FUNCTIONAL RATING INDEX

FOR USE WITH NECK AND/OR BACK 0ROBLEMS 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

0	1	2	3	4
NO PAIN	MILD PAIN	MODERATE PAIN	SEVERE PAIN	WORST POSSIBLE PAIN

2. SLEEPING

0	1	2	3	4
PERFECT SLEEP	M-ILDLY DISTURBED SLEEP	MODERATELY DISTURBED SLEEP	GREATLY DISTURBED SLEEP	TOTALLY DISTURBED SLEEP

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

0	1	2	3	4
NO PAIN; NO RESTRICTIONS	MILD PAIN; NO RESTRICTIONS	MODERATE PAIN; NEED TO GO SLOWLY	MODERATE PAIN; NEED SOME ASSISTANCE	SEVERE PAIN; NEED 100% ASSISTANCE

4. TRAVEL (DRIVING, ETC.)

0	1	2	3	4
NO PAIN ON LONG TRIPS	MILD PAIN ON LONG TRIPS	MODERATE PAIN ON LONG TRIPS	MODERATE PAIN ON SHORT TRIPS	SEVERE PAIN ON SHORT TRIPS

5. WORK

0	1	2	3	4
#AN DO USUAL WORK PLUS UNLIMITED EXTRA WORK	#AN DO USUAL WORK; NO EXTRA WORK	#AN DO 50% OF USUAL WORK	#AN DO 25% OF USUAL WORK	#ANNOT WORK

6. RECREATION

0	1	2	3	4
CAN DO ALL ACTIVITIES	CAN DO MOST ACTIVITIES	CAN DO SOME ACTIVITIES	CAN DO A FEW ACTIVITIES	CANNOT DO ANY ACTIVITIES

7. FREQUENCY OF PAIN

0	1	2	3	4
NO PAIN	OCCASIONAL PAIN; 25% OF THE DAY	INTERMITTENT PAIN; 50% OF THE DAY	FREQUENT PAIN; 75% OF THE DAY	CONSTANT PAIN; 100% OF THE DAY

8. LIFTING

0	1	2	3	4
NO PAIN WITH HEAVY WEIGHT	INCREASED PAIN WITH HEAVY WEIGHT	INCREASED PAIN WITH MODERATE WEIGHT	INCREASED PAIN WITH LIGHT WEIGHT	INCREASED PAIN WITH ANY WEIGHT

9. WALKING

0	1	2	3	4
NO PAIN; ANY DISTANCE	INCREASED PAIN AFTER 1 MILE	INCREASED PAIN AFTER 1/2 MILE	INCREASED PAIN AFTER 1/4 MILE	I)NCREASED PAIN WITH ALL WALKING

10. STANDING

0	1	2	3	4
NO PAIN AFTER SEVERAL HOURS	INCREASED PAIN AFTER SEVERAL HOURS	INCREASED PAIN AFTER 1 HOUR	INCREASED PAIN AFTER 1/2 HOUR	INCREASED PAIN WITH ANY STANDING

NAME _____
PRINTED

_____
SIGNATURE

_____
DATE

TOTAL SCORE_____

INSTITUTE OF EVIDENCE-BASED CHIROPRACTIC
www.chiroevidence.com

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: _____

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
_____ Bloated 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 _____

Grant Family Chiropractic

585 Sheridan Road, Noblesville, IN

(317) 219-0354

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.

Grant Family Chiropractic

585 Sheridan Road, Noblesville, IN

(317) 219-0354

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.