RE-EXAMINATION PROGRESS QUESTIONNAIRE

Patient Name: ____ Date: ____________________

1. How do you classify your improvement since beginning your current treatment plan?
   ☐ Excellent ☐Good ☐Fair ☐Poor

2. What symptoms have NOT improved?
   ____
   ____
   ____

3. Do you find it easier (check all that apply):
   ☐ Walking ☐ Traveling ☐ Working ☐ Bending
   ☐ Standing ☐ Sitting ☐ Lifting ☐ Same

4. What changes have been made in your general feelings? Are you (check all that apply):
   ☐Stronger ☐More Relaxed ☐ More Alert
   ☐Less Nervous ☐Sleep Better ☐Appetite Improved

5. Do you have any of the following symptoms (check all that apply):
   ☐Low Back Pain ☐Mid-Back Pain ☐Neck Pain ☐Pain Between Shoulders
   ☐Arm Problems ☐Leg Problems ☐Swollen Joints ☐Painful Joints
   ☐ Stiff Joints ☐ Sore Muscles ☐ Weak Muscles ☐ Numbness
   ☐ Loss of Feeling ☐ Dizziness ☐ Muscle Jerking ☐ Headaches

6. Is you digestion: ☐Better ☐Same ☐Worse
   ☐ PoorAppetite ☐ Excessive Hunger ☐ Excessive Thirst ☐Excessive Urination
   ☐ Constipation ☐ Hemorrhoids ☐Diarrhea ☐Weight Trouble

7. Is there any other condition that we have not covered that you wish to discuss now? ☐Yes ☐No
   If yes, please explain:
   ____
   ____
   ____

8. Do you have any questions about any phase of your progress? ☐Yes ☐No
   If yes, please explain:
   ____
   ____
   ____

9. Has anyone asked about your progress? ☐Yes ☐No

10. Have you referred anyone for chiropractic care? ☐Yes ☐No

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Functional Rating Index

For use with neck and/or back problems only. For each item below, please circle the number which most closely describes your condition right now.

Patient Name ____ Date__________________

1. Pain Intensity

0	1	2	3	4
0- No Pain	**1-** Mild Pain	**2-** Moderate Pain	**3-** Severe Pain	**4-** Worst Possible Pain

2. Sleeping

0	1	2	3	4
0- Perfect Sleep	**1-** Mildly Disturbed	**2-** Moderately Disturbed	**3-** Greatly Disturbed	**4-** Totally Disturbed Sleep

3. Personal Care (washing, dressing, etc.)

0	1	2	3	4
0- No Pain No Restrictions	**1-** Mild Pain; No Restrictions	**2-** Moderate Pain; Go Slowly	**3-** Moderate Pain; Some Assistance	**4-** Severe Pain; 100% Assistance

4. Travel (driving, etc.)

0	1	2	3	4
0- No Pain on Long Trips	**1-** Mild Pain on Long Trips	**2-** Moderate Pain on Long Trips	**3-** Moderate Pain on Short Trips	**4-** Severe Pain on Short Trips

5. Work

0	1	2	3	4
0- Usual Work + Extra	**1-** Usual Work, No Extra	**2-** 50% of Usual Work	**3-** 25% of Usual Work	**4-** Cannot Work

6. Recreation

0	1	2	3	4
0- All Activities	**1-** Most Activities	**2-** Some Activities	**3-** Few Activities	**4-** No Activities

7. Frequency of Pain

0	1	2	3	4
0- No Pain	**1-** Occasional (25%)	**2-** Intermittent (50%)	**3-** Frequent (75%)	**4-** Constant (100%)

8. Lifting

0	1	2	3	4
0- No Pain with Heavy Weight	**1-** Increased Pain with Heavy Weight	**2-** Increased Pain with Moderate Weight	**3-** Increased Pain with Light Weight	**4-** Increased Pain with Any Weight

9. Walking

0	1	2	3	4
0- No Pain with Any Distance	**1-** Increased Pain after 1 Mile	**2-** Increased Pain after ½ Mile	**3-** Increased Pain after ¼ Mile	**4-** Increased Pain after Any Distance

10. Standing

0	1	2	3	4
0- No Pain with Any Time	**1-** Increased Pain after Several Hours	**2-** Increased Pain after 1 Hour	**3-** Increased Pain after ½ Hour	**4-** Increased Pain after Any Time

Total __________ (/4, X10) = Functional Rating Score __________%

Patient or Guardian Signature ____ Date_______________

Treating Doctor Signature ____ Date_______________

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