Progressive Exam Questionnaire

ChiropracticWellness

This questionnaire is designed to track your health and wellness goals to make sure that they continue to progress optimally. Please be sure to let us know of any changes you're experiencing during your course of care with us.

Patient Name: _____ Date: _____

Your Wellness Goals

What conditions are you seeking treatment for? (i.e. headaches, lower back pain, neck pain, constipation, etc.)

Condition #1: _____

- This condition is...(circle all that apply) Left Right Bilateral
  New *Better* *Same* *Worse* *Comes&Goes* *Constant*
  Sharp *Shooting* *Aching* *Throbbing* *Burning* *Numbness* *Weak*
- If you have symptoms, what percentage of the time are the symptoms present? 0% 25% 50% 75% 100%
- What is your level of discomfort on a scale of 0-10 (0=No Pain, 10= Extreme Pain) _____/10
- What makes this condition better? _____
- What makes it worse? _____

Condition #2: _____

- This condition is...(circle all that apply) Left Right Bilateral
  New *Better* *Same* *Worse* *Comes&Goes* *Constant*
  Sharp *Shooting* *Aching* *Throbbing* *Burning* *Numbness* *Weak*
- If you have symptoms, what percentage of the time are the symptoms present? 0% 25% 50% 75% 100%
- What is your level of discomfort on a scale of 0-10 (0=No Pain, 10= Extreme Pain) _____/10
- What makes this condition better? _____
- What makes it worse? _____

Condition #3: _____

- This condition is...(circle all that apply) Left Right Bilateral
  New *Better* *Same* *Worse* *Comes&Goes* *Constant*
  Sharp *Shooting* *Aching* *Throbbing* *Burning* *Numbness* *Weak*
- If you have symptoms, what percentage of the time are the symptoms present? 0% 25% 50% 75% 100%
- What is your level of discomfort on a scale of 0-10 (0=No Pain, 10= Extreme Pain) _____/10
- What makes this condition better? _____
- What makes it worse? _____

Your Progress

- Have you noticed any improvements in the following? (Please circle all that apply)

  More Energy *Better Digestion* *Decreased Headaches* *Better Breathing* *Better Sleep* *Less Medication*
  No Medication *Less Pain* *No Pain* *Overall Better Health* *More Strength* *Better Motion* *Fewer Illnesses*
  No Illness *Improved Flexibility* *Less Emotional Stress* *Improved Daily Activity* *Work Life*

- Your improvement is: taking longer than expected progressing as expected faster than expected symptoms gone
- Any accidents, injuries, surgeries/hospitalizations since your last exam (Y/N) if yes, explain:

  _____

  _____

- Current Activities (hobbies, sports, yard work etc…):

  _____

  _____

- Repetitive Motions and positions of the spine (bending, twisting, looking up and down, computer work, phone usage etc…): _____

  _____

- List all current medications/supplements If none please list none: _____

  _____

  _____

- Current stressors in life? _____

Office Evaluation

We are constantly striving to make your care the best it can be. We appreciate all and any feedback from you!

What do you like most about our office?

What would you change about our office, staff, or procedures to improve your experience?

Would you be willing to share how chiropractic has impacted your health?

Please circle all that apply: Yes, I'll share my story via video

Yes, I'll share my story via written and photographic testimonial

Consent to Examination and Treatment

I, the undersigned, do hereby authorize Dr. Jennifer C. Daniel-Price, D.C. and/or any other licensed chiropractic physicians and assistants employed by Chiropractic Wellness Connection to perform any examination, diagnostic tests, diagnosis and render necessary treatment as deemed necessary by the doctor to myself or minor child.

Patient Signature: _____ Date: _____

Parent Signature (If Patient is Minor): _____ Date: _____

Review of Systems

Name:_____ Date:_____

At Chiropractic Wellness Connection, we strive to find the CAUSE of your concerns. This questionnaire will help us to identify what is going on specifically for you. Please rate each of the following symptoms based what you have experienced in the **last 60 days.**

Point Scale: **leave blank** = *never* have the symptom, **1** = *occasionally* have symptom, **2** = *regularly* have symptom, **3** = *frequently* have symptom, **4** = *constantly* have symptom

Eyes, Ears, Nose, Throat:
__chronic ear infections
__ringing in the ears
__blurred or tunnel vision
__eye pain
__itchy or watery eyes
__nasal congestion
__nose bleeds
__loss of smell
__sore throat
__sores in mouth
__difficulty swallowing/gagging
__white patches on throat/tongue
__need to repetitively clear throat

Musculoskeletal:
__joint pain
__joint stiffness
__pain in muscles
__abnormal muscle movements
__muscle weakness

General:
__unexplained weight loss
__unexplained weight gain
__severe fatigue
__fever
__excessive thirst
__frequent illnesses
__difficulty sleeping

Urinary:
__difficulty urinating
__blood in urine
__chronic UTIs
__frequent urination

Neurological:
__tremors/tics
__difficulty walking
__difficulty with balance
__headaches
__numbness or tingling
__bruises easily
__ seizures

Digestive:
__nausea or vomiting
__diarrhea
__constipation
__bloated belly
__heart burn
__abdominal pain
__blood in stool

Mental/Emotional:
__memory loss
__depression
__anxiety/social anxiety
__confusion
__inability to focus
__hyperactivity
__loss of interest/motivation
__homicidal/suicidal thoughts

Respiratory:
__short of breath
__wheezing
__asthma
__coughing

Integumentary:
__itchy skin
__rashes
__jaundice
__swollen lymph nodes
__hair loss

Cardiovascular:
__chest pain
__heart palpitations
__irregular heartbeat
__fainting
__swelling in hands/feet
__difficulty with speech
__dizziness
__restless legs
__slurred speech

Female Reproductive Only:
__abnormal periods
__excessive bleeding/clots
__period irregularity
__loss of pregnancy
__slurred speech

Total:_____

Low Back Pain Disability Questionnaire (Rev. Oswestry)

Name:_____ Date:_____

Please circle the number below that best describes your low back pain in each category.

Section 1: Pain Intensity
0. I can tolerate the pain without having to use pain killers.
1. The pain is bad but I can manage without taking painkillers.
2. Painkillers give complete relief from pain.
3. Painkillers give moderate relief from pain.
4. Painkillers give little relief from pain.
5. Painkillers have no effect on the pain and I do not use them.

Section 2: 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 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.

Section 3: 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 manage if they are conveniently placed (ex. On a table)
3. Pain prevents me from lifting heavy objects, but I can manage light to medium weights if they are conveniently positioned.
4. I can only lift light weights.
5. I cannot lift or carry anything.

Section 4: Walking
0. Pain does not prevent me from walking any distance.
1. Pain prevents me from walking more than one mile.
2. Pain prevents me from walking more than one-half mile.
3. Pain prevents me from walking more than one-quarter mile.
4. I can only walk using a stick or crutches.
5. I am in bed most of the time and have to crawl to the toilet

Section 5: 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. Pain prevents me from sitting at all.

Section 6: Standing
0. I can stand as long as I want without extra pain.
1. I can stand as long as I want but it gives me extra pain.
2. Pain prevents me from standing more than 1 hour.
3. Pain prevents me from standing more than 30 minutes.
4. Pain prevents me from standing more than 10 minutes.
5. Pain prevents me from standing at all.

Section 7: Sleeping
0. Pain does not prevent me from sleeping well.
1. I can sleep well only by using tablets.
2. Even when I take tablets I have less than 6 hours sleep.
3. Even when I take tablets I have less than 4 hours sleep.
4. Even when I take tablets I have less than 2 hours sleep.
5. Pain prevents me from sleeping at all.

Section 8: 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.
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.

Section 9: Traveling
0. I can travel anywhere without extra pain.
1. I can travel anywhere but it gives me extra pain.
2. Pain is bad but I manage journeys over 2 hours.
3. Pain is bad but I manage journeys less than 1 hour.
4. Pain restricts me to short necessary journeys under 30 minutes.
5. Pain prevents me from travelling except to the doctor or hospital.

Section 10: 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 improvements is slow at present.
3. My pain is neither getting better nor getting worse.
4. My pain is gradually worsening.
5. My pain is rapidly worsening.

Neck Pain Disability Index Questionnaire

Name:_____ Date:_____

Please circle the number below that best describes your neck pain in each category.

Section 1: Pain Intensity
0. I have no pain at the moment.
1. The pain is very mild at the moment.
2. The pain 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 in the worst imaginable at the moment.

Section 2: 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 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.*

Section 3: 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 manage if they are conveniently placed (ex. On a table)
3. Pain prevents me from lifting heavy objects, but I can manage light to medium weights if they are conveniently positioned.
4. I can only lift light weights.
5. I cannot lift or carry anything.

Section 4: Reading
0. I can read as much as I want to 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.

Section 5: 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.

Section 6: 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 in concentrating when I want.
3. I have a lot of difficulty in concentrating when I want to.
4. I have a great deal of difficulty in concentrating when I want to.
5. I cannot concentrate at all.

Section 7: 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 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.

Section 8: 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 like 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 my car at all because of severe pain in my neck.
5. I can't drive my car at all.

Section 9: Sleeping
0. I have no trouble sleeping.
1. My sleep is slightly disturbed (less than 1 hr. sleeplessness)
2. My sleep is moderately disturbed (1-2 hrs. sleepless)
3. My sleep is moderately disturbed (2-3 hrs. sleepless)
4. My sleep is greatly disturbed (3-4 hrs. sleepless)
5 My sleep is completely disturbed (5-6 hrs. sleepless)

Section 10: 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 recreation activities with some neck pain.
2. I am able to engage in most, but not all of my usual recreation activities because of neck pain.
3. I am able to engage in a few of my usual recreation activities because of neck pain.
4. I can hardly do any recreation activities because of pain in my neck.
5. I can't do any recreation activities at all.