RE-EXAM CHIROPRACTIC PATIENT QUESTIONNAIRE

NAME: _____

DOB: _____ **DATE:** _____

PRE-AUTH NEEDED: ☐ Yes ☐ No ☐ Kaiser ☐ Evicore ☐ United ☐ MVA

How would you CLASSIFY YOUR IMPROVEMENT since beginning care?

☐ Excellent ☐ Good ☐ Fair ☐ Poor ☐ New Condition

On a scale of 1-10 (10 being the best)**:** How would you rate your improvement? _____

Please indicate the RESPONSE TO TREATMENT since the initial assessment for this condition:

☐ Pain 0-24% improvement
☐ Pain 25-49% improvement
☐ Pain 50-74% improvement
☐ Pain 75-100% improvement
☐ Did not improve or worsen with treatment
☐ Condition is worse
☐ New Condition
☐ Other: _____

What symptoms have IMPROVED? _____

_____

What symptoms are STILL PRESENT? _____

_____

How often do you continue to experience pain: ☐ 0-25% ☐ 26-50% ☐ 51-75% ☐ 76-100%

Please rate your typical SYMPTOM INTENSITY:
On a scale of 1-10 (10 being the worst)

BEFORE a chiropractic manipulation: _____

AFTER a chiropractic manipulation: _____

Are your symptoms worse during certain times of the day? ☐ Yes ☐ No **When?**

☐ Morning ☐ Afternoon ☐ After Work/Exercise ☐ Bedtime
☐ Before I get out of bed ☐ During my sleep ☐ Other: _____ _____

What makes your symptoms BETTER? _____

What makes your symptoms WORSE? _____

NAME: _____ DOB: _____ DATE: _____

Check the items that currently apply to you:

- ☐ Pain in multiple areas
- ☐ Ache in area of current complaint
- ☐ Decreased range of motion
- ☐ Burning
- ☐ Muscle Spasms
- ☐ Headaches
- ☐ Trouble Sleeping
- ☐ Wake up at Night

Other: _____

What changes have been made in your general feelings since starting care?

- ☐ Stronger
- ☐ More Relaxed
- ☐ More Alert
- ☐ Less Nervous
- ☐ Sleep Better
- ☐ Improved Appetite
- ☐ More Rested

Other: _____

Do you find it easier to?

- ☐ Walk
- ☐ Ride
- ☐ Work
- ☐ Bend
- ☐ Stand
- ☐ No Change
- ☐ Sit
- ☐ Lift
- ☐ Climb Stairs
- ☐ Drive
- ☐ Sleep
- ☐ Other _____
- ☐ Focus
- ☐ Care for my family
- ☐ Do Housework
- ☐ Personal Care

What have you tried at home to help alleviate your symptoms?

- ☐ Stretching
- ☐ RX Pain Medications
- ☐ Exercise
- ☐ OTC Pain Medications
- ☐ Ice/Heat
- ☐ Laying Down/Rest
- ☐ Other_____

Have you received OTHER CARE for your current complaint? ☐ Yes ☐ No

Please list: _____

Have you recently had IMAGING? ☐ Yes ☐ No

Are there any other conditions which we have not discussed but you wish to explore today?

_____

_____

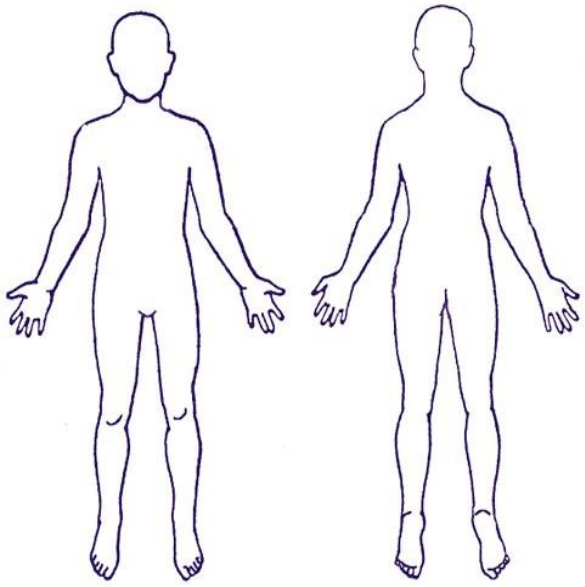
Do you have any other questions or concerns about your progress?

_____

_____

NW Family Wellness Pain Scale

Patient Name: _____ **DOB:** _____



Tell us where you hurt:

Mark the areas on your body where you feel pain on the diagram to the right.

*If your pain radiates, draw an arrow from where it starts to where it stops.

Use the symbols listed below

>>>>	Ache
XXXX	Burning
====	Numbness
////	Stabbing
0000	Pins/Needles
~~~~	Throbbing

How often are your symptoms present? (Please check the appropriate box)

☐ 0 – 25% ◆ ☐ 26 – 50% ◆ ☐ 51 – 75% ◆ ☐ 76 – 100%

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

0 ◆ 1 ◆ 2 ◆ 3 ◆ 4 ◆ 5 ◆ 6 ◆ 7 ◆ 8 ◆ 9 ◆ 10

No Interference — Unable To Carry Out Activities

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

0 1 2 3 4 5 6 7 8 9 10

What is your symptom intensity **AT ITS WORST**?

0 1 2 3 4 5 6 7 8 9 10

SYMPTOM RATING SCALE

Please circle the number(s) in each box that best describes your symptoms.

0= No Symptoms

10 = Unbearable

What is your **TYPICAL** symptom intensity over the last week?

0 1 2 3 4 5 6 7 8 9 10