

# KNIGHT *Family* CHIROPRACTIC

## OUTCOME ASSESSMENT

Name \_\_\_\_\_ Date \_\_\_\_\_

NO  
SYMPTOMS

EXTREME  
SYMPTOMS

Please place an "X" on the line above to indicate your level of problem.

1. What was the chief symptom or reason you visited our clinic? (low back pain, neck pain, etc.)  
\_\_\_\_\_
2. How do you classify your improvement so far since beginning your care?  
Excellent \_\_\_\_\_ Good \_\_\_\_\_ Fair \_\_\_\_\_ Poor \_\_\_\_\_
3. On a scale of 1 to 10 with 10 being the best, how would you rate your improvement? \_\_\_\_\_
4. What symptoms have improved? \_\_\_\_\_  
\_\_\_\_\_
5. What symptoms do you still have? \_\_\_\_\_  
\_\_\_\_\_
6. What changes have been made in your general feelings? Are you: (check those indicated)  
Stronger \_\_\_\_\_ More Relaxed \_\_\_\_\_ More Alert \_\_\_\_\_  
Less Nervous \_\_\_\_\_ Sleep Better \_\_\_\_\_ Appetite Improved \_\_\_\_\_
7. Do you find it easier: (check those indicated)  
Walking \_\_\_\_\_ Riding \_\_\_\_\_ Working \_\_\_\_\_ Bending \_\_\_\_\_  
Standing \_\_\_\_\_ Sitting \_\_\_\_\_ Lifting \_\_\_\_\_ Same \_\_\_\_\_
8. Is there any other condition you have that we have not discussed that you would like to discuss at this time? \_\_\_\_\_ If yes, please explain \_\_\_\_\_  
\_\_\_\_\_
9. Is there any confusion or question about any phase of your progress? \_\_\_\_\_  
\_\_\_\_\_
10. For Wellness Care, would you prefer:  
\_\_\_\_\_ 1 time per week \_\_\_\_\_ 2 times per month \_\_\_\_\_ 1 time per month
11. Have you had an opportunity to refer anyone to our office?  
Yes \_\_\_\_\_ No \_\_\_\_\_ Intend to do so \_\_\_\_\_
12. Your honest evaluation of the our office is always appreciated. Please comment on any areas where the Doctor/Staff may improve. \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
Patient's Signature

# KNIGHT *Family* CHIROPRACTIC

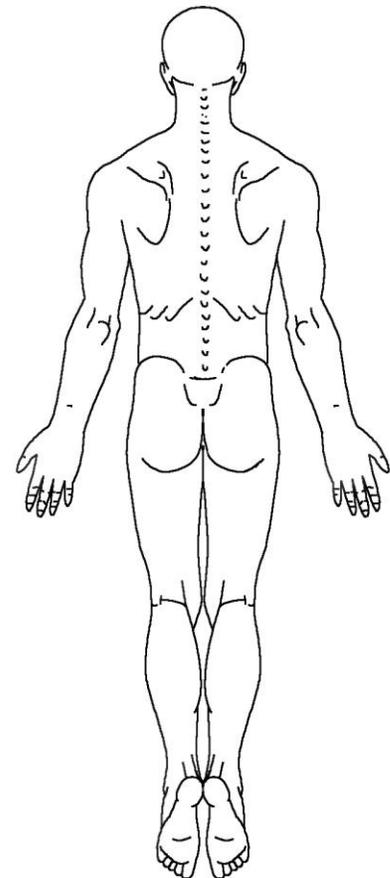
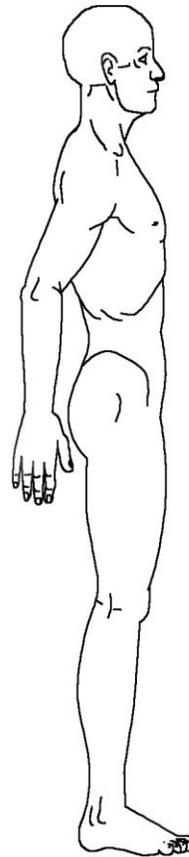
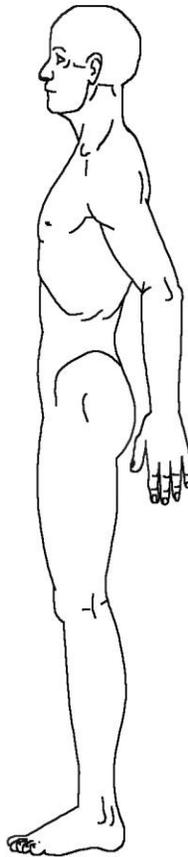
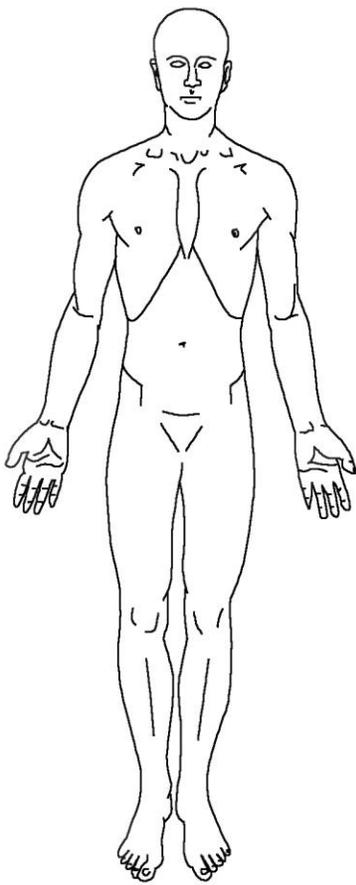
## PAIN DRAWING

Name \_\_\_\_\_

Date \_\_\_\_\_

Using the following descriptive symbols, draw the location of your pain on body outlines below.  
In addition, mark the level of your pain on the pain line at the bottom of the page.

<u>ACHE</u>	<u>BURNING</u>	<u>NUMBNESS</u>	<u>PINS &amp; NEEDLES</u>	<u>STABBING</u>	<u>OTHER</u>
~~~~~	====	OOOO	.....	///////	XXX



No Pain 1 \_\_\_\_\_

\_\_\_\_\_ 10

Worst Possible Pain

Please make a slash through this line to indicate the level of your pain.

Patient Signature

\_\_\_\_\_

# Ryan L. Knight, D.C. Knight Family Chiropractic

Patient Name: \_\_\_\_\_

Date: \_\_\_\_\_

## LOW BACK DISABILITY QUESTIONNAIRE (REVISED OSWESTRY)

*This questionnaire has been designed to give the doctor information as to how your back pain has affected your ability to manage everyday life. Please answer every section and mark in each section only ONE sentence that applies to you. We realize you may consider that two of the statements in any one section relate to you, but please just mark the one that most closely describes your problem.*

<p><b>SECTION 1 - Pain Intensity</b></p> <p>A The pain comes and goes and is very mild.            B The pain is mild and does not vary much.            C The pain comes and goes and is moderate.            D The pain is moderate and does not vary much.            E The pain comes and goes and is severe.            F The pain is severe and does not vary much.</p>	<p><b>SECTION 6 - Standing</b></p> <p>A I can stand as long as I want without pain.            B I have some pain while standing, but it does not increase with time.            C I cannot stand for longer than one hour without increasing pain.            D I cannot stand for longer than 1/2 hour without increasing pain.            E I cannot stand for longer than ten minute without increasing pain.            F I avoid standing, because it increases the pain straight away.</p>
<p><b>SECTION 2 - Personal Care</b></p> <p>A I would not have to change my way of washing or dressing in order to avoid pain.            B I do not normally change my way of washing or dressing even though it causes some pain.            C Washing and dressing increases the pain, but I manage not to change my way of doing it.            D Washing and dressing increases the pain and I find it necessary to change my way of doing it.            E Because of the pain, I am unable to do some washing and dressing without help.            F Because of the pain, I am unable to do any washing or dressing without help.</p>	<p><b>SECTION 7 - Sleeping</b></p> <p>A I get no pain in bed.            B I get pain in bed, but it does not prevent me from sleeping well.            C Because of pain, my normal night's sleep is reduced by less than one than one quarter.            D Because of pain, my normal night's sleep is reduced by less than one-half.            E Because of pain, my normal night's sleep is reduced by less than three-quarters.            F Pain prevents me from sleeping at all.</p>
<p><b>SECTION 3 - Lifting</b></p> <p>A I can lift heavy weights without extra pain.            B I can lift heavy weights, but it causes extra pain.            C Pain prevents me from lifting heavy weights off the floor.            D Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned, eg. on a table.            E Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.            F I can only lift very light weights, at the most.</p>	<p><b>SECTION 8 - Social Life</b></p> <p>A My social life is normal and gives me no pain.            B My social life is normal, but increases the degree of my pain.            C Pain has no significant effect on my social life apart from limiting my more energetic interests, My e.g., dancing, etc.            D Pain has restricted my social life and I do not go out very often.            E Pain has restricted my social life to my home.            F I have hardly any social life because of the pain.</p>
<p><b>SECTION 4 - Walking</b></p> <p>A Pain does not prevent me from walking any distance.            B Pain prevents me from walking more than one mile.            C Pain prevents me from walking more than 1/2 mile.            D Pain prevents me from walking more than 1/4 mile.            E I can only walk while using a cane or on crutches.            F I am in bed most of the time and have to crawl to the toilet.</p>	<p><b>SECTION 9 - Traveling</b></p> <p>A I get no pain while traveling.            B I get some pain while traveling, but none of my usual forms of travel make it any worse.            C I get extra pain while traveling, but it does not compel me to seek alternative forms of travel.            D I get extra pain while traveling which compels me to seek alternative forms of travel.            E Pain restricts all forms of travel.            F Pain prevents all forms of travel except that done lying down.</p>
<p><b>SECTION 5 - Sitting</b></p> <p>A I can sit in any chair as long as I like without pain.            B I can only sit in my favorite chair as long as I like.            C Pain prevents me from sitting more than one hour.            D Pain prevents me from sitting more than 1/2 hour.            E Pain prevents me from sitting more than ten minutes.            F Pain prevents me from sitting at all.</p>	<p><b>SECTION 10 - Changing Degree of Pain</b></p> <p>A My pain is rapidly getting better.            B My pain fluctuates, but overall is definitely getting better.            C My pain seems to be getting better, but improvement is slow at present.            D My pain is neither getting better nor worse.            E My pain is gradually worsening.            F My pain is rapidly worsening.</p>

## LOW BACK DISABILITY QUESTIONNAIRE

**Pain Severity Scale:** Rate the severity of your pain by checking one box on the following scale

<b>No pain</b>	<b>1</b>	<b>2</b>	<b>3</b>	<b>4</b>	<b>5</b>	<b>6</b>	<b>7</b>	<b>8</b>	<b>9</b>	<b>10</b>	<b>Extreme Pain</b>
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# Ryan L. Knight, D.C.

## Knight Family Chiropractic

Patient Name: \_\_\_\_\_

Date: \_\_\_\_\_

### NECK DISABILITY QUESTIONNAIRE (REVISED OSWESTRY)

*This questionnaire has been designed to give the doctor information as to how your back pain has affected your ability to manage everyday life. Please answer every section and mark in each section only ONE sentence that applies to you. We realize you may consider that two of the statements in any one section relate to you, but please just mark the one that most closely describes your problem.*

<p><b>SECTION 1 - Pain Intensity</b></p> <p>A I have no pain at the moment.            B The pain is very mild at the moment.            C The pain is moderate at the moment.            D The pain is fairly severe at the moment.            E The pain is very severe at the moment.            F The pain is the worst imaginable at the moment.</p>	<p><b>SECTION 6 - Concentration/</b></p> <p>A I can concentrate fully when I want to with no difficulty.            B I can concentrate fully when I want to with slight difficulty.            C I have a fair degree of difficulty in concentrating when I want to.            D I have a lot of difficulty in concentrating when I want to.            E I have a great deal of difficulty in concentrating when I want to.            F I cannot concentrate at all.</p>
<p><b>SECTION 2 - Personal Care (Washing, Dressing, etc.)</b></p> <p>A I can look after myself normally without causing extra pain.            B I can look after myself normally, but it causes extra pain.            C It is painful to look after myself and I am slow and careful.            D I need some help, but manage most of my personal care.            E I need help every day in most aspects of self care.            F I do not get dressed, I wash with difficulty and stay in bed.</p>	<p><b>SECTION 7 - Work</b></p> <p>A I can do as much work as I want to.            B I can only do my usual work, but no more.            C I can do most of my usual work, but no more.            D I cannot do my usual work.            E I can hardly do any work at all.            F I cannot do any work at all.</p>
<p><b>SECTION 3 - Lifting</b></p> <p>A I can lift heavy weights without extra pain.            B I can lift heavy weights, but it gives extra pain.            C Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned, for example, on a table.            D Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.            E I can lift very light weights.            F I cannot lift or carry anything at all.</p>	<p><b>SECTION 8 - Driving</b></p> <p>A I can drive my car without any neck pain.            B I can drive my car as long as I want with slight pain in my neck.            C I can drive my car as long as I want with moderate pain in my neck.            D I cannot drive my car as long as I want because of moderate pain in my neck.            E I can hardly drive at all because of severe pain in my neck.            F I cannot drive my car at all.</p>
<p><b>SECTION 4 - Reading</b></p> <p>A I can read as much as I want to with no pain in my neck.            B I can read as much as I want to with slight pain in my neck.            C I can read as much as I want to with moderate pain in my neck.            D I cannot read as much as I want because of moderate pain in my neck.            E I cannot read as much as I want because of severe pain in my neck.            F I cannot read at all.</p>	<p><b>SECTION 9 - Sleeping</b></p> <p>A I have no trouble sleeping.            B My sleep is slightly disturbed (less than 1 hour sleepless).            C My sleep is mildly disturbed (1-2 hours sleepless).            D My sleep is moderately disturbed (2-3 hours sleepless).            E My sleep is greatly disturbed (3-5 hours sleepless).            F My sleep is completely disturbed (5-7 hours)</p>
<p><b>SECTION 5 - Headaches</b></p> <p>A I have no headaches at all.            B I have slight headaches which come infrequently.            C I have moderate headaches which come infrequently.            D I have moderate headaches which come frequently.            E I have severe headaches which come frequently.            F I have headaches almost all the time.</p>	<p><b>SECTION 10 - Recreation</b></p> <p>A I am able to engage in all of my recreational activities with no neck pain at all.            B I am able to engage in all of my recreational activities with some pain in my neck.            C I am able to engage in most, but not all of my recreational activities because of pain in my neck.            D I am able to engage in a few of my recreational activities because of pain in my neck.            E I can hardly do any recreational activities because of pain in my neck.            F I cannot do any recreational activities at all.</p>

## NECK DISABILITY QUESTIONNAIRE

**Pain Severity Scale:** Rate the severity of your pain by checking one box on the following scale

No pain	1	2	3	4	5	6	7	8	9	10	Extreme Pain
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