INTEGRATIVE
CHIROPRACTIC and PHYSICAL THERAPY
SOLUTIONS

Name:_____ Consultation Date:_____

1. Present Complaint, please indicate site of involvement:

_____
_____
_____

2. Character of your current pain (check all that apply and describe site of involvement)

- o Sharp/Stabbing_____
- o Dull Ache_____
- o Soreness_____
- o Weakness_____
- o Throbbing_____
- o Burning_____
- o Tingling_____
- o Numbness_____
- o Shooting/Radiating_____
- o Gripping/Constricting_____

3. How often are the complaints present? Please indicate area you are describing.

- o Constant (76-100%)_____
- o Frequent (51-75%)_____
- o Occasional (26-50%)_____
- o Intermittent (25% or less)_____

4. Is your pain worse in the AM, mid-day, or PM, can you sleep at night? (describe)

_____
_____

5. Is your pain getting better, worse, or staying the same?

_____
_____

6. When did your problem begin?

_____
_____

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7. What makes you feel better? Worse?

_____

_____

8. Does a cough, sneeze, or bowel movement increase your pain? Which?

_____

_____

9. Have you had treatment for this/these problems? Describe in detail:

_____

_____

10. Have you had treatment before for any of these conditions?

_____

_____

11. Grade your general stress level: ☐Little-No stress ☐Minimal ☐Moderate☐ Severe

12. Work Activity: ☐ sitting more than 50% of day ☐ Light Labor ☐ moderate☐ Max

13. General Physical Activity:☐No exercise ☐Light exercise ☐Moderate ☐ Heavy

14. Are your complaints affecting your ability to work or otherwise be active?

_____

_____

15. Are you out of work as a result of this problem? ☐ Yes ☐ No If yes, when will you return to work?

_____

_____

16. What is your weight _____ Height _____Ft _____Inches

17. What is your goal of therapy?_____

_____

_____

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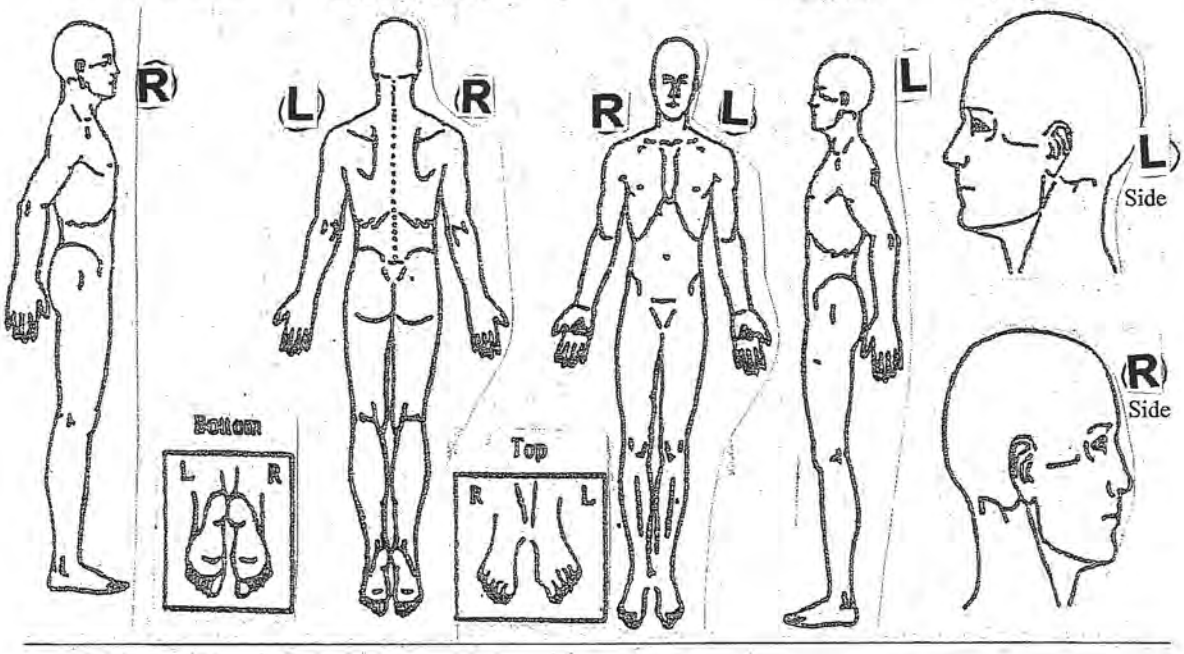
PAIN DRAWING: Please mark your problem areas

Numbness ---------- Pins & Needles oooooooooo Burning ^^^^^^ Aching xxxxxx Stabbing



If zero (0) equals no pain and ten (10) equals EXTREME pain, then how much pain are you in today? Circle the appropriate response!

0 1 2 3 4 5 6 7 8 9 10

New Symptoms and Changes in Condition

Please list or describe in the space below, any new symptoms that you are experiencing or any changes in your condition that you feel the doctor should be aware of in relation to your case.

Patient Signature_____ **Date**_____

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PAIN QUESTIONAIRE

Name:_____ Primary Complaint:_____

1. Please indicate your usual level of pain during the past week:
   No Pain 0 1 2 3 4 5 6 7 8 9 10 Worst possible pain

2. Does pain, numbness, tingling, or weakness extend into your leg (from the low back) or arm (from the neck)?
   None of the time 0 1 2 3 4 5 6 7 8 9 10 All of the time

3. How would rate your overall general health?
   Poor 0 1 2 3 4 5 6 7 8 9 10 Excellent

4. If you had to spend the rest of your life with your condition as it is right now, how would you feel about it?
   Delighted 0 1 2 3 4 5 6 7 8 9 10 Terrible

5. How anxious (i.e. tense, uptight, irritable, fearful, difficulty in concentrating or relaxing) have you been feeling during the past week?
   Not at all 0 1 2 3 4 5 6 7 8 9 10 Extremely anxious

6. How much have you been able to control (i.e. reduce/help) your pain/complaint on your own during the past week?
   I can reduce it 0 1 2 3 4 5 6 7 8 9 10 I can't reduce it at all

7. Please indicate how depressed (i.e. down in the dumps, sad, downhearted, in low spirits, pessimistic, feelings of hopelessness) you have been feeling in the past week:
   Not depressed at all 0 1 2 3 4 5 6 7 8 9 10 Extremely depressed

8. On a scale of zero to ten how certain are you that you will be doing normal activities or working in six months?
   Very certain 0 1 2 3 4 5 6 7 8 9 10 Not certain at all

9. I can do light work for an hour:
   Completely agree 0 1 2 3 4 5 6 7 8 9 10 Completely disagree

10. I can sleep at night:
    Completely agree 0 1 2 3 4 5 6 7 8 9 10 Completely disagree

11. An increase in pain is an indication that I should stop what I am doing until the pain decreases:
    Completely disagree 0 1 2 3 4 5 6 7 8 9 10 Completely agree

12. Physical activity makes my pain worse:
    Completely disagree 0 1 2 3 4 5 6 7 8 9 10 Completely agree

13. I should not do my normal activities, including work, with my present pain:
    Completely disagree 0 1 2 3 4 5 6 7 8 9 10 Completely agree

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Outcome Assessment Form for Integrative Chiropractic and PT Solutions

Section 1 – Pain Intensity
- ❑ I have no pain at the moment
- ❑ The pain is very mild at the moment
- ❑ The pain in moderate at the moment
- ❑ The pain is fairly severe at the moment
- ❑ The pain is very severe at the moment
- ❑ The pain is the worst imaginable at the moment

Section 2 – Personal Care (Washing, Dressing, etc.)
- ❑ I can look after myself normally without 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 every day 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 weights without extra pain
- ❑ I can lift heavy weights but it gives extra pain
- ❑ Pain prevents me from lifting heavy weights off the floor, I can manage if they are conveniently positioned
- ❑ Pain prevents me from lifting heavy weights but I can manage light to medium weights
- ❑ I can lift only light weights
- ❑ I cannot lift or carry anything at all

Section 4 – Reading
- ❑ I can read as much as I want with no pain in my neck
- ❑ I can read as much as I want with slight pain in my neck
- ❑ I can read as much as I want with moderate pain in my neck
- ❑ I can't read as much as I want due to moderate pain
- ❑ I can hardly read at all because of severe pain
- ❑ I cannot read at all

Section 5 – Headaches
- ❑ I have no headaches 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 – 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 1 hour
- ❑ Pain prevents me from sitting more than ½ hour
- ❑ Pain prevents me from sitting more than 10 minutes
- ❑ Pain prevents me from sitting at all

Section 7 – 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
- ❑ I have a lot of difficulty in concentrating when I want
- ❑ I have a great deal of difficulty concentrating when I want
- ❑ I cannot concentrate at all

Section 8 – Work
- ❑ I can do as much work as I want
- ❑ I can only do my usual work, but no more
- ❑ I can most of my usual work, but no more
- ❑ I cannot do my usual work
- ❑ I can hardly do any work at all
- ❑ I can't do any work at all

Section 9 – Driving
- ❑ I can drive my car without any neck pain
- ❑ I can drive my car a long time with slight neck pain
- ❑ I can drive my car a long time with moderate pain
- ❑ I can't drive my car long due to moderate pain
- ❑ I can hardly drive at all due to severe pain in my neck
- ❑ I can't drive my car at all

Section 10 – 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 (2-3 hrs. sleepless)
- ❑ My sleep is greatly disturbed (3-5 hrs. sleepless)
- ❑ My sleep is completely disturbed (5-7 hrs. sleepless)

Section 11 – Recreation
- ❑ I can perform all recreational activities with no pain
- ❑ I can perform all recreational activities w/some pain
- ❑ I can perform in most recreational activities with pain
- ❑ I can perform in few recreational activities due to pain
- ❑ I can hardly do any recreational activities due to pain
- ❑ I can't do any recreational activities at all

Section 12 – Walking
- ❑ Pain does not prevent me from walking any distance
- ❑ Pain prevents me from walking more than 1 mile
- ❑ Pain prevents me from walking more then ½ mile
- ❑ Pain prevents me from walking more than ¼ mile
- ❑ I can only walk using a stick or crutches
- ❑ I am in bed most of the time and have to crawl to the toilet

Section 13 – Standing
- ❑ I can stand as long as I want without extra pain
- ❑ I can stand as long as I want but it gives me extra pain
- ❑ Pain prevents me from standing for more than 1 hour
- ❑ Pain prevents me from standing more than ½ hour
- ❑ Pain prevents me from standing more than 10 minutes
- ❑ Pain prevents me from standing at all

Section 14 – Traveling
- ❑ I can travel anywhere without extra pain
- ❑ I can travel anywhere but it gives me extra pain
- ❑ Pain is bad but I manage trips over two hours
- ❑ Pain restricts me to trips of less than one hour
- ❑ Pain restricts me to trips under 30 minutes
- ❑ Pain prevents me from traveling except to Dr. and hospital