

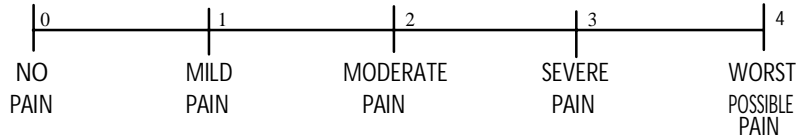
FUNCTIONAL RATING INDEX

FOR USE WITH NECK AND/OR BACK PROBLEMS ONLY.

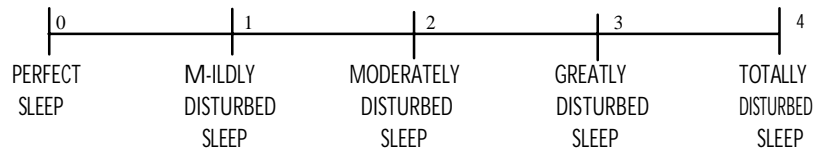
IN ORDER TO PROPERLY ASSESS YOUR CONDITION, WE MUST UNDERSTAND HOW MUCH YOUR NECK AND/OR BACK PROBLEMS HAVE AFFECTED YOUR ABILITY TO MANAGE EVERYDAY ACTIVITIES.

FOR EACH ITEM BELOW, PLEASE CIRCLE THE NUMBER WHICH MOST CLOSELY DESCRIBES YOUR CONDITION RIGHT NOW.

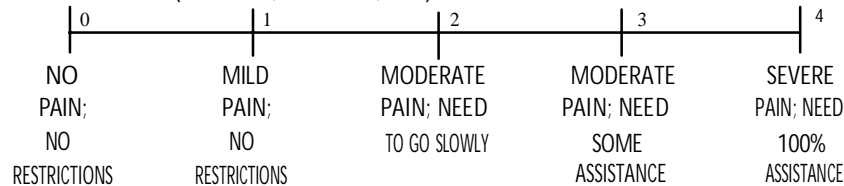
1. PAIN INTENSITY



2. SLEEPING



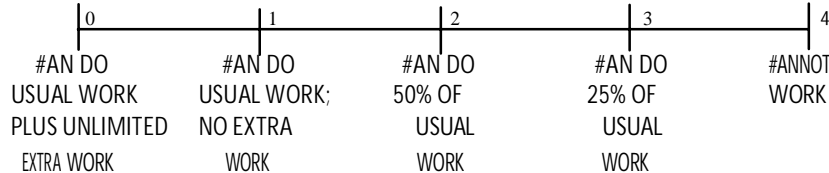
3. PERSONAL CARE (WASHING, DRESSING, ETC.)



4. TRAVEL (DRIVING, ETC.)



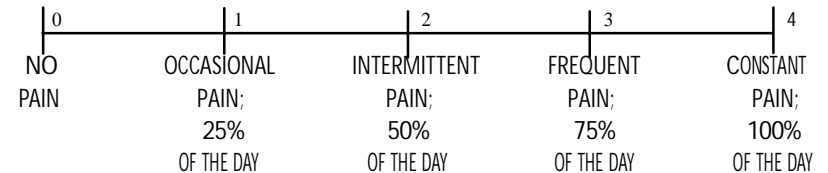
5. WORK



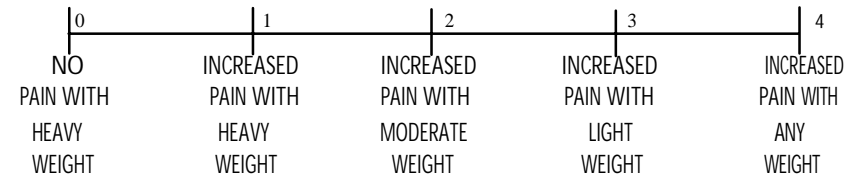
6. RECREATION



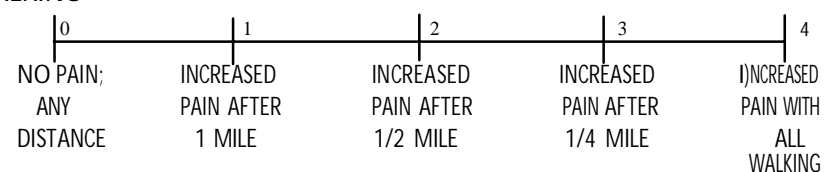
7. FREQUENCY OF PAIN



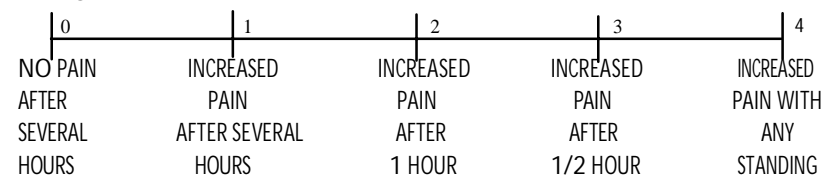
8. LIFTING



9. WALKING



10. STANDING



NAME _____

PRINTED

SIGNATURE

TOTAL SCORE _____

DATE

Health Satisfaction Score (HSS)

Name: _____ Date: _____

Email Address: _____

Please answer the questions on a scale of 1 to 10, 1 representing that you don't agree with the statement and 10 representing that there is no doubt in your mind or heart that you agree with the statement.

[1 - Absolutely Disagree] [2] [3] [4] [5] [6] [7] [8] [9] [10 - Absolutely Agree]

Section 1 - Physical Health

1. I am a physically fit person and formally exercise on a regular basis.
[1] [2] [3] [4] [5] [6] [7] [8] [9] [10]
2. I have a physically attractive body that I am proud to look at in the mirror.
[1] [2] [3] [4] [5] [6] [7] [8] [9] [10]
3. I have not had many traumas in my life (auto accident, broken bones, bad falls).
[1] [2] [3] [4] [5] [6] [7] [8] [9] [10]
4. I get at least 7 hours of sleep, 7 days a week
[1] [2] [3] [4] [5] [6] [7] [8] [9] [10]
5. I have gotten regular Chiropractic care within the past 5 years.
[1] [2] [3] [4] [5] [6] [7] [8] [9] [10]

Section 1 total _____

Section 2 - Emotional/Mental Health

6. I am a calm, peaceful person. I can shut my mind off and focus my mind at will.
[1] [2] [3] [4] [5] [6] [7] [8] [9] [10]
7. I practice some form of relaxation (meditation/yoga/breathing exercises/prayer, etc.) on a regular basis.
[1] [2] [3] [4] [5] [6] [7] [8] [9] [10]
8. Most of the time, I am truly happy and feel a sense of purpose in my life.
[1] [2] [3] [4] [5] [6] [7] [8] [9] [10]
9. I have healthy relationships and a rich social network of friends and activities.
[1] [2] [3] [4] [5] [6] [7] [8] [9] [10]
10. I am organized, have time for myself, and can prioritize the important tasks in my life.
[1] [2] [3] [4] [5] [6] [7] [8] [9] [10]

Section 2 total _____

Section 3 - Chemical/Nutritional Health

11. I eat 4-6 small meals daily and properly combine my protein, carbs. and fats.
[1] [2] [3] [4] [5] [6] [7] [8] [9] [10]
12. I supplement everyday with good supplements such as a vitamin/mineral complex, antioxidants, and good fatty acids (fish oil, flax seeds).
[1] [2] [3] [4] [5] [6] [7] [8] [9] [10]
13. I do not take medications for chronic medical problems such as digestive disorders; cardiovascular problems; headaches; chronic pain; blood sugar problems; chronic fatigue; immune problems or chronic infections; or any other chronic conditions.
[1] [2] [3] [4] [5] [6] [7] [8] [9] [10]
14. I do not smoke cigarettes.
[1] [2] [3] [4] [5] [6] [7] [8] [9] [10]
15. I drink water as my primary beverage and consume at least 30 ounces per day.
[1] [2] [3] [4] [5] [6] [7] [8] [9] [10]

Section 3 total _____

Grand total of all three sections: _____

E:\data\gfc\gfc\New Patients\NP Paperwork\CP_WellnessScoreExamForm\Health_Satisfaction_Score

Medical Symptoms Questionnaire (MSQ)

Name: _____ Date: _____

Email Address: _____

Rate each of the following symptoms based upon your typical health profile for the past 30 days.

Point Scale

0 - Never or almost never have the symptom

1 - Occasionally have it, effect is not severe

2 - Occasionally have it, effect is severe

3 - Frequently have it, effect is not severe

4 - Frequently have it, effect is severe

Head _____ Headaches
_____ Faintness
_____ Dizziness
_____ Insomnia
Total _____

Eyes _____ Watery or Itchy Eyes
_____ Swollen, Reddened or Sticky Eyelids
_____ Bags or Dark Circles Under Eyes
_____ Blurred or Tunnel Vision (does not include near or far-sighted)
Total _____

Ears _____ Itchy Ears
_____ Earaches, Ear Infections
_____ Drainage from Ear
_____ Ringing in Ears, Hearing Loss
Total _____

Nose _____ Stuffy Nose
_____ Sinus Problems
_____ Hay Fever
_____ Sneezing Attacks
_____ Excessive Mucus Formation
Total _____

Mouth/ Throat _____ Chronic Coughing
_____ Gagging, Frequent Need to Clear Throat
_____ Sore Throat, Hoarseness, Loss of Voice
_____ Swollen or Discolored Tongue, Gums, or Lips
_____ Canker Sores
Total _____

Skin _____ Acne
_____ Hives, Rashes, Dry Skin
_____ Hair Loss
_____ Flushing, Hot Flashes
_____ Excessive Sweating
Total _____

Heart _____ Irregular or Skipped Heartbeat
_____ Rapid or Pounding Heartbeat
_____ Chest Pain
Total _____

Sub-Total-pg 1 _____

Please Turn Over

Lungs	_____ Chest Congestion
	_____ Asthma, Bronchitis
	_____ Shortness of Breath
	_____ Difficulty Breathing
	Total _____
Digestion	_____ Nausea, Vomiting
	_____ Diarrhea
	_____ Constipation
	_____ Bloating Feeling
	_____ Belching, Passing Gas
	_____ Heartburn
	_____ Intestinal/Stomach Pain
	Total _____
Joints/ Muscles	_____ Pain or Aches in Joints
	_____ Arthritis
	_____ Stiffness or Limitation of Movement
	_____ Pain or Aches in Muscles
	_____ Feeling of Weakness or Tiredness
	Total _____
Weight	_____ Binge Eating/Drinking
	_____ Craving Certain Foods
	_____ Excessive Weight
	_____ Compulsive Eating
	_____ Water Retention
	_____ Underweight
	Total _____
Energy/ Activity	_____ Fatigue, Sluggishness
	_____ Apathy, Lethargy
	_____ Hyperactivity
	_____ Restlessness
	Total _____
Mind	_____ Poor Memory
	_____ Confusion, Poor Comprehension
	_____ Poor Concentration
	_____ Poor Physical Condition
	_____ Difficulty in Making Decisions
	_____ Stuttering or Stammering
	_____ Slurred Speech
	_____ Learning Disabilities
	Total _____
Emotions	_____ Mood Swings
	_____ Anxiety, Fear, Nervousness
	_____ Anger, Irritability, Aggressiveness
	_____ Depression
	Total _____
Other	_____ Frequent Illness
	_____ Frequent or Urgent Urination
	_____ Genital Itch or Discharge
	Total _____

Sub-Total-pg 1 _____

Sub-Total-pg 2 _____

Grand Total _____



Oswestry Neck Disability Index

Score: ____/50x100 = ____%

This questionnaire is designed to help us better understand how your neck pain affects your ability to manage everyday life activities. Please check the box for the one statement in each section that applies to you. Although you may consider that two of the statements in any one section relate to you, please mark the box that *most closely* describes your present-day situation. Thank you.

Patient Name _____

Date _____

Please check one box in each section.

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 is the worst imaginable at the moment.

Section 2 – Personal Care (washing, dressing, etc.)

- ☐ 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; I am slow & 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 increase pain.
- ☐ 1 I can lift heavy weights, but it causes increased pain.
- ☐ 2 Pain prevents me from lifting heavy weights off the floor, but I can manage if the weights are conveniently positioned (ex. on a table).
- ☐ 3 Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
- ☐ 4 I can lift only very light weights.
- ☐ 5 I cannot lift or carry anything at all.

Section 4 – 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 with slight pain in my neck.
- ☐ 2 I can read as much as I want with moderate pain in my neck.
- ☐ 3 I cannot read as much as I want because of moderate pain in my neck.
- ☐ 4 I can hardly read at all because of moderate 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 moderate headaches which come infrequently.
- ☐ 3 I have moderate headaches which come frequently.
- ☐ 4 I have severe headaches which come frequently.
- ☐ 5 I have headaches almost all the time.

Section 6 – Concentration

- ☐ 0 I can concentrate fully when I want with no difficulty.
- ☐ 1 I can concentrate fully when I want 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.
- ☐ 4 I have a great deal of difficulty in concentrating when I want.
- ☐ 5 I cannot concentrate at all.

Section 7 – Work

- ☐ 0 I can do as much work as I want.
- ☐ 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 cannot 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 neck pain.
- ☐ 2 I can drive my car as long as I want with moderate neck pain.
- ☐ 3 I cannot drive my car as long as I want because of moderate neck pain.
- ☐ 4 I can hardly drive at all because of severe neck pain.
- ☐ 5 I cannot drive my car at all.

Section 9 – 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 (3-5 hours sleepless).
- ☐ 5 My sleep is completely disturbed (5-7 hours sleepless).

Section 10 – Recreation

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

Oswestry **LOW BACK** Disability Index

Score: ____/50x100 = ____%

This questionnaire is designed to help us better understand how your back or leg pain affects your ability to manage everyday life activities. Please check the box for *the one statement* in each section that applies to you. Although you may consider that two of the statements in any one section relate to you, please mark the box that *most closely* describes your present-day situation. Thank you.

Patient Name

Date

Please check one box in each section.

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 is the worst imaginable at the moment.

Section 2 – Personal Care (washing, dressing, etc.)

- ☐ 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; I am slow & 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 increase pain.
- ☐ 1 I can lift heavy weights, but it causes increased pain.
- ☐ 2 Pain prevents me from lifting heavy weights off the floor, but I can manage if the weights are conveniently positioned (ex. on a table).
- ☐ 3 Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
- ☐ 4 I can lift only very light weights.
- ☐ 5 I cannot lift or carry anything at all.

Section 4 – Walking

- ☐ 0 Pain does not prevent me walking any distance.
- ☐ 1 Pain prevents me from walking more than 1 mile.
- ☐ 2 Pain prevents me from walking more than ½ mile.
- ☐ 3 Pain prevents me from walking more than 100 yards.
- ☐ 4 I can only walk using a stick or crutches.
- ☐ 5 I am in bed most of the time.

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 30 minutes.
- ☐ 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 for more than 1 hour.
- ☐ 3 Pain prevents me from standing for more than 30 minutes.
- ☐ 4 Pain prevents me from standing for more than 10 minutes.
- ☐ 5 Pain prevents me from standing at all.

Section 7 – Sleeping

- ☐ 0 My sleep is never disturbed by pain.
- ☐ 1 My sleep is slightly disturbed (less than 1 hour sleepless).
- ☐ 2 My sleep is mildly disturbed (2 hours sleepless).
- ☐ 3 My sleep is moderately disturbed (4 hours sleepless).
- ☐ 4 My sleep is greatly disturbed (6 hours sleepless).
- ☐ 5 Pain prevents me from sleeping at all.

Section 8 – Sex Life (if applicable)

- ☐ 0 My sex life is normal and causes no extra pain.
- ☐ 1 My sex life is normal but causes some extra pain.
- ☐ 2 My sex life is nearly normal but is very painful.
- ☐ 3 My sex life is severely restricted by pain.
- ☐ 4 My sex life is nearly absent because of pain.
- ☐ 5 Pain prevents any sex life at all.

Section 9 – 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 (ex. sports).
- ☐ 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 no social life because of pain.

Section 10 – Recreation

- ☐ 0 I can travel anywhere without 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 restricts me to journeys of less than 1 hour.
- ☐ 4 Pain restricts me to journeys of less than 30 minutes.
- ☐ 5 Pain prevents me from travelling except to receive treatment.