Re-Exam Questionnaire

Patient Name:_____ Date: _____

The following hi-lighted symptoms are what brought you into our office originally.
DIRECTIONS: Please rate ALL hi-lighted symptoms: S = same; B = better; W = worse
Example: Headaches S B W

Symptoms	S	B	W	Symptoms	S	B	W
Headaches	S	B	W	Upperback pain	S	B	W
Problems Concentrating	S	B	W	Shortness of breath	S	B	W
Loss of Memory	S	B	W	Asthma	S	B	W
Dizziness	S	B	W	Allergies	S	B	W
Mood Swings	S	B	W	Chest pain	S	B	W
Depression	S	B	W	Middle back pain	S	B	W
Irritability	S	B	W	Stomach upset	S	B	W
Nervousness	S	B	W	Heartburn/ gas	S	B	W
Tension	S	B	W	Indigestion	S	B	W
Stress	S	B	W	Ulcers	S	B	W
Light bothers eyes	S	B	W	Problems urinating	S	B	W
Sinuses	S	B	W	Frequent urination	S	B	W
Buzzing in ears	S	B	W	Diarrhea	S	B	W
Ringing in ears	S	B	W	Constipation	S	B	W
Loss of balance	S	B	W	Sleeping problems	S	B	W
Head too heavy	S	B	W	Fatigue	S	B	W
Difficulty chewing	S	B	W	Menstrual pain	S	B	W
Clicking jaw/ TMJ	S	B	W	Irregular menstrual cycle	S	B	W
Sore throat	S	B	W	Low back pain	S	B	W
Neck pain	S	B	W	Hip pain	S	B	W
Neck stiffness	S	B	W	Pins & Needles in legs	S	B	W
Shoulder pain	S	B	W	Numbness in toes	S	B	W
Elbow pain	S	B	W	Foot/ Ankle pain	S	B	W
Wrist pain	S	B	W	Knee pain	S	B	W
Carpal tunnel pain	S	B	W	Leg pain	S	B	W
Numbness in fingers	S	B	W	Sciatic pain	S	B	W
Pins & Needles in arms/ finger	S	B	W	Pelvis Pain	S	B	W
Arm pain	S	B	W	Buttocks Pain	S	B	W
Hand pain	S	B	W		S	B	W
Upper Shoulder	S	B	W		S	B	W

Please write down any new problems, symptoms or issues that have occurred since your last exam.

_____

_____

_____

_____

_____

Patient Name:_____ Date: _____

PLEASE FILL OUT THIS FORM FOR HOW YOU ARE FEELING OVERALL NOW FOR YOUR CURRENT CONDITION AS COMPARED TO WHEN YOU FIRST CAME IN FOR CARE.

√ Check each of your health problems.	√ Check which side of your body it is located.	Describe your health problem. (10 is the most severe) ***Circle** the number for severe. **Put an X** on the average pain.*	What percentage of your waking day do you feel your health problems? (100% is constant)
HEAD PROBLEMS	WHICH SIDE?	MILD MODERATE SEVERE	OCCASIONAL CONSTANT
□ 1. Headaches or Migraines	□ Left □ Both □ Right	0 1 2 3 4 5 6 7 8 9 10	0% 25% 50% 75% 100%
□ 2. TMJ (jaw) Pain/Clicking	□ Left □ Both □ Right	0 1 2 3 4 5 6 7 8 9 10	0% 25% 50% 75% 100%
SPINAL PROBLEMS	WHICH SIDE?	MILD MODERATE SEVERE	OCCASIONAL CONSTANT
□ 3. Neck □ Pain □ Stiffness	□ Left □ Both □ Right	0 1 2 3 4 5 6 7 8 9 10	0% 25% 50% 75% 100%
□ 4. Upper Shoulder (trapezius) Pain	□ Left □ Both □ Right	0 1 2 3 4 5 6 7 8 9 10	0% 25% 50% 75% 100%
□ 5. Upper Back (Shoulder blades) Pain	□ Left □ Both □ Right	0 1 2 3 4 5 6 7 8 9 10	0% 25% 50% 75% 100%
□ 6. Middle Back □ Pain □ Stiffness	□ Left □ Both □ Right	0 1 2 3 4 5 6 7 8 9 10	0% 25% 50% 75% 100%
□ 7. Low Back □ Pain □ Stiffness	□ Left □ Both □ Right	0 1 2 3 4 5 6 7 8 9 10	0% 25% 50% 75% 100%
□ 8. Pelvis/Buttock Pain	□ Left □ Both □ Right	0 1 2 3 4 5 6 7 8 9 10	0% 25% 50% 75% 100%
UPPER EXTREMITY (ARM) PROBLEMS	WHICH SIDE?	MILD MODERATE SEVERE	OCCASIONAL CONSTANT
□ 9. Shoulder Joint Pain	□ Left □ Both □ Right	0 1 2 3 4 5 6 7 8 9 10	0% 25% 50% 75% 100%
□ 10. Elbow Joint Pain	□ Left □ Both □ Right	0 1 2 3 4 5 6 7 8 9 10	0% 25% 50% 75% 100%
□ 11. Wrist Pain	□ Left □ Both □ Right	0 1 2 3 4 5 6 7 8 9 10	0% 25% 50% 75% 100%
□ 12. Hand □Pain □Numbness □Tingling	□ Left □ Both □ Right	0 1 2 3 4 5 6 7 8 9 10	0% 25% 50% 75% 100%
□ 13. Arm □ Pain □Numbness □Tingling	□ Left □ Both □ Right	0 1 2 3 4 5 6 7 8 9 10	0% 25% 50% 75% 100%
LOWER EXTREMITY (LEG) PROBLEMS	WHICH SIDE?	MILD MODERATE SEVERE	OCCASIONAL CONSTANT
□ 14. Hip Joint Pain	□ Left □ Both □ Right	0 1 2 3 4 5 6 7 8 9 10	0% 25% 50% 75% 100%
□ 15. Knee Joint Pain	□ Left □ Both □ Right	0 1 2 3 4 5 6 7 8 9 10	0% 25% 50% 75% 100%
□ 16. Ankle Joint Pain	□ Left □ Both □ Right	0 1 2 3 4 5 6 7 8 9 10	0% 25% 50% 75% 100%
□ 17. Foot □ Pain □Numbness □Tingling	□ Left □ Both □ Right	0 1 2 3 4 5 6 7 8 9 10	0% 25% 50% 75% 100%
□ 18. Leg □ Pain □Numbness □Tingling	□ Left □ Both □ Right	0 1 2 3 4 5 6 7 8 9 10	0% 25% 50% 75% 100%
CHEST, ABDOMINAL OR PELVIC PROBLEMS	WHICH SIDE?	MILD MODERATE SEVERE	OCCASIONAL CONSTANT
□ 19. Chest Pain/ Symptoms	□ Left □ Both □ Right	0 1 2 3 4 5 6 7 8 9 10	0% 25% 50% 75% 100%
□ 20. Abdominal Pain/ Symptoms	□ Left □ Both □ Right	0 1 2 3 4 5 6 7 8 9 10	0% 25% 50% 75% 100%
□ 21. Pelvic Pain/ Symptoms	□ Left □ Both □ Right	0 1 2 3 4 5 6 7 8 9 10	0% 25% 50% 75% 100%

Answer the following questions regarding your health problems as they present themselves NOW:

Which health problem concerns you the most? _____

Describe your health problem: □ sharp □ dull ache □ burning □ radiating/spreading □ throbbing □ pinching □ twinge

Explain: _____

How many days out of the week do you experience your health problem? □ daily □ 6 □ 5 □ 4 □ 3 □ 2 □ 1 day (s)

What time of the day is your health problem the worst? □ morning □ afternoon □ evening □ sleeping □ all day □ varies

Which of the following activities of daily life are being adversely affected by your current health problem?

□ Bending over	□ Driving Car	□ Household chores	□ Reaching overhead	□ Staying asleep
□ Caring for family	□ Exercising	□ Lifting objects	□ Rising out of chair / bed	□ Using a computer
□ Climbing stairs	□ Getting in/out of car	□ Looking over shoulder	□ Showering or bathing	□ Walking
□ Concentrating	□ Getting to sleep	□ Making love	□ Sitting	□ Participating in yardwork
□ Dressing self	□ Grocery shopping	□ Lying down	□ Standing	

Patient Signature: _____

Patient Name:_____ Date: _____

This questionnaire will give Family Chiropractic information about how your BACK condition affects your everyday life.

Please answer every section by marking the one statement that applies to you. If two or more statements in one section apply, please mark the ONE statement that most closely describes your problem. Circle the number that corresponds to your answer.

PLEASE ANSWER THESE QUESTIONS SPECIFIC TO YOUR BACK.

PAIN INTENSITY
0 The pain comes and goes and is very mild.
1 The pain is mild and does not vary much.
2 The pain comes and goes and is moderate.
3 The pain is moderate and does not vary much.
4 The pain comes and goes and is very severe.
5 The pain is very severe and does not vary much.

PERSONAL CARE
0 I would not have to change my way of washing or dressing in order to avoid pain.
1 I do not normally change my way of washing or dressing even though it causes some pain.
2 Washing and dressing increases the pain, but I manage not to change my way of doing it.
3 Washing and dressing increases the pain and I find it necessary to change my way of doing it.
4 Because of the pain, I am unable to do some washing and dressing without help.
5 Because of the pain, I am unable to do any washing and dressing without help.

LIFTING
0 I can lift heavy weights without extra pain.
1 I can lift heavy weights but it causes extra pain.
2 Pain prevents me from lifting heavy weights off the floor, but I can if they are in convenient places (e.g. on a table).
3 Pain prevents me from lifting heavy weights off the floor.
4 Pain prevents me from lifting heavy weights, but I can manage medium weights if they are conveniently positioned.
5 I can only lift very light weights at the most.

WALKING
0 I have no pain while walking.
1 I have some pain while walking but it does not increase with distance.
2 I cannot walk more than 1 mile without increasing pain.
3 I cannot walk more than ½ mile without increasing pain.
4 I cannot walk more than ¼ mile without increasing pain.
5 I cannot walk at all without increasing pain.

SITTING
0 I can sit in any chair as long as I like.
1 I can only sit in my favorite chair as long as I like.
2 Pain prevents me from sitting more than 1 hour.
3 Pain prevents me from sitting more than ½ hour.
4 Pain prevents me from sitting more than 10 minutes.
5 I avoid sitting because it increases my pain right away.

STANDING
0 I can stand as long as I want without extra pain.
1 I have some pain while standing, but it does not increase with time.
2 I cannot stand for longer than 1 hour without increasing pain.
3 I cannot stand for longer than ½ hour without increasing pain.
4 I cannot stand for longer than 10 minutes without increasing pain.
5 I avoid standing because it increases the pain right away.

SLEEPING
0 I get no pain in bed.
1 I get pain in bed, but it does not prevent me from sleeping well.
2 Because of pain my normal sleep is reduced by less than 25%.
3 Because of pain my normal sleep is reduced by less than 50%.
4 Because of pain my normal sleep is reduced by less than 75%.
5 Pain prevents me from sleeping at all.

SOCIAL LIFE
0 My social life is normal and gives me no extra pain.
1 My social life is normal but increases the degree of pain.
2 Pain has no significant effect on my social life apart from limiting my more energetic interests (e.g. dancing, etc).
3 Pain has restricted my social life and I do not go out as often.
4 Pain has restricted my social life to my home.
5 I have hardly any social life because of pain.

TRAVELING
0 I get no pain while traveling.
1 I get some pain while traveling, but none of my usual forms of travel makes it any worse.
2 I get extra pain while traveling but it does not compel me to seek alternative forms of travel.
3 I get extra pain while traveling, which compels me to seek alternate forms of travel.
4 Pain restricts all forms of travel.
5 Pain restricts all forms of travel except that done by lying down.

CHANGING DEGREE OF PAIN
0 My pain is rapidly getting better.
1 My pain fluctuates, but is definitely getting better.
2 My pain seems to be getting better but improvement is slow at present.
3 My pain is neither getting better nor worse.
4 My pain is gradually worsening.
5 My pain is rapidly worsening.

Patient Name:_____ Date: _____

This questionnaire will give Family Chiropractic information about how your NECK condition affects your everyday life.

Please answer every section by marking the one statement that applies to you. If two or more statements in one section apply, please mark the ONE statement that most closely describes your problem. Circle the number that corresponds to your answer.

PLEASE ANSWER THESE QUESTIONS SPECIFIC TO YOUR NECK.

PAIN INTENSITY
0 I have no pain at the moment.
1 The pain is very mild at the moment.
2 The is moderate at the moment.
3 The pain is fairly severe at the moment.
4 The pain is very severe at the moment.
5 The pain is the worst imaginable at the moment.

PERSONAL CARE
0 I can look after myself normally without causing extra pain.
1 I can look after myself normally but it causes extra pain.
2 It is painful to look after myself and I am slow and careful.
3 I need some help but I manage most of my personal care.
4 I need help every day in most aspects of self care.
5 I do not get dressed, I wash with difficulty and stay in bed.

LIFTING
0 I can lift heavy weights without extra pain.
1 I can lift heavy weights but it gives me extra pain.
2 Pain prevents me from lifting heavy weights off the floor, but I can if they are conveniently positioned (e.g. on a table).
3 Pain prevents me from lifting heavy weights, but I can manage medium weights if they are conveniently positioned.
4 I can lift very light weights.
5 I cannot lift or carry anything at all.

READING
0 I can read as much as I want with no pain in my neck.
1 I can read as much as I want to with slight pain in my neck.
2 I can read as much as I want with moderate pain.
3 I can't read as much as I want because of moderate pain in my neck.
4 I can hardly read at all because of severe pain in my neck.
5 I cannot read at all

HEADACHES
0 I have no headaches at all.
1 I have slight headaches which come infrequently.
2 I have slight headaches which come frequently.
3 I have moderate headaches which come infrequently.
4 I have moderate headaches which come frequently.
5 I have headaches almost all the time.

CONCENTRATION
0 I can concentrate fully when I want to with no difficulty.
1 I can concentrate fully when I want to with slight difficulty.
2 I have a fair degree of difficulty concentrating when I want.
3 I have a lot of difficulty concentrating when I want.
4 I have a great deal of difficulty concentrating when I want.
5 I cannot concentrate at all.

WORK
0 I can do as much work as I want to.
1 I can only do my usual work, but no more.
2 I can only do most of my usual work, but no more.
3 I cannot do my usual work.
4 I can hardly do any work at all.
5 I can't do any work at all.

DRIVING
0 I can drive my car without any neck pain.
1 I can drive my car as long as I want with slight pain in my neck.
2 I can drive my car as long as I want with moderate pain in my neck.
3 I can't drive my car as long as I want because of moderate pain in my neck.
4 I can hardly drive at all because of severe pain in my neck.
5 I can't drive my car at all.

SLEEPING
0 I have no trouble sleeping.
1 My sleep is slightly disturbed (less than 1 hour sleepless).
2 My sleep is mildly disturbed (1-2 hours sleepless).
3 My sleep is moderately disturbed (2-3 hours sleepless).
4 My sleep is greatly disturbed (3-4 hours sleepless).
5 My sleep is completely disturbed (5-7) hours sleepless).

RECREATION
0 I am able to engage in all my recreation activities with no neck pain at all.
1 I am able to engage in all my usual recreation activities with some pain in my neck.
2 I am able to engage in most, but not all of my usual recreation activities because of pain in my neck.
3 I am only able to engage in a few of my usual recreation activities because of pain in my neck.
4 I can hardly do any recreation activities because of pain in my neck.
5 I can't do any recreation activities at all.

Patient Name:_____ Date: _____

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

Progress

What changes in your condition have you noticed since beginning care?

_____

_____

On a scale of 1 to 10, rate the level of improvement of your symptoms so far.

No change *Condition Eliminated*

1 2 3 4 5 6 7 8 9 10

Would you say your improvement is

- ☐ Progressing at the speed you expected
- ☐ Taking longer than you expected
- ☐ Occurring much faster than you expected

What positive changes have you noticed in your life?

_____

Is there anything you don't understand about your condition or treatment?

_____

_____

Do you understand the difference between patch vs. fix care? Yes No

Office Staff and Procedures

How would you rate the concern shown by our staff?

Uninterested *Deeply Concerned*

1 2 3 4 5 6 7 8 9 10

How would you rate the training, qualifications, and competency of our staff?

Unorganized and unprepared *Efficient and knowledgeable*

1 2 3 4 5 6 7 8 9 10

What do you like most about our office?

_____

_____

Have you ever had any trouble scheduling an appointment with Family Chiropractic? Yes No
Have you ever experienced a busy signal while calling Family Chiropractic? Yes No
Is the amount of time you wait to see the doctor acceptable? Yes No
What ways would you change the staff, office or procedures we use to improve the quality of care?

_____

_____

Support

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

_____

Referral Inquiry

- ☐ I have referred family.
- ☐ I would gladly refer family or friends to this office.
- ☐ I would not refer family or friends to this office.

As with all private professionals, our practice is built upon referrals. Please list the people you feel would benefit from chiropractic and we will be happy to send them information.

Name _____ Address _____

Name _____ Address _____

Patient Signature: _____ Date: _____