

MIDWAY CHIROPRACTIC
23100 PACIFIC HWY S SUITE 201 DES MOINES, WA 98198
206-824-9500

INTERM REPORT QUESTIONS

NAME: _____

PLEASE WRITE DOWN THE COMPLAINTS YOU HAVE RIGHT NOW, AND HOW OFTEN THEY OCCUR:

COMPLAINTS:

HOW OFTEN IT OCCURS:

IF YOU HAD TO ESTIMATE, HOW MUCH BETTER DO YOU FEEL? (100% = COMPLETELY BETTER, 0% = NOT BETTER AT ALL):

0% 5% 10% 20% 30% 40% 50% 60% 70% 80% 90% 100%

WHAT KIND OF IMPROVEMENTS HAVE YOU NOTICED?:

IF YOU WERE TAKEN OFF OF WORK, HAVE YOU GONE BACK YET?

YES

NO

IF YES, DATE RETURNED TO WORK: _____

IF YOU HAVE ANY OTHER COMMENTS PLEASE WRITE THEM HERE:

PATIENT SIGNATURE: _____ DATE: _____

DOCTOR SIGNATURE: _____

Name: _____

Pain/Discomfort Rating Scale

Please choose the number which best describes your pain in each of the questions below

(0= No Pain 10= Unbearable Pain)

What is your pain/discomfort RIGHT NOW?

HEADACHE	0	1	2	3	4	5	6	7	8	9	10
NECK	0	1	2	3	4	5	6	7	8	9	10
UPPER BACK	0	1	2	3	4	5	6	7	8	9	10
LOW BACK	0	1	2	3	4	5	6	7	8	9	10

What is your pain/discomfort TYPICAL OR AVERAGE?

HEADACHE	0	1	2	3	4	5	6	7	8	9	10
NECK	0	1	2	3	4	5	6	7	8	9	10
UPPER BACK	0	1	2	3	4	5	6	7	8	9	10
LOW BACK	0	1	2	3	4	5	6	7	8	9	10

What is your pain/discomfort AT ITS WORST?

HEADACHE	0	1	2	3	4	5	6	7	8	9	10
NECK	0	1	2	3	4	5	6	7	8	9	10
UPPER BACK	0	1	2	3	4	5	6	7	8	9	10
LOW BACK	0	1	2	3	4	5	6	7	8	9	10

PAIN DISABILITY INDEX QUESTIONNAIRE

PLEASE USE THE LETTERS BELOW TO MARK THE AREAS IN WHICH YOU FEEL THE CORRESPONDING SENSATIONS.

A = ACHE

B = BURNING

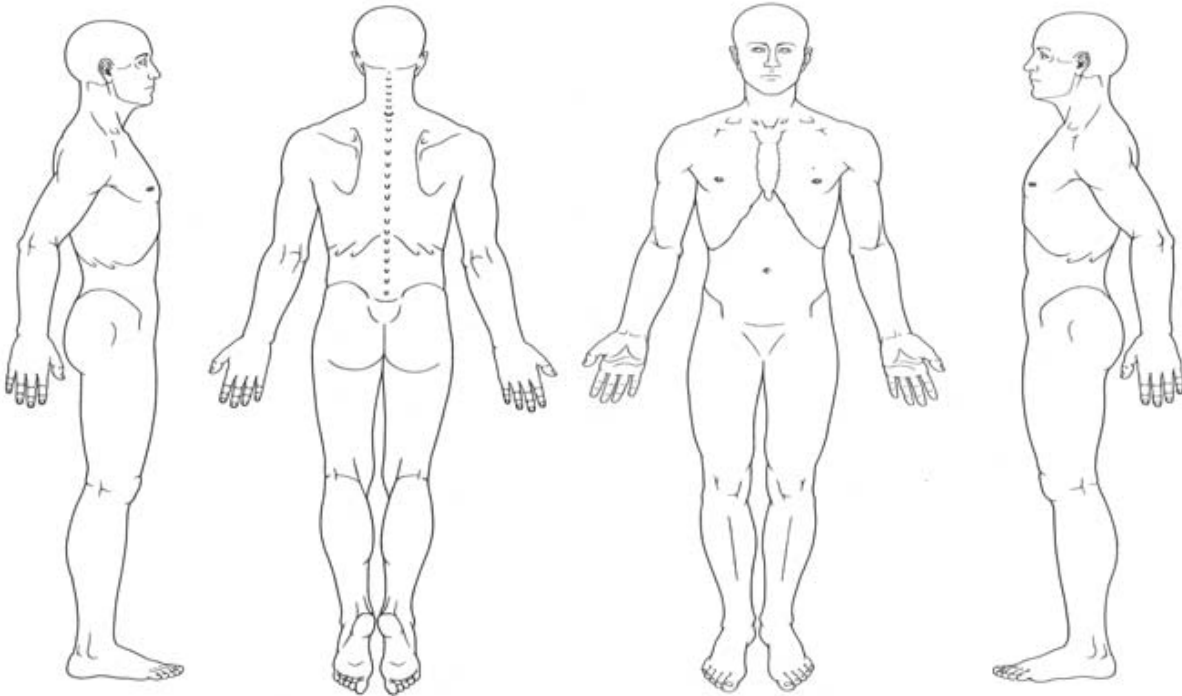
S = STABBING

P = PINS/NEEDLES

O = OTHER

N = NUMBNESS

COLOR IN AREAS TO INDICATE BRUISING



PATIENT SIGNATURE: _____

DATE: _____

DOCTOR SIGNATURE: _____

PATIENT-SPECIFIC FUNCTIONAL SCALE

NAME: _____

We want to know what 3 activities in your life you are unable to perform, or are having the most difficulty performing, as a result of your chief problem.

In the 3 boxes below marked "Activity", write down 3 different activities that are being affected by your problem. You can choose any activity you like, such as running, using the computer, washing the dishes, lifting your children, or even simply sitting.

10 MEANS YOU ARE PERFECTLY FINE AND 0 MEANS YOU CAN'T DO IT!!!

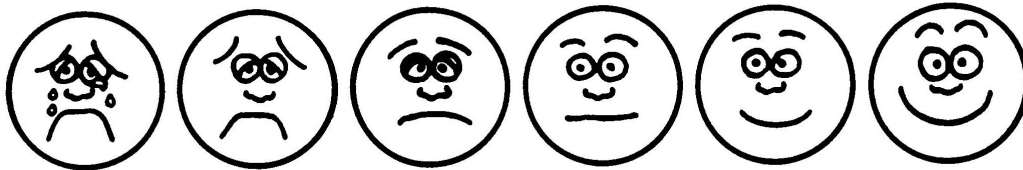
ACTIVITY 1	SCORE
ACTIVITY 2	SCORE
ACTIVITY 3	SCORE

After you've listed your activities, now it's time to *score* them. Look at the number scale below. On this scale, **0** means that you can't do your activity at all, for example you can't sit because of your problem. **10** would mean that you can sit normally, like before your problem started. Using the scale, write a number to the right of each activity above. After you finish, sign your name at the bottom of this form and you're done!

Unable to
Perform Activity

Able to Perform Activity At Same
Level As Before Injury/Problem

0 1 2 3 4 5 6 7 8 9 10



IMPORTANT: PLEASE READ THIS FORM CAREFULLY. IT MUST BE COMPLETED BEFORE YOU CAN BEGIN/CONTINUE TREATMENT.

PATIENT SIGNATURE: _____ DATE: _____

DOCTOR SIGNATURE: _____

Neck Index

Patient Name: _____

*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

- ☐ I have no pain at the moment.
- ☐ The pain is very mild at the moment.
- ☐ The pain comes and goes and is moderate.
- ☐ The pain is fairly severe at the moment.
- ☐ The pain is very severe at the moment.
- ☐ The pain is the worst imaginable at the moment.

Sleeping

- ☐ I have no trouble sleeping.
- ☐ My sleep is slightly disturbed (less than 1 hour sleepless).
- ☐ My sleep is mildly disturbed (1-2 hours sleepless).
- ☐ My sleep is moderately disturbed (2-3 hours sleepless).
- ☐ My sleep is greatly disturbed (3-5 hours sleepless).
- ☐ My sleep is completely disturbed (5-7 hours sleepless).

Reading

- ☐ I can read as much as I want with no neck pain.
- ☐ I can read as much as I want with slight neck pain.
- ☐ I can read as much as I want with moderate neck pain.
- ☐ I cannot read as much as I want because of moderate neck pain.
- ☐ I can hardly read at all because of severe neck pain.
- ☐ I cannot read at all because of neck pain.

Concentration

- ☐ I can concentrate fully when I want with no difficulty.
- ☐ I can concentrate fully when I want with slight difficulty.
- ☐ I have a fair degree of difficulty concentrating when I want.
- ☐ I have a lot of difficulty concentrating when I want.
- ☐ I have a great deal of difficulty concentrating when I want.
- ☐ I cannot concentrate at all.

Work

- ☐ I can do as much work as I want.
- ☐ I can only do my usual work but no more.
- ☐ I can only do most of my usual work but no more.
- ☐ I cannot do my usual work.
- ☐ I can hardly do any work at all.
- ☐ I cannot do any work at all.

Personal Care

- ☐ I can look after myself normally without causing extra pain.
- ☐ I can look after myself normally but it causes extra pain.
- ☐ It is painful to look after myself and I am slow and careful.
- ☐ I need some help but I manage most of my personal care.
- ☐ I need help every day in most aspects of self care.
- ☐ I do not get dressed, I wash with difficulty and stay in bed.

Lifting

- ☐ I can lift heavy weights without extra pain.
- ☐ I can lift heavy weights but it causes extra pain.
- ☐ Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned (e.g., on a table).
- ☐ Pain prevents me from lifting heavy weights off the floor, but I can manage light to medium weights if they are conveniently positioned.
- ☐ I can only lift very light weights.
- ☐ I cannot lift or carry anything at all.

Driving

- ☐ I can drive my car without any neck pain.
- ☐ I can drive my car as long as I want with slight neck pain.
- ☐ I can drive my car as long as I want with moderate neck pain.
- ☐ I cannot drive my car as long as I want because of moderate neck pain.
- ☐ I can hardly drive at all because of severe neck pain.
- ☐ I cannot drive my car at all because of neck pain.

Recreation

- ☐ I am able to engage in all my recreation activities without neck pain.
- ☐ I am able to engage in all my usual recreation activities with some neck pain.
- ☐ I am able to engage in most but not all my usual recreation activities because of neck pain.
- ☐ I am only able to engage in a few of my usual recreation activities because of neck pain.
- ☐ I can hardly do any recreation activities because of neck pain.
- ☐ I cannot do any recreation activities at all.

Headaches

- ☐ I have no headaches at all.
- ☐ I have slight headaches which come infrequently.
- ☐ I have moderate headaches which come infrequently.
- ☐ I have moderate headaches which come frequently.
- ☐ I have severe headaches which come frequently.
- ☐ I have headaches almost all the time.

PATIENT SIGNATURE: _____

DATE: _____

DOCTOR SIGNATURE: _____

Low Back Index (Oswestry)

Patient Name: _____

*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

- ☐ I have no pain at the moment.
- ☐ The pain is very mild at the moment.
- ☐ The pain is moderate at the moment.
- ☐ The pain is fairly severe at the moment.
- ☐ The pain is very severe at the moment.
- ☐ The pain is the worst imaginable at the moment.

Personal Care (Washing, Dressing, ect.)

- ☐ I can look after myself normally without causing extra pain.
- ☐ I can look after myself normally but it causes extra pain.
- ☐ It is painful to look after myself and I am slow and careful.
- ☐ I need some help but manage most of my personal care.
- ☐ I need help every day in most aspects of personal care.
- ☐ I do not get dressed, I wash with difficulty, and I stay in bed.

Lifting

- ☐ I can lift heavy weights without increased pain.
- ☐ I can lift heavy weights but it causes increased pain.
- ☐ Pain prevents me from lifting heavy weights off of the floor, but I can manage if they are conveniently positioned (e.g. on a table).
- ☐ Pain prevents me from lifting heavy weights off of the floor, but I can manage light to medium weights if they are conveniently positioned.
- ☐ I can lift only very light weights.
- ☐ I cannot lift or carry anything at all.

Walking

- ☐ Pain does not prevent me walking any distance.
- ☐ Pain prevents me from walking more than 1 mile.
- ☐ Pain prevents me from walking more than 1/2 mile.
- ☐ Pain prevents me from walking more than 100 yards.
- ☐ I can only walk using a stick or crutches.
- ☐ I am in bed most of the time and have to crawl to the toilet.

Sitting

- ☐ I can sit in any chair as long as I like.
- ☐ I can sit in my favorite chair as long as I like.
- ☐ Pain prevents me from sitting for more than 1 hour.
- ☐ Pain prevents me from sitting more than 1/2 hour.
- ☐ Pain prevents me from sitting more than 10 minutes.
- ☐ Pain prevents me from sitting at all.

Standing

- ☐ I can stand as long as I want without increased pain.
- ☐ I can stand as long as I want but my pain increases with time.
- ☐ Pain prevents me from standing more than 1 hour.
- ☐ Pain prevents me from standing more than 1/2 hour.
- ☐ Pain prevents me from standing more than 10 minutes.
- ☐ Pain prevents me from standing at all.

Sleeping

- ☐ My sleep is not disturbed by pain.
- ☐ My sleep is occasionally disturbed by pain.
- ☐ Because of my pain, my sleep is only 3/4 of my normal amount.
- ☐ Because of my pain, my sleep is only 1/4 of my normal amount.
- ☐ Because of my pain, my sleep is only 1/2 of my normal amount.
- ☐ Pain prevents me from sleeping at all.

Social life

- ☐ My social life is normal and does not increase my pain.
- ☐ My social life is normal, but it increases my level of pain.
- ☐ Pain has no significant effect on my social life, but prevents me from participating in more energetic activities (e.g. sports, dancing).
- ☐ Pain has restricted my social life and prevents me from going out very often.
- ☐ Pain has restricted my social life to my home.
- ☐ I have no social life because of pain.

Traveling

- ☐ I get no increased pain when traveling.
- ☐ I get some pain while traveling, but none of my usual forms of travel make it any worse.
- ☐ I get increased pain while traveling, but it does not cause me to seek alternative forms of travel.
- ☐ I get increased pain while traveling, which causes me to seek alternative forms of travel.
- ☐ My pain restricts all forms of travel except that which is done while I am laying down.
- ☐ My pain restricts all forms of travel.

Sex life (If applicable)

- ☐ My sex life is normal and does not increase my pain.
- ☐ My sex life is normal, but it increases my level of pain.
- ☐ My sex life is nearly normal, but is very painful.
- ☐ My sex life is severely restricted by pain.
- ☐ My sex life is nearly absent because of pain.
- ☐ Pain prevents any sex life at all.

PATIENT SIGNATURE: _____

DATE: _____

DOCTOR SIGNATURE: _____