NAME: _____ DATE: _____

PATIENT FOLLOW-UP FORM

In an effort to monitor outcomes in our office, we would ask that you answer the questions listed below. These correspond to questions asked on your first visit to our office.

Jernigan CHIROPRACTIC CLINIC

1A. Describe the current status of your original complaint: _____

_____

_____

1B. Any new complaints? □ NO □ YES Describe: _____

2. Please describe the character of your current pain (YOU MAY CHECK ONE OR MORE ANSWERS): □ Sharp/Stabbing □ Sharp/Dull □ Aches □ Dull □ Soreness □ Weakness □ Throbbing/Gnawing □ Numbness □ Shooting □ Gripping/Constricting □ Burning □ Tingling

3. How often are the complaints present? □ Constant (76-100%) □ Frequent (51-75%) □ Occasional (26-50%) □ Intermittent (25% or less)

4. Indicate the intensity of your pain at its lowest and highest level. Please circle a number: 0 1 2 3 4 5 6 7 8 9 10
NO PAIN UNBEARABLE PAIN

5. Since your treatment began, is the pain: □ Increasing □ Decreasing □ Not Changing

6A. Have you during the course of treatment done anything to make your problem worse? □ YES □ NO

6B. If yes, please explain: _____

7A. Are you currently receiving any other therapy? □ YES □ NO

7B. If yes, by □ Anti-inflammatories □ Muscle Relaxers □ Physical Therapy from PT □ Other _____

8. What makes your problem better? □ Nothing □ Lying Down □ Walking □ Standing □ Sitting □ Movement/Exercise □ Inactivity

9. What makes your problem worse? □ Nothing □ Lying Down □ Walking □ Standing □ Sitting □ Movement/Exercise □ Inactivity

10. How would you grade your general stress level? □ No Stress □ Minimal Stress □ Moderate Stress □ Greatly Stressed

11. Physcial activity at work: □ Sitting more than 50% of Workday □ Light manual labor □ Manual Labor □ Heavy Manual Labor

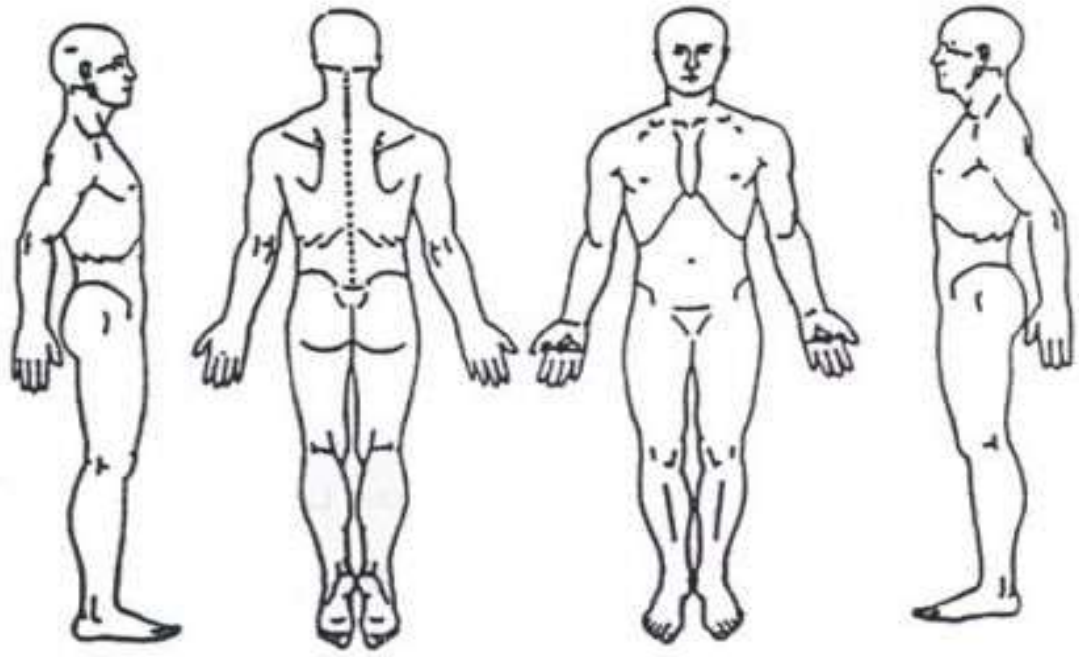
12. General Physical activity: □ No Regular Exercise Program □ Light exercise program □ Strenuous exercise program

13. How would you rate your satisfaction with the treatment received to date? □ Very Pleased □ Pleased □ Somewhat lacking
I would appreciate further information/or have additional questions concerning: _____

_____

14. Has your weight recently changed by more than 10 pounds? □ NO □ GAIN □ LOSS

MARK ON THE PICTURE WHERE YOU CONTINUE TO HAVE PAIN OR OTHER SYMPTOMS



PATIENT'S SIGNATURE _____ Date: _____

Patient Name: _____ **Date:** _____

Neck Index

*This questionnaire will give your provider 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** that most closely describes your problem.*

Pain Intensity

⓪ I have no pain at the moment.
① The pain is very mild at the moment.
② The pain comes and goes and is moderate.
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.

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).

Reading

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

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 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.
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 cannot do any work at all.

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 my care.
⑤ I do not get dressed, I was with difficulty and stay in bed.

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 manage if they are conveniently positioned (e.g. on a table).
③ Pain prevents me from lifting heavy weights off the floor, but I can manage light to medium weights if they are conveniently positioned
④ I can only lift very light weights.
⑤ I cannot lift or carry anything 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 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 because of neck pain.

Recreation

⓪ I am able to engage in all my recreation activities without neck pain.
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 my usual recreational activities because of neck pain
③ I am only 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 neck pain.
⑤ I cannot do any recreation activities at all.

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 most of the time.

Patient Signature: _____ Neck Score Index

Patient Name: _____ **Date:** _____

Back Index

*This questionnaire will give your provider 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** that most closely describes your problem.*

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.

Sleeping

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

Sitting

(0) I can sit in my 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 pain immediately.

Standing

(0) I can stand as long as I want without 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 pain immediately.

Walking

(0) I have no pain while walking.
(1) I have some pain while walking but it doesn't 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.

Personal Care

(0) I do 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 increase the pain but I manage not to change my way of doing it
(3) Washing and dressing increase 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.
(3) Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned (e.g. on a table)
(4) Pain prevents me from lifting heavy weights off the floor, but I can manage light to medium weights if they are conveniently positioned.
(5) I can only lift very light weights.

Traveling

(0) I get no pain while traveling.
(1) I get some pain while traveling but none of my usual forms of travel make it worse.
(2) I get extra pain while traveling but it does not cause me to seek alternate forms of travel
(3) I get extra pain while traveling which causes me to seek alternate forms of travel.
(4) Pain restricts all forms of travel except that done while lying down,
(5) Pain restricts all forms of travel.

Social Life

(0) My social life is normal and gives me no extra pain.
(1) My social life is normal but increase the degree of pain.
(2) Pain has no significant affect on my social life apart from limiting my more energetic interests
(3) Pain has restricted my social life and I do not go out very often.
(4) Pain has restricted my social life to my home.
(5) I have hardly any social life because of the pain.

Changing degree of pain

(0) My pain is rapidly getting better.
(1) My pain fluctuates but overall is definitely getting better.
(2) My pain seems to be getting better but improvement is slow.
(3) My pain is neither getting better or worse.
(4) My pain is gradually worsening.
(5) My pain is rapidly worsening.

Patient Signature: _____ Neck Score Index