently receiving other therapy/treatment? NO YES, please describe: _____

How would you grade your general stress level? No Stress Minimal Stress Moderate Stress Greatly Stressed

General physical activity: No Regular Exercise Light Exercise Strenuous Exercise

Any changes with your Diet Vitamin/Herb Supplements Medication/s? NO YES
If YES, please describe: _____

ADDITIONAL COMPLAINTS

Please circle all additional complaints that you have *at this time*

Loss of Concentration
Eyes Sensitive to Light
Memory Loss
Heavy Feeling of Head
Dizziness
Ringing in Ears
Loss of Balance
Loss of Smell
Loss of Taste

Pain behind Eyes
Fainting
Palpitation
Vision Problems
Chest Pain
Shortness of Breath
Irritable
Insomnia
Fatigue

Excess Perspiration
Digestive Trouble
Nausea
Vomiting
Diarrhea
Constipation
Cold Hands
Cold Feet
Convulsions

ADDITIONAL MEDICAL HISTORY

Have you had *ANY* of the following since your last visit here?
[ ] Surgery [ ] Major Illness [ ] Hospitalization [ ] CT Scan [ ] MRI [ ] Spinal X-rays [ ] Accident/ Fall
If Yes, please list the incident, treatment and place this was performed: _____

_____

_____

List current medications (including supplements): _____

_____

List all allergies: _____

THIS SECTION FOR WOMEN ONLY

Is there any chance that you ***might*** be pregnant? (Circle) [ ] Yes [ ] No Date of last cycle:_____ Initials:_____

Patient Interests

___ Massage ___ Foot Orthotics ___ Diet/ Nutrition ___ Exercise/ Weight Control ___ Detoxification

New Conditions, Complaints, Accidents or Aggravations

If you have a new complaint, have had a new accident or have recently aggravated a current or chronic condition you need to call prior to coming in for your previously scheduled appointment. It is possible that a re-evaluation and x-rays will be needed for diagnosis and treatment.

Rate your overall satisfaction with the treatment received to date? Very Pleased Pleased Somewhat Lacking

Patient Signature: _____ Date: _____

THE NECK DISABILITY QUESTIONNAIRE

Please Read: This questionnaire is designed to enable us to understand how much your neck pain has affected your ability to manage everyday activities. Please answer each Section by circling the **ONE CHOICE** that most applies to you. We realize that you may feel that more than one statement may relate to you, but ***please just circle the one choice which closely describes your problem right now.***

SECTION 1--Pain Intensity
A. I have no pain at the moment
B. The pain is mild at the moment.
C. The pain comes and goes and is moderate.
D. The pain is moderate and does not vary much.
E. The pain is severe but comes and goes.
F. The pain is severe and does not vary much.

SECTION 2--Personal Care (Washing, Dressing etc.)
A. I can look after myself without causing extra pain.
B. I can look after myself normally but it causes extra pain.
C. It is painful to look after myself and I am slow and careful.
D. I need some help, but manage most of my personal care.
E. I need help every day in most aspects of self-care.
F. I do not get dressed, I wash with difficulty and stay in bed.

SECTION 3--Lifting
A. I can lift heavy weights without extra pain.
B. I can lift heavy weights, but it causes extra pain.
C. Pain prevents me from lifting heavy weights off the floor but I can if they are conveniently positioned, for example on a table.
D. Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
E. I can lift very light weights.
F. I cannot lift or carry anything at all.

SECTION 4 --Reading
A. I can read as much as I want to with no pain in my neck.
B. I can read as much as I want with slight pain in my neck.
C. I can read as much as I want with moderate pain in my neck.
D. I cannot read as much as I want because of moderate pain in my neck.
E. I cannot read as much as I want because of severe pain in my neck.
F. I cannot read at all.

SECTION 5--Headache
A. I have no headaches at all.
B. I have slight headaches which come infrequently.
C. I have moderate headaches which come in-frequently.
D. I have moderate headaches which come frequently.
E. I have severe headaches which come frequently.
F. I have headaches almost all the time.

SECTION 6 -- Concentration
A. I can concentrate fully when I want to with no difficulty.
B. I can concentrate fully when I want to with slight difficulty.
C. I have a fair degree of difficulty in concentrating when I want to.
D. I have a lot of difficulty in concentrating when I want to.
E. I have a great deal of difficulty in concentrating when I want to.
F. I cannot concentrate at all.

SECTION 7--Work
A. I can do as much work as I want to.
B. I can only do my usual work, but no more.
C. I can do most of my usual work, but no more.
D. I cannot do my usual work.
E. I can hardly do any work at all.
F. I cannot do any work at all.

SECTION 8--Driving
A. I can drive my car without neck pain.
B. I can drive my car as long as I want with slight pain in my neck.
C. I can drive my car as long as I want with moderate pain in my neck.
D. I cannot drive my car as long as I want because of moderate pain in my neck.
E. I can hardly drive my car at all because of severe pain in my neck.
F. I cannot drive my car at all.

SECTION 9--Sleeping
A. I have no trouble sleeping
B. My sleep is slightly disturbed (less than 1 hour sleepless).
C. My sleep is mildly disturbed (1-2 hours sleepless).
D. My sleep is moderately disturbed (2-3 hours sleepless).
E. My sleep is greatly disturbed (3-5 hours sleepless).
F. My sleep is completely disturbed (5-7 hours sleepless).

SECTION 10--Recreation
A. I am able engage in all recreational activities with no pain in my neck at all.
B. I am able engage in all recreational activities with some pain in my neck.
C. I am able engage in most, but not all recreational activities because of pain in my neck.
D. I am able engage in a few of my usual recreational activities because of pain in my neck.
E. I can hardly do any recreational activities because of pain in my neck.
F. I cannot do any recreational activities all.

SIGNATURE:_____ **DATE:**_____

THE LOWER BACK DISABILITY QUESTIONNAIRE

Please Read: This questionnaire is designed to enable us to understand how much your ~~neck~~ back pain has affected your ability to manage everyday activities. Please answer each Section by circling the **ONE CHOICE** that most applies to you. We realize that you may feel that more than one statement may relate to you, but ***please just circle the one choice which closely describes your problem right now.***

SECTION 1--Pain Intensity
A. The pain comes and goes and is very mild.
B. The pain is mild and does not vary much.
C. The pain comes and goes and is moderate.
D. The pain is moderate and does not vary much.
E. The pain is comes and goes and is severe.
F. The pain is severe and does not vary much.

SECTION 2--Personal Care (Washing, Dressing etc.)
A. I would not have to change my way of washing or dressing in order to avoid pain.
B. I don't normally change my way of washing or dressing even though it causes some pain.
C. Washing and dressing increases the pain, but I manage not to change my way of doing it.
D. Washing and dressing increases the pain and I find it necessary to change my way of doing it.
E. Because of the pain, I am unable to do some washing and dressing without help.
F. Because of the pain, I am unable to do any washing or dressing without help.

SECTION 3--Lifting
A. I can lift heavy weights without extra pain.
B. I can lift heavy weights, but it causes extra pain.
C. Pain prevents me from lifting heavy weights off the floor.
D. Pain prevents me from lifting heavy weights off the floor but I can if they are conveniently positioned, for example on a table.
E. Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
F. I can lift very light weights.

SECTION 4 --Walking
A. Pain does not prevent me from walking any distances.
B. Pain prevents me from walking more than 1 mile.
C. Pain prevents me from walking more than ½ mile.
D. Pain prevents me from walking more than ¼ mile.
E. I can only walk while using a cane or crutches.
F. I am in bed most of the time and have to crawl to the toilet.

SECTION 5--Sitting
A. I can sit in any chair as long as I like without pain.
B. I can only sit in my favorite chair as long as I like.
C. Pain prevents me form sitting more than 1 hour.
D. Pain prevents me from sitting more than 30 minutes.
E. Pain prevents me form sitting more than 10 minutes.
F. Pain prevents me from sitting at all.

SECTION 6 --Standing
A. I can stand as long as I want without pain.
B. I have some pain while standing, but it does not increase with time.
C. I cannot stand for longer than 1 hour without increasing pain.
D. I cannot stand for longer than 30 minutes without increasing pain.
E. I cannot stand for longer than 10 minutes without increasing pain.
F. I avoid standing because it increases my pain right away.

SECTION 7--Sleeping
A. I get no pain in bed.
B. I get pain in bed, but it does not prevent me from sleeping well.
C. Because of pain, my normal night's sleep is reduced by less than ¼.
D. Because of pain, my normal night's sleep is reduced by less than ½.
E. Because of pain, my normal night's sleep is reduced by less than ¾.
F. Pain prevents me from sleeping at all..

SECTION 8--Social Life
A. My social life is normal and gives me no pain.
B. My social life is normal, but increases the degree of my pain.
C. Pain has no significant effect on my social life apart from limiting my more energetic interests, .g. dancing, etc.
D. Pain has restricted my social life and I do not go out often.
E. Pain has restricted my social life to my home.
F. I have hardly any social life because of pain.

SECTION 9--Traveling
A. I get no pain while traveling.
B. I get some pain while traveling but non of my usual forms of travel make it any worse.
C. I get extra pain while traveling, but it does not compel me to seek alternative forms of travel.
D. I get extra pain while traveling which compels me to seek alternative forms of travel.
E. Pain restricts all forms of travel.
F. Pain prevents all forms of travel except that done lying down.

SECTION 10—Changing Degree of Pain
A. My pain is rapidly getting better.
B. My pain fluctuates, but overall is definitely getting better.
C. My pain seems to getting better, but improvement is slow at present.
D. My pain is neither getting better nor worse.
E. My pain is gradually getting worse.
F. My pain is rapidly worsening.

SIGNATURE:_____ DATE:_____