VanNess
Chiropractic • Massage • Rehabilitation

DATE: _____

TREATMENT UPDATE

NAME: _____ **ADDRESS:** _____

PHONE: _____

Please rate your primary complaint?

Primary Complaint: _____

_____

- Rate your discomfort 1-10: (10 worst) Now: ____ at its best: _____ at its worst: ____
- Frequency of discomfort 0%-100%: _____ Onset: Gradual / Sudden
- How long since you first noticed the discomfort? _____ getting better/worse/no change
- Aggravated by: _____ Relieved by: _____
- Discomfort is sharp/achy/tingling/numb/other: _____
- Time of day when it is most noticeable: _____
- Have you ever had this discomfort before (if yes, explain):_____

Please rate secondary complaint?

Secondary Complaint: _____

_____

- Rate your discomfort 1-10: (10 worst) Now: ____ at its best: _____ at its worst: ____
- Frequency of discomfort 0%-100%: _____ Onset: Gradual / Sudden
- How long since you first noticed the discomfort? _____ getting better/worse/no change
- Aggravated by: _____ Relieved by: _____
- Discomfort is sharp/achy/tingling/numb/other: _____
- Time of day when it is most noticeable: _____
- Have you ever had this discomfort before (if yes, explain):_____

*** Rate your progress so far:** 10% 20% 30% 40% 50% 60% 70% 80% 90% 100%

Very Poor Excellent

*** What positive changes have you noticed to your health and overall function since beginning care?**

_____

_____

Please note if you have noticed any improvement in the following:

__ Digestion __ Energy Level __ Elimination __ Sleeping __ Breathing __ Strength __ Composure __ Stamina

Daily Activities: Effects of Current Condition on Performance: (1= No limitations – 10=Unable to Perform)

Carrying Groceries:	1	2	3	4	5	6	7	8	9	10
Changing Positions:	1	2	3	4	5	6	7	8	9	10
Climbing Stairs:	1	2	3	4	5	6	7	8	9	10
Computer Strain:	1	2	3	4	5	6	7	8	9	10
Driving:	1	2	3	4	5	6	7	8	9	10
Household Chores:	1	2	3	4	5	6	7	8	9	10
Lifting Children:	1	2	3	4	5	6	7	8	9	10
Pet Care:	1	2	3	4	5	6	7	8	9	10
Reading/Concentration:	1	2	3	4	5	6	7	8	9	10

Self-care: Bathing:	1	2	3	4	5	6	7	8	9	10
Self-care: Dressing	1	2	3	4	5	6	7	8	9	10
Self-care: Shaving	1	2	3	4	5	6	7	8	9	10
Sexual Activities:	1	2	3	4	5	6	7	8	9	10
Sitting Still:	1	2	3	4	5	6	7	8	9	10
Sleep:	1	2	3	4	5	6	7	8	9	10
Standing Still:	1	2	3	4	5	6	7	8	9	10
Walking:	1	2	3	4	5	6	7	8	9	10
Yard work:	1	2	3	4	5	6	7	8	9	10

Given your current understanding of chiropractic care and the results you have achieved, what are your goals through chiropractic care?

__ Just pain relief

__ Pain relief, plus improved spinal posture

__ Pain relief, improved spinal posture, plus long term increased vitality and spinal wellness

Are there any new complaints since starting care that you would like to make the doctor aware of?

New Complaint: _____

_____

- Rate your discomfort 1-10: (10 worst) Now: ____ at its best: _____ at its worst: ____
- Frequency of discomfort 0%-100%: _____ Onset: Gradual / Sudden
- How long since you first noticed the discomfort? _____ getting better/worse/no change
- Aggravated by: _____ Relieved by: _____
- Discomfort is sharp/achy/tingling/numb/other: _____
- Time of day when it is most noticeable: _____
- Have you ever had this discomfort before (if yes, explain):_____

As many spinal conditions have a genetic component, are there any health and wellness questions, pertaining to your children or spouse that you would like to discuss with the doctor today?

Yes __ No ___ (Names / Ages):_____

Would you be willing to give a (video) or (online) testimonial of your success with our practice? Yes / No

Signature: _____

For Doctor Use Only:

Cervical ROM: Flexion 50/____ Ext 60/____ RRot 80/____ LRot 80/____ RLat 45/____ LLat 45/____

Lumbar ROM: Flexion 60/____ Extension 25/____ RLat 25/____ LLat 25/____

Scales: Left____ Right____ Orthotics: Yes____ No____

NDI Total Score: New: ___ Prior: ____ BDI Total Score: New:____ Prior:_____

Previous (+) Orthopedic Tests: _____

Doctor Notes:

_____

Back Index

Form BI100

rev 3/27/2003

Patient Name _____ **Date** _____

This questionnaire will give your provider information about how your back 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 statement 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 Because of pain my normal sleep is reduced by less than 25%.
③ Because of pain my normal sleep is reduced by less than 50%.
④ Because of pain my normal sleep is reduced by less than 75%.
⑤ Pain prevents me from sleeping at all.

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 1/2 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 1/2 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 1/2 mile without increasing pain.
④ I cannot walk more than 1/4 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 increases the pain but I manage not to change my way of doing it.
③ Washing and dressing increases 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 increases the degree of pain.
② Pain has no significant affect on my social life apart from limiting my more energetic interests (e.g., dancing, etc).
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.

Index Score = [Sum of all statements selected / (# of sections with a statement selected x 5)] x 100

Back Index Score _____

Neck Index

Form N1-100

rev 3/27/2003

Patient Name _____ **Date** _____

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 statement 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.

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 self care.
⑤ I do not get dressed, I wash with difficulty and stay in bed.

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).

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.

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.

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.

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.

Recreation

⓪ I am able to engage in all my recreation activities without neck pain.
① I am able to engage in all my usual recreation activities with some neck pain.
② I am able to engage in most but not all my usual recreation 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.

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.

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.

~~Index Score = [Sum of all statements selected / (# of sections with a statement selected x 5)] x 100~~

Neck Index Score _____