

**PATIENT RE-EXAM QUESTIONNAIRE**

**Patient Name:** \_\_\_\_\_ **DOB:** \_\_\_\_\_ **Today's Date:** \_\_\_\_\_

**1. How do you rate your improvement so far since initiating treatment with at Blyss Chiropractic?**

Excellent                      Good                      Fair                      Poor

**2. On a scale of 1 to 10 with 10 being the best, how would you rate your improvement?**

1    2    3    4    5    6    7    8    9    10

**3. Which symptoms are improving?** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**4. Which symptoms continue?** \_\_\_\_\_  
\_\_\_\_\_

**How often?**    \_\_\_\_\_ x/day    \_\_\_\_\_ x/week    \_\_\_\_\_ x/month

**Lasting:**    < 5 mins    < 1 hour    1 - 5 hours    6 - 12 hours    All day

**5. In the past week how much has your pain interfered with your daily activities?**

1    2    3    4    5    6    7    8    9    10

**6. Which of the following activities are easier to perform?**

Walk    Ride    Run    Work    Stand    Sit    Lift    Bend    No Change

**7. Are there any concerns or conditions you wish to go into that we might not have covered so far during your treatment? If yes, please explain.**

\_\_\_\_\_  
\_\_\_\_\_

**8. Are there any questions about your progress or frustrations you might have?**

\_\_\_\_\_  
\_\_\_\_\_

**PAIN DRAWING**

**SYMPTOM RATING SCALE**

*Symptoms often vary in intensity. Please answer these questions about your **CURRENT** symptoms.*

Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Ache  
 <<<<<<  
 <<<<<<

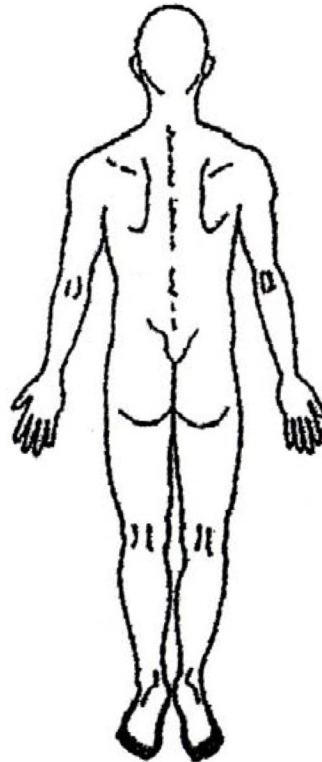
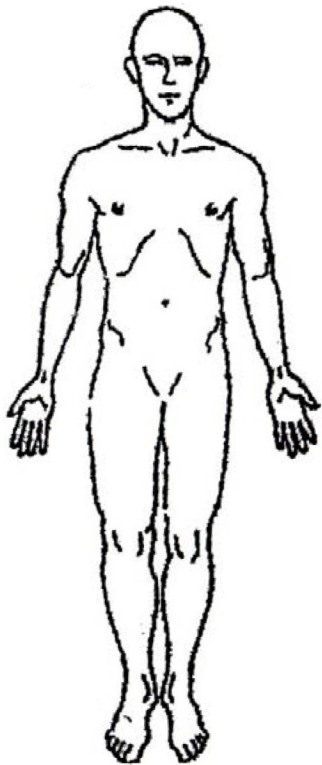
Numbness  
 .....  
 .....

Pins & Needles  
 00000  
 00000

Burning  
 xxxxxx  
 xxxxxx

Stabbing  
 /////  
 /////

Throbbing  
 ~~~~~  
 ~~~~~



1. What is your symptom intensity **RIGHT NOW**?

0	1	2	3	4	5	6	7	8	9	10
No Symptoms							Unbearable Symptoms			

2. What is your **TYPICAL or AVERAGE** symptom intensity?

0	1	2	3	4	5	6	7	8	9	10
No Symptoms							Unbearable Symptoms			

3. What is your symptom intensity at its **WORST**?

0	1	2	3	4	5	6	7	8	9	10
No Symptoms							Unbearable Symptoms			

4. In the past week, how much has pain interfered with your daily activities?

0	1	2	3	4	5	6	7	8	9	10
No Symptoms							Unbearable Symptoms			

5. How often are your symptoms present? \_\_\_\_\_ %

What are you concerned about today? \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**NECK PAIN AND DISABILITY INDEX**

Patient Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

**Please read instructions carefully:** This questionnaire has been designed to give the doctor information as to how your neck pain has affected your ability to manage everyday life. Please read all statements in each section then mark the box that most closely describes your problem.

**SECTION 1 – PAIN INTENSITY**

- I have no pain at the moment.
- The pain is very mild at the moment.
- The pain is moderate at the moment.
- The pain is fairly severe at the moment.
- The pain is very severe at the moment.
- The pain is worse than imaginable at the moment.

**SECTION 2 – PERSONAL CARE**

- I can look after myself normally, without causing extra pain.
- I can look after myself normally but it causes extra pain.
- It is painful to look after myself and I am slow and careful.
- I need some help but manage most of my personal care.
- I need help everyday in most aspects of self care.
- I do not get dressed. I wash with difficulty and stay in bed.

**SECTION 3 – LIFTING**

- I can lift heavy objects without any extra pain.
- I can lift heavy objects, but it gives extra pain.
- Pain prevents me from lifting heavy objects off the floor but I can manage if they are conveniently positioned on a table.
- Pain prevents me from lifting heavy objects but I can manage light to medium objects.
- I can only lift very light objects.
- I cannot lift or carry anything at all.

**SECTION 4 – READING**

- I can read as much as I want to with no pain in my neck.
- I can read as much as I want to with light pain in my neck.
- I can read as much as I want to with moderate pain in my neck.
- I can't read as much as I want to because of moderate pain in my neck.
- I can hardly read at all because of severe pain in my neck.
- I cannot read at all.

**SECTION 5 – HEADACHES**

- I have no headache at all.
- I have slight headaches which come infrequently.
- I have moderate headaches which come infrequently.
- I have moderate headaches which come frequently.
- I have severe headaches which come frequently.
- I have headaches almost all the time.

**SECTION 6 – CONCENTRATION**

- I can concentrate fully when I want to with no difficulty.
- I can concentrate fully when I want to with slight difficulty.
- I have a fair degree of difficulty in concentrating when I want to.
- I have a lot of difficulty in concentrating when I want to.
- I have a great deal of difficulty in concentrating when I want to.
- I cannot concentrate at all.

**SECTION 7 – WORK**

- I can do as much work as I want.
- I can do only my usual work, but no more.
- I can do most of my usual work, but no more.
- I cannot do my usual work.
- I can hardly work at all.
- I cannot do any work at all.

**SECTION 8 – DRIVING**

- I can drive without any neck pain.
- I can drive as long as I want with slight neck pain.
- I can drive as long as I want with moderate neck pain.
- I can hardly drive at all because of severe neck pain.
- I cannot drive at all.

**SECTION 9 - SLEEPING**

- I have no trouble sleeping.
- My sleep is slightly disturbed (less than 1 hr sleepless).
- My sleep is mildly disturbed (1-2 hrs sleepless).
- My sleep is moderately disturbed (3-5 hrs sleepless).
- My sleep is completely disturbed (5-7 hrs sleepless).

**SECTION 10 – RECREATION**

- I am able to engage in all my recreational activities with no neck pain.
- I am able to engage in all my recreational activities with some neck pain.
- I am able to engage in most, but not all of my usual recreational activities because of neck pain.
- I am able to engage in a few of my usual recreational activities because of neck pain.
- I can hardly do any recreational activities because of neck pain.
- I cannot do any recreational activities at all.

**NECK PAIN SCALE**

Rate the severity of your Neck Pain by indicating on the following scale.

Absent I-----I Extreme



**LOW BACK PAIN AND DISABILITY INDEX (REVISED OSWESTRY)**

Patient Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

**Please read instructions carefully:** This questionnaire has been designed to give the doctor information as to how your low back pain has affected your ability to manage everyday life. Please read all statements in each section then mark the box that most closely describes your problem.

**SECTION 1 – PAIN INTENSITY**

- The pain comes and goes and is very mild.
- The pain is mild and does not vary much.
- The pain comes and goes and is moderate.
- The pain is moderate and does not vary much.
- The pain comes and goes and is very severe.
- The pain is severe and does not vary much.

**SECTION 2 – PERSONAL CARE**

- I do not have to change my way of washing or dressing to avoid pain.
- I do not normally change my way of washing or dressing even though it causes some pain.
- Washing and dressing increases the pain but I manage not to change my way of doing it.
- Washing and dressing increases the pain and I find it necessary to change my way of doing it.
- Because of the pain, I am unable to do some washing and dressing without help.
- Because of the pain, I am unable to do any washing or dressing without help.

**SECTION 3 – LIFTING**

- I can lift heavy objects without any extra pain.
- I can lift heavy objects, but it gives extra pain.
- Pain prevents me from lifting heavy objects off the floor.
- Pain prevents me from lifting heavy objects off the floor but I can manage if they are conveniently positioned on a table.
- Pain prevents me from lifting heavy objects but I can manage light to medium objects.
- I can only lift very light objects at the most.

**SECTION 4 – WALKING**

- I have no pain on walking.
- I have some pain but it does not increase with distance.
- I cannot walk more than one mile without increasing pain.
- I cannot walk more than 1 / 2 mile without increasing pain
- I cannot walk more than 1 / 4 mile without increasing pain.
- I cannot walk at all without increasing pain.

**SECTION 5 – SITTING**

- I can sit in any chair as long as I like.
- I can only sit in my favorite chair as long as I like.
- Pain prevents me from sitting more than one hour.
- Pain prevents me from sitting more than half an hour.
- Pain prevents me from sitting more than ten minutes.
- I avoid sitting because it increases pain.

**SECTION 6 - STANDING**

- I can stand as long as I want without pain.
- I have some pain on standing but it does not increase with time.
- I cannot stand for longer than one hour without increasing pain.
- I cannot stand for longer than ½ hour without increasing pain.
- I cannot stand longer than ten minutes without increasing pain.
- I avoid standing because it increases the pain.

**SECTION 7 – SLEEPING**

- I have no pain in bed.
- I have pain in bed but it does not prevent me from sleeping well.
- Pain reduces my normal sleep by 1 / 4 each night.
- Pain reduces my normal sleep by 1 / 2 each night.
- Pain reduces my normal sleep by 3 / 4 each night.
- Pain prevents me from sleeping at all.

**SECTION 8 – SOCIAL LIFE**

- My social life is normal and gives me no pain.
- My social life is normal but increases the degree of pain.
- My social life is unaffected by pain apart from limiting more energetic interests.
- Pain has restricted my social life and I do not go out very often.
- Pain has restricted my social life to my home.
- I have hardly any social life because of the pain.

**SECTION 9 – DRIVING / RIDING IN CAR**

- I have no pain while traveling.
- I have some pain while traveling but none of my usual forms of travel make it any worse.
- I have extra pain while traveling but it does not compel me to seek alternate forms of travel.
- I have extra pain while traveling which compels me to seek alternate forms of travel.
- Pain restricts all forms of travel.
- Pain restricts all forms of travel except those done lying down.

**SECTION 10 – CHANGING DEGREE OF PAIN**

- My pain is rapidly getting better.
- My pain fluctuates but overall is definitely getting better.
- My pain seems to be getting better but improvement is slow at present.
- My pain is neither getting better or worse.
- My pain is gradually worsening.
- My pain is rapidly worsening.

**LOW BACK PAIN SCALE**

Rate the severity of your **Low Back Pain** by indicating on the following scale.

Absent I-----I Extreme