

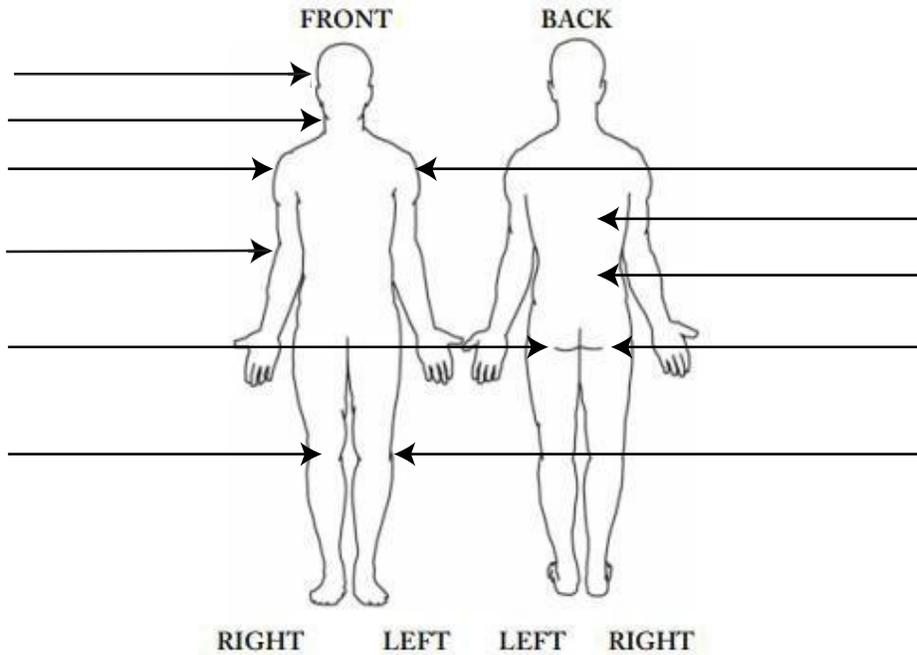
Re-Exam Packet
Patient Evaluation Chart and Questionnaire

Name: _____

Date: _____

Primary Onset (circle one): Traumatic Injury Chronic issue Sports injury Car accident Work injury

Please indicate on the diagram where your major symptoms are:



Please mark the body front and back with the appropriate letters from the chart listed below.

CP – Constant pain

S – Swelling

N – Numbness

R – Redness

L - Limitation

P – Pain

T – Tenderness

Tg – Tingling

E – Effusion (puffiness or edema)

W - Weakness

How long have you had these symptoms? (Itemize the different body areas if appropriate):

Symptom List

Please list the concerns that brought you in today:

First Area of complaint: _____

Pain level (please circle one): Mild Moderate Severe **Frequency:** Constant Intermittent

Symptoms (please circle one): Aches Stabs Burns Other: _____

Rate your symptom level on a 0-10 scale. (0- no pain 5 moderate pain 10 worst pain possible):

No												Worst
Pain	0	1	2	3	4	5	6	7	8	9	10	Possible pain

Second Area of complaint: _____

Pain level (please circle one): Mild Moderate Severe **Frequency:** Constant Intermittent

Symptoms (please circle one): Aches Stabs Burns Other: _____

Rate your symptom level on a 0-10 scale. (0- no pain 5 moderate pain 10 worst pain possible):

No												Worst
Pain	0	1	2	3	4	5	6	7	8	9	10	Possible pain

Third Area of complaint: _____

Pain level (please circle one): Mild Moderate Severe **Frequency:** Constant Intermittent

Symptoms (please circle one): Aches Stabs Burns Other: _____

Rate your symptom level on a 0-10 scale. (0- no pain 5 moderate pain 10 worst pain possible):

No												Worst
Pain	0	1	2	3	4	5	6	7	8	9	10	Possible pain

Fourth Area of complaint: _____

Pain level (please circle one): Mild Moderate Severe **Frequency:** Constant Intermittent

Symptoms (please circle one): Aches Stabs Burns Other: _____

Rate your symptom level on a 0-10 scale. (0- no pain 5 moderate pain 10 worst pain possible):

No												Worst
Pain	0	1	2	3	4	5	6	7	8	9	10	Possible pain

Fifth Area of complaint: _____

Pain level (please circle one): Mild Moderate Severe **Frequency:** Constant Intermittent

Symptoms (please circle one): Aches Stabs Burns Other: _____

Rate your symptom level on a 0-10 scale. (0- no pain 5 moderate pain 10 worst pain possible):

No												Worst
Pain	0	1	2	3	4	5	6	7	8	9	10	Possible pain

Activities of Daily Living Questionnaire

Work:

What type of work do you do? _____

How many hours per day are you able to work now? _____

Prior to Injury? _____

Days per week now? _____

How is your work affected or lost by your injury? _____

Home/Family:

List the activities affected by your injury? _____

Sleep: How many hours per night do you sleep now? _____ Prior to injury? _____

Do you feel rested now? _____ Prior to injury? _____

What affects your sleep? (Examples- pain, not able to go to sleep, not able to wake up etc.)

Social/Recreational:

Activities: _____

Prior to injury? _____

How are your current activities affected? _____

Name: _____

Date: _____

Signature: _____

Oswestry Neck Pain Disability Questionnaire

PLEASE READ: This questionnaire is designed to enable use to understand how much you **NECK** pain has affected your ability to manage your 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 MOST 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 comes and goes and is severe.
- F – The pain is severe and does not vary much.

Section 2 – Personal Care

- A – I would not have to change my way of washing or dressing in order to avoid pain
- B – I do not 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 manage if they are conveniently position, (example on a chair or table).
- E – Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently position.
- F – I can only lift very light weights, at the most.

Section 4 –Walking

- A – Pain does not prevent me from walking any distance.
- B – Pain prevents me from walking more than one 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 on 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 from sitting more than one hour.
- D – Pain prevents me from sitting more than ½ hour.
- E – Pain prevents me from 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 one hour without increasing pain.
- D – I cannot stand for longer than ½ hour without increasing pain.
- E – I cannot stand for longer than 10 minutes without increasing pain.
- F – I avoid standing, because it increases the pain straight away.

Oswestry Neck Pain Disability Questionnaire Continued

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 one-quarter.
- D – Because of pain, my normal night’s sleep is reduced by less than one-half.
- E – Because of pain, my normal night’s sleep is reduced by less than three-quarters.
- 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 activities, (example dancing, ect.)
- D – Pain has restricted my social life and I do not go out very often.
- E – Pain has restricted my social life to my home.
- F – I have hardly any social life because of the pain.

Section 9 – Traveling

- A – I get not pain while traveling.
- B – I get some pain while traveling, but none 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 be getting better, but improvement is slow at present.
- D – My pain is neither getting better nor worse.
- E – My pain is gradually worsening.
- F – My pain is rapidly worsening.

Additional Comments:

Name: _____ Date: _____ Score: _____

Oswestry Low Back Pain Disability Questionnaire

PLEASE READ: This questionnaire is designed to enable use to understand how much you **LOWER BACK** pain has affected your ability to manage your 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 MOST 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 comes and goes and is severe.
- F – The pain is severe and does not vary much.

Section 2 – Personal Care

- A – I would not have to change my way of washing or dressing in order to avoid pain.
- B – I do not 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 manage if they are conveniently position (example- on a chair or table).
- E – Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently position.
- F – I can only lift very light weights at the most.

Section 4 – Walking

- A – Pain does not prevent me from walking any distance.
- B – Pain prevents me from walking more than one 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 on 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 from sitting more than one hour.
- D – Pain prevents me from sitting more than ½ hour.
- E – Pain prevents me from 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 one hour without increasing pain.
- D – I cannot stand for longer than ½ hour without increasing pain.
- E – I cannot stand for longer than 10 minutes without increasing pain.
- F – I avoid standing, because it increases the pain straight away.

Oswestry Low Back Pain Disability Questionnaire Continued

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 one-quarter.
- D – Because of pain, my normal night’s sleep is reduced by less than one-half.
- E – Because of pain, my normal night’s sleep is reduced by less than three-quarters.
- F – Pain prevents me from sleeping at all.

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- A – My social life is normal and gives me no pain.
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- C – Pain has no significant effect on my social life apart from limiting my more energetic activities.
- D – Pain has restricted my social life and I do not go out very often.
- E – Pain has restricted my social life to my home.
- F – I have hardly any social life because of the pain.

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- A – I get not pain while traveling.
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- 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.

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- A – My pain is rapidly getting better.
- B – My pain fluctuates, but overall is definitely getting better.
- C – My pain seems to be getting better, but improvement is slow at present.
- D – My pain is neither getting better nor worse.
- E – My pain is gradually worsening.
- F – My pain is rapidly worsening.

Additional Comments:

Name: _____ Date: _____ Score: _____

Bourree Chiropractic and Massage

Patient Care Progress Report

Name: _____

Date: _____

Our goal is to offer the very highest quality patient care possible. Would you help us by responding to these questions about your progress?

Changes often happen quickly during Initial Intensive Care as your body begins the natural healing process. Many patients neglect to tell us about them. Here's a way you can help us help you.

Care

What changes have you noticed since beginning care?

Positive changes: _____

Negative changes: _____

On a scale of 1 to 10, rate YOUR level of overall improvement. (1- no change 5- moderate change 10- major change) _____

On a scale of 1 to 10, rate the level of improvement of your spine so far. (1- no change 5- moderate change 10- major change) _____

Would you say your improvement is:

____ Progressing at the speed you expected. ____ Taking longer than you expected. ____ Occurring much faster than you expected.

Do you think you could adequately describe the difference between initial intensive care and wellness care? (Circle one) **YES** **NO**

Staff

How would you rate the concern shown by our staff? (1- uninterested 10- deeply concerned) _____

How would you rate the training, qualifications, and competency of our staff? (1- unorganized and unprepared 10- efficient and knowledgeable) _____

Is there anyone who has been especially helpful? _____

In what ways would you change the staff, office, or procedures we use to improve the quality of care? _____

What do you like most about our office? _____

We strive to fully inform our patients about their care and explain chiropractic and their health. How would you describe our educational efforts?

____ Excellent, I've learned a lot ____ Helpful and interesting ____ Still leaves some questions unanswered
____ Could be significantly improved ____ Waste of patients and staff time

Support

Children could avoid many health problems if they had Chiropractic care. Would you like the opportunity to bring your children? (Circle one) **YES** **NO**

What kind of comments have you heard from your friends or family when you've told them about seeing a chiropractor?

What has been your greatest difficulty when explaining chiropractic and what we do to others?