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. What is easier for you to do? (check those indicated)
   ☐ Walking ☐ Riding ☐ Working ☐ Bending
   ☐ Standing ☐ Sitting ☐ Lifting ☐ Same

8. Is there any other condition(s) 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(s) 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 our clinic is always appreciated. Please comment on any areas where the Doctor or Staff may improve. _____
    _____
    _____

_____
Patient's Signature

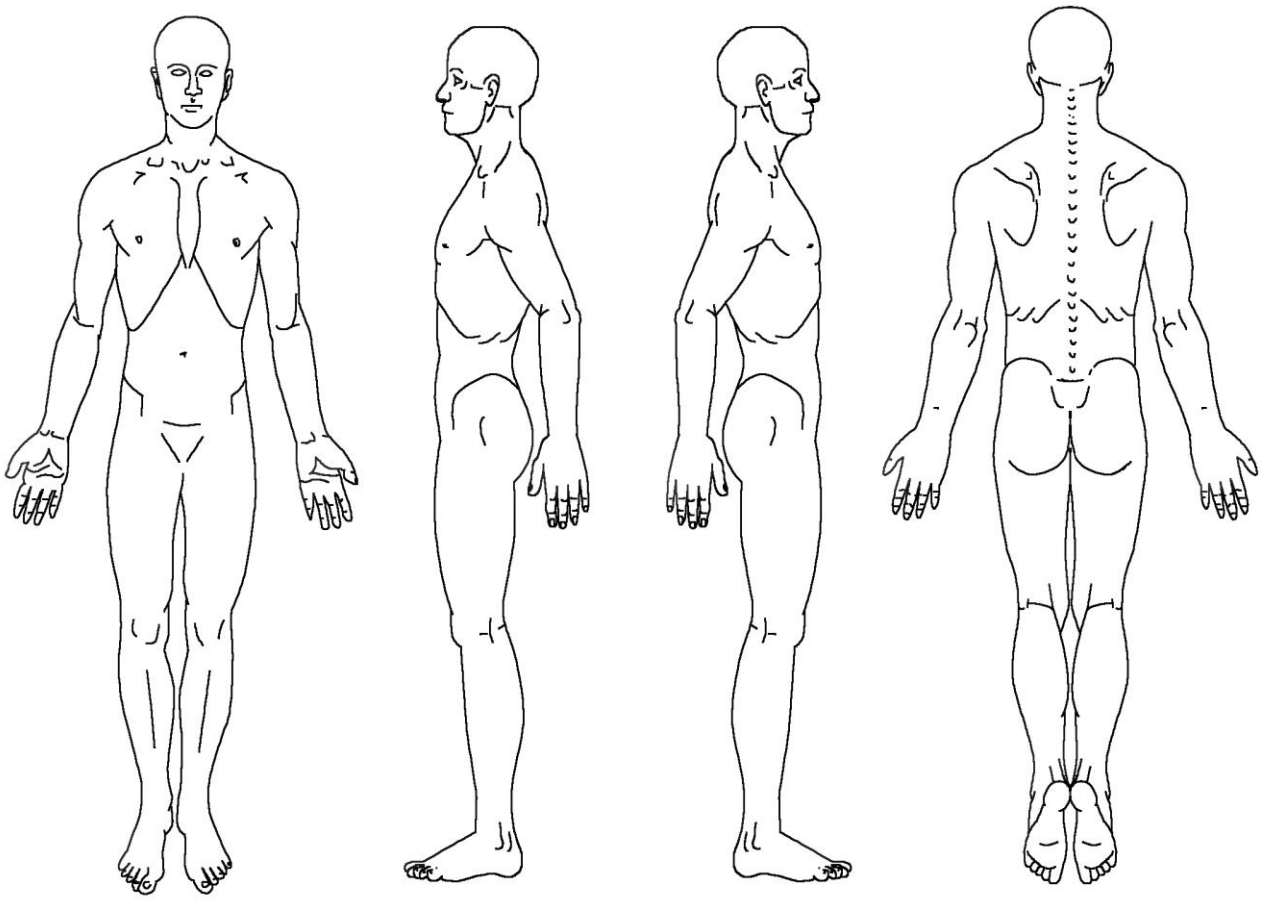
KNIGHT *Family* CHIROPRACTIC

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.

ACHE	BURNING	NUMBNESS	PINS & NEEDLES	STABBING	OTHER
≈≈	====	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

_____

KNIGHT *Family* CHIROPRACTIC

BACK BOURNEMOUTH QUESTIONNAIRE

Patient Name _____ Date _____

Instructions: The following scales have been designed to find out about your back pain and how it is affecting you. Please answer ALL the scales, and mark the ONE number on EACH scale that best describes how you feel.

1. Over the past week, on average, how would you rate your back pain?

No pain — Worst pain possible

0 1 2 3 4 5 6 7 8 9 10

2. Over the past week, how much has your back pain interfered with your daily activities (housework, washing, dressing, walking, climbing stairs, getting in/out of bed/chair)?

No interference — Unable to carry out activity

0 1 2 3 4 5 6 7 8 9 10

3. Over the past week, how much has your back pain interfered with your ability to take part in recreational, social, and family activities?

No interference — Unable to carry out activity

0 1 2 3 4 5 6 7 8 9 10

4. Over the past week, how anxious (tense, uptight, irritable, difficulty in concentrating/relaxing) have you been feeling?

Not at all anxious — Extremely anxious

0 1 2 3 4 5 6 7 8 9 10

5. Over the past week, how depressed (down-in-the-dumps, sad, in low spirits, pessimistic, unhappy) have you been feeling?

Not at all depressed — Extremely depressed

0 1 2 3 4 5 6 7 8 9 10

6. Over the past week, how have you felt your work (both inside and outside the home) has affected (or would affect) your back pain?

Have made it no worse — Have made it much worse

0 1 2 3 4 5 6 7 8 9 10

7. Over the past week, how much have you been able to control (reduce/help) your back pain on your own?

Completely control it — No control whatsoever

0 1 2 3 4 5 6 7 8 9 10

_____
Examiner:

OTHER COMMENTS:

_____

With Permission from: Bolton JE, Breen AC: The Bournemouth Questionnaire: A Short-form Comprehensive Outcome Measure. I. Psychometric Properties in Back Pain Patients. *JMPT* 1999; 22 (9): 503-510.

KNIGHT Family CHIROPRACTIC

NECK BOURNEMOUTH QUESTIONNAIRE

Patient Name _____ Date _____

Instructions: The following scales have been designed to find out about your neck pain and how it is affecting you. Please answer ALL the scales, and mark the ONE number on EACH scale that best describes how you feel.

1. Over the past week, on average, how would you rate your neck pain?

No pain — Worst pain possible

0 1 2 3 4 5 6 7 8 9 10

2. Over the past week, how much has your neck pain interfered with your daily activities (housework, washing, dressing, lifting, reading, driving)?

No interference — Unable to carry out activity

0 1 2 3 4 5 6 7 8 9 10

3. Over the past week, how much has your neck pain interfered with your ability to take part in recreational, social, and family activities?

No interference — Unable to carry out activity

0 1 2 3 4 5 6 7 8 9 10

4. Over the past week, how anxious (tense, uptight, irritable, difficulty in concentrating/relaxing) have you been feeling?

Not at all anxious — Extremely anxious

0 1 2 3 4 5 6 7 8 9 10

5. Over the past week, how depressed (down-in-the-dumps, sad, in low spirits, pessimistic, unhappy) have you been feeling?

Not at all depressed — Extremely depressed

0 1 2 3 4 5 6 7 8 9 10

6. Over the past week, how have you felt your work (both inside and outside the home) has affected (or would affect) your neck pain?

Have made it no worse — Have made it much worse

0 1 2 3 4 5 6 7 8 9 10

7. Over the past week, how much have you been able to control (reduce/help) your neck pain on your own?

Completely control it — No control whatsoever

0 1 2 3 4 5 6 7 8 9 10

_____
Examiner

OTHER COMMENTS: _____

With Permission from: Bolton JE, Humphreys BK: The Bournemouth Questionnaire: A Short-form Comprehensive Outcome Measure. II. Psychometric Properties in Neck Pain Patients. *JMPT* 2002; 25 (3): 141-148.