Patient Name:_____

Chiropractic Supplemental Questionnaire

Please list three questions you would like to discuss with your provider at this appointment:

1. _____
   _____
2. _____
   _____
3. _____
   _____

Please list your top three movement and activity goals. If this is a workers compensation case, please list work related movements. Then **rate your current ability to do each movement or activity by circling a number on the scale.** Zero (0) means "I can't do it at all" Ten (10) means "I can easily do it as much as I want".

1. _____
   _____

0	1	2	3	4	5	6	7	8	9	10

2. _____
   _____

0	1	2	3	4	5	6	7	8	9	10

3. _____
   _____

0	1	2	3	4	5	6	7	8	9	10

Patient Name:_____

Functional Rating Index

In order to properly assess your condition, we must understand how much your pain has affected your ability to manage everyday activities. For each item, please **circle** the number which most closely describes your condition right now.

1. Pain Intensity					6. Recreation				
0	1	2	3	4	0	1	2	3	4
No pain	Mild pain	Moderate pain	Severe pain	Worst possible pain	Can do all activities	Can do most activities	Can do some activities	Can do a few activities	Cannot do any activities
2. Sleeping					**7. Frequency of Pain**				
0	1	2	3	4	0	1	2	3	4
Perfect sleep	Mildly disturbed sleep	Moderately disturbed sleep	Greatly disturbed sleep	Totally disturbed sleep	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
3. Personal Care (washing, dressing, etc.)					**8. Lifting**				
0	1	2	3	4	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	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
4. Traveling (driving, etc.)					**9. Walking**				
0	1	2	3	4	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	No pain; any distance	Increased pain after 1 mile	Increased pain after ½ mile	Increased pain after ¼ mile	Increased pain with all walking
5. Work					**10. Standing**				
0	1	2	3	4	0	1	2	3	4
Can do usual work plus unlimited extra work	Can do usual work no extra work	Can do 50% of usual work	Can do 25% of usual work	Cannot work	No pain after several hours	Increased pain after several hours	Increased pain after 1 hour	Increased pain after ½ hour	Increased pain with any standing

Patient Name: _____
Print Name Signature Date

- OR -

Patient Representative: _____
Print Name & Relationship to Patient Signature Date