

# Chiropractic Outcomes Results-at-a-Glance - Baseline Visit



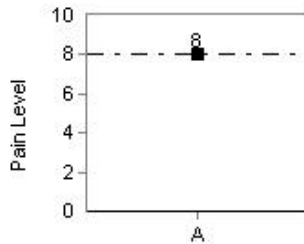
**Name:** \_\_\_\_\_  
**ID Number:** 000000000029  
**Date Tested:** 5/18/2006 5:33:29 PM

**Visit:** Baseline  
**Age:** 43  
**Gender:** Female

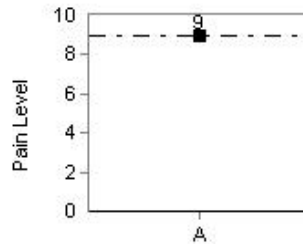
## Medical History Summary

Alcoholism: Yes | Breast Lump: Yes | Migraine Headaches: Yes |

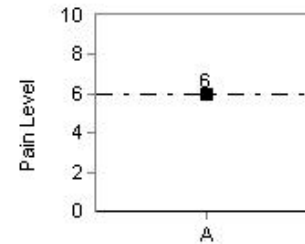
## Quadruple VAS Summary



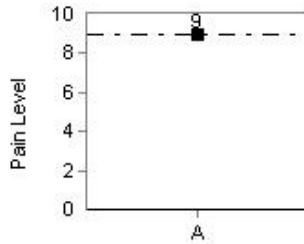
Pain Right Now



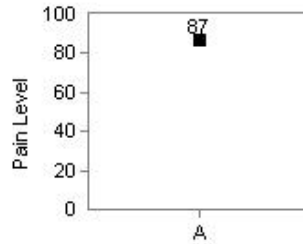
Typical or Average Pain



Pain Level at its Best



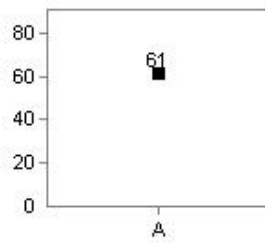
Pain Level at its Worst



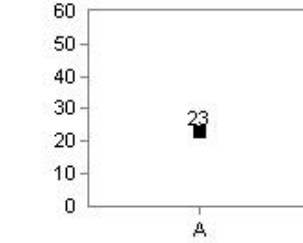
Total Score

**Legend**  
A - 5/18/2006 5:33:29 PM

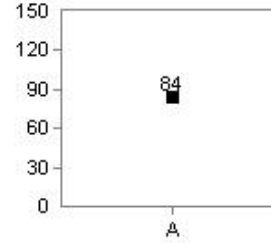
## Pain Disability Questionnaire Summary



Functional Status Component



Psychosocial Status Component

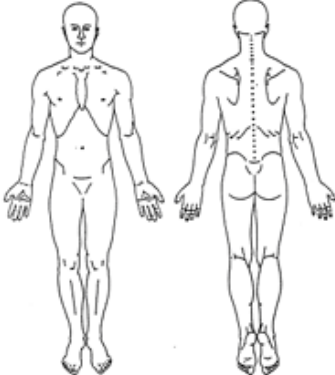


Total PDQ Score

**Legend**  
A - 5/18-2006 5:33:29 PM

Chiropractic Registration and History

ID Number: 00000000029 Date Tested: 5/18/2006 5:22:00 PM Date Uploaded: 5/18/2006 5:33:29 PM

<p><b>PATIENT INFORMATION</b></p> <p>Patient Name: _____                  Name: Last Name _____                  First Name Middle Initial _____                  Address: _____                  City: _____                  State: _____ Zip: _____                  E-mail: _____                  Sex: Female Age: 43                  Birthdate: _____                  Marital Status: _____                  Occupation: _____                  Patient Employer/School: _____                  Employer/School Address: _____                  Employer/School Phone: _____                  Spouse's Name: _____                  Birthdate: _____                  SS#: _____                  Spouse's Employer: _____                  Whom may we think for referring you? _____</p> <p><b>PHONE NUMBERS</b></p> <p>Home Phone _____ Cell Phone _____                  Best time and place to reach you _____</p> <p><b>IN CASE OF EMERGENCY, CONTACT</b></p> <p>Name _____ Relationship _____                  Home Phone _____ Work Phone _____</p>	<p><b>INSURANCE</b></p> <p>Who is responsible for this account? _____                  Relationship to Patient: _____                  Insurance Co: _____                  Group #: _____                  Is patient covered by additional insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No                  Subscriber's Name _____                  Birthdate: _____ SS#: _____                  Relationship to Patient: _____                  Insurance Co. _____                  Group # _____</p> <p><b>ASSIGNMENT AND RELEASE</b></p> <p>I certify that I, and/or my dependent(s), have insurance coverage with _____ and assign directly to _____                  Name of Insurance Company(ies) _____                  Dr. _____ all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.                  The above-named doctor may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.</p> <p>_____                  Signature of Patient, Parent, Guardian or Personal Representative</p> <p>_____                  Please print name of Patient, Parent, Guardian or Personal Representative</p> <p>_____                  Date Relationship to Patient _____</p>
<p><b>ACCIDENT INFORMATION</b></p> <p>Is condition due to an accident? <input type="checkbox"/> Yes <input type="checkbox"/> No Date _____                  Type of accident: <input type="checkbox"/> Auto <input type="checkbox"/> Work <input type="checkbox"/> Home <input type="checkbox"/> Other                  To whom have you made a report of your accident?  <input type="checkbox"/> Auto Insurance <input type="checkbox"/> Employer <input type="checkbox"/> Worker Comp. <input type="checkbox"/> Other                  Attorney Name (if applicable) _____</p> <p><b>PATIENT CONDITION</b></p> <p>Mark an X on the picture where you continue to have pain, numbness, or tingling.                  Reason for Visit: Low Back Pain/Stiffness                  When did your symptoms appear? 2-4 weeks ago                  Is this condition getting progressively worse? Yes                  Does it interfere with your: <input checked="" type="checkbox"/> Work <input checked="" type="checkbox"/> Sleep <input type="checkbox"/> Daily Routine <input type="checkbox"/> Recreation                  Activities or movements that are painful to perform: <input type="checkbox"/> Sitting <input type="checkbox"/> Standing <input type="checkbox"/> Walking <input type="checkbox"/> Bending <input type="checkbox"/> Lying Down</p>	

ID Number: 00000000029

Age: 43

Date Tested: 5/18/2006 5:22:00 PM

What treatment have you already received for your condition?  Medications  Surgery  Physical Therapy  
 Chiropractic Services  None  Other \_\_\_\_\_

Name and address of other doctor(s) who have treated you for your condition: \_\_\_\_\_

Date of

Last: Physical Exam \_\_\_\_\_ Spinal X-Ray \_\_\_\_\_ Blood Test \_\_\_\_\_  
 Spinal Exam \_\_\_\_\_ Chest X-Ray \_\_\_\_\_ Urine Test \_\_\_\_\_  
 Dental X-Ray \_\_\_\_\_ MRI, CT-Scan, Bone Scan \_\_\_\_\_

	Yes	No		Yes	No		Yes	No
AIDS/HIV	<input type="checkbox"/>	<input checked="" type="checkbox"/>	Chicken Pox	<input type="checkbox"/>	<input checked="" type="checkbox"/>	Liver Disease	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Alcoholism	<input checked="" type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input checked="" type="checkbox"/>	Measles	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Allergy Shots	<input type="checkbox"/>	<input checked="" type="checkbox"/>	Emphysema	<input type="checkbox"/>	<input checked="" type="checkbox"/>	Migraine Headaches	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Anemia	<input type="checkbox"/>	<input checked="" type="checkbox"/>	Epilepsy	<input type="checkbox"/>	<input checked="" type="checkbox"/>	Miscarriage	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Anorexia	<input type="checkbox"/>	<input checked="" type="checkbox"/>	Fractures	<input type="checkbox"/>	<input checked="" type="checkbox"/>	Mononucleosis	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Appendicitis	<input type="checkbox"/>	<input checked="" type="checkbox"/>	Glaucoma	<input type="checkbox"/>	<input checked="" type="checkbox"/>	Multiple Sclerosis	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Arthritis	<input type="checkbox"/>	<input checked="" type="checkbox"/>	Goiter	<input type="checkbox"/>	<input checked="" type="checkbox"/>	Mumps	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Asthma	<input type="checkbox"/>	<input checked="" type="checkbox"/>	Gonorrhea	<input type="checkbox"/>	<input checked="" type="checkbox"/>	Osteoporosis	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Bleeding Disorders	<input type="checkbox"/>	<input checked="" type="checkbox"/>	Gout	<input type="checkbox"/>	<input checked="" type="checkbox"/>	Pacemaker	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Breast Lump	<input checked="" type="checkbox"/>	<input type="checkbox"/>	Heart Disease	<input type="checkbox"/>	<input checked="" type="checkbox"/>	Parkinson's Disease	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Bronchitis	<input type="checkbox"/>	<input checked="" type="checkbox"/>	Hepatitis	<input type="checkbox"/>	<input checked="" type="checkbox"/>	Pinched Nerve	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Bulimia	<input type="checkbox"/>	<input checked="" type="checkbox"/>	Hernia	<input type="checkbox"/>	<input checked="" type="checkbox"/>	Pneumonia	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Cancer	<input type="checkbox"/>	<input checked="" type="checkbox"/>	Herniated Disk	<input type="checkbox"/>	<input checked="" type="checkbox"/>	Polio	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Cataracts	<input type="checkbox"/>	<input checked="" type="checkbox"/>	Herpes	<input type="checkbox"/>	<input checked="" type="checkbox"/>	Prostate Problem	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Chemical Dependency	<input type="checkbox"/>	<input checked="" type="checkbox"/>	High Cholesterol	<input type="checkbox"/>	<input checked="" type="checkbox"/>	Prosthesis	<input type="checkbox"/>	<input checked="" type="checkbox"/>
			Kidney Disease	<input type="checkbox"/>	<input checked="" type="checkbox"/>	Psychiatric Care	<input type="checkbox"/>	<input checked="" type="checkbox"/>
						Other _____	<input type="checkbox"/>	<input checked="" type="checkbox"/>
						_____	<input type="checkbox"/>	<input checked="" type="checkbox"/>

EXERCISE

None  
 Moderate  
 Daily  
 Heavy

WORK ACTIVITY

Sitting  
 Standing  
 Light Labor  
 Heavy Labor

HABITS

Smoking  
 Alcohol  
 Coffee/Caffeine Drinks  
 High Stress Level

Packs/Day \_\_\_\_\_  
 Drinks/Week 06  
 Cups/Day 04  
 Reason Work

Are you pregnant?  Yes  No Due Date \_\_\_\_\_

Injuries/Surgeries you have had

Description

Date

Falls \_\_\_\_\_  
 Head Injuries \_\_\_\_\_  
 Broken Bones \_\_\_\_\_  
 Dislocations \_\_\_\_\_  
 Surgeries \_\_\_\_\_

MEDICATIONS

ALLERGIES

VITAMINS/HERBS/MINERALS

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Pharmacy Name \_\_\_\_\_  
 Pharmacy Phone \_\_\_\_\_

**McGill Short Form Questionnaire**

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

Age: 43

ID Number: 000000000029

Reviewed by: \_\_\_\_\_

Date Tested: 5/18/2006 5:22:00 PM

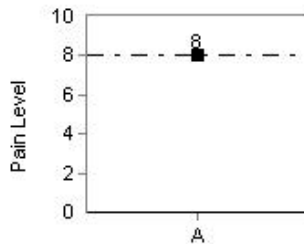
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	<b>Sensory Pain Rating Index (S-PRI)</b>	<b>6</b>
	<b>Affective Pain Rating Index (A-PRI)</b>	<b>3</b>
	<b>Total Pain Rating Index (T-PRI)</b>	<b>4</b>
S1.	Throbbing	<b>Moderate</b>
S2.	Shooting	Mild
S3.	Stabbing	Mild
S4.	Sharp	Mild
S5.	Cramping	Mild
S6.	Gnawing	<b>Severe</b>
S7.	Hot-Burning	Mild
S8.	Aching	<b>Severe</b>
S9.	Heavy	None
S10.	Tender	Mild
S11.	Splitting	<b>Severe</b>
S12.	Tiring-Exhausting	None
S13.	Sickening	None
S14.	Fearful	<b>Moderate</b>
S15.	Punishing-Cruel	None
S16.	Mark your average pain on the line.	<b>8</b>
S17.	Please indicate which statement best describes your pain.	<b>Distressing</b>

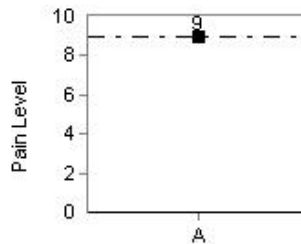
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## Quadruple Visual Analogue Scale

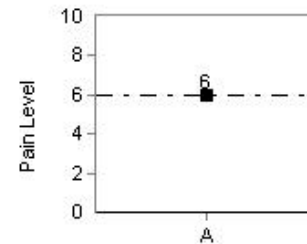
Name: \_\_\_\_\_ Visit: Baseline  
 ID Number: 000000000029 Age: 43  
 Date Tested: 5/18/2006 5:33:29 PM Gender: Female



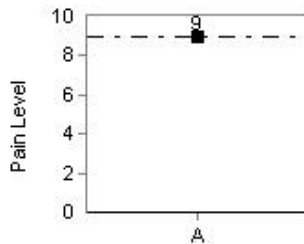
Pain Right Now



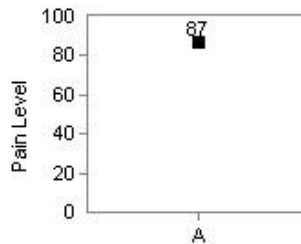
Typical or Average Pain



Pain Level at its Best



Pain Level at its Worst



Total Score

### Legend

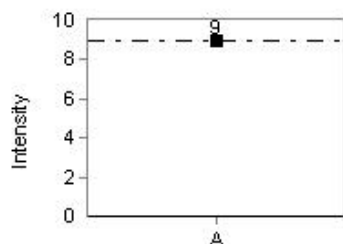
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### Quadruple Visual Analogue Scale Responses:

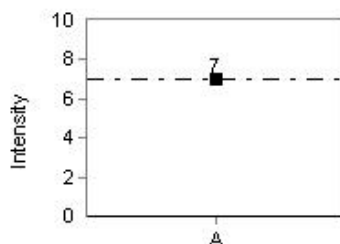
- |    |   |   |
|----|---|---|
| 1. | Please indicate your pain level RIGHT NOW?    | 8 |
| 2. | Please indicate your TYPICAL or AVERAGE pain: | 9 |
| 3. | What is your pain level AT ITS BEST?          | 6 |
| 4. | What is your pain level AT ITS WORST?         | 9 |

## Bournemouth Back Questionnaire Report

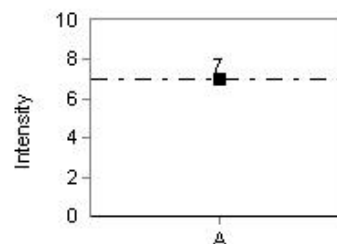
Name: \_\_\_\_\_ Visit: Baseline  
 ID Number: 000000000029 Age: 43  
 Date Tested: 5/18/2006 5:33:29 PM Gender: Female



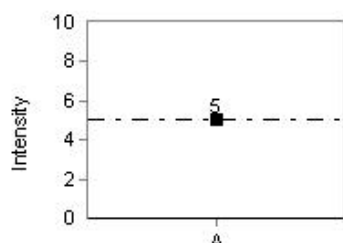
Average Back Pain



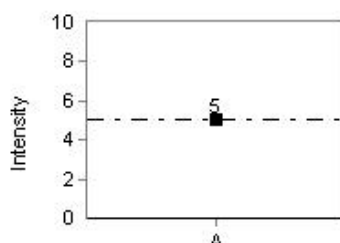
Back Pain: Daily Activity



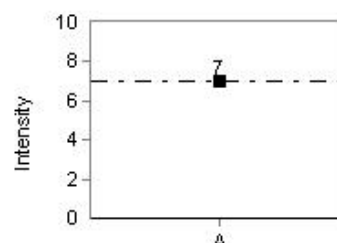
Back Pain: Social Activity



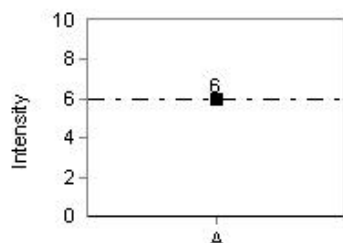
Anxiety



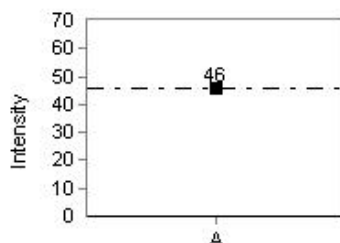
Depression



Back Pain: Work



Back Pain: Control



Total Score

### Legend

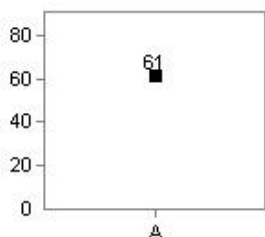
A -5/18/ 5:33:29 PM

### Bournemouth Back Item Responses:

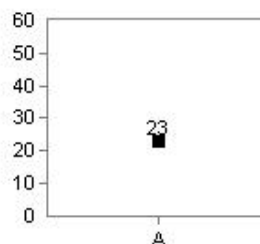
- |   |   |
|---|---|
| 1. Over the past week, on average, how would you rate your back pain?   | 9 |
| 2. Over the past week, how much has your back pain interfered with your daily activities (housework, washing, dressing, walking, climbing stairs, getting in/out of bed/chair)? | 7 |
| 3. Over the past week, how much has your back pain interfered with your ability to take part in recreational, social, and family activities?                                    | 7 |
| 4. Over the past week, how anxious (tense, uptight, irritable, difficulty in concentrating/ relaxing) have you been feeling?  | 5 |
| 5. Over the past week, how depressed (down-in-the-dumps, sad, in low spirits, pessimistic, unhappy) have you been feeling?  | 5 |
| 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?  | 7 |
| 7. Over the past week, how much have you been able to control (reduce/help) your back pain on your own?   | 6 |

## Pain Disability Questionnaire Report

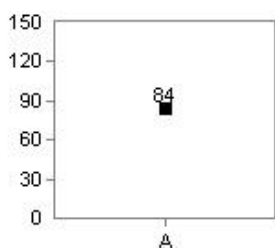
Name: \_\_\_\_\_ Visit: Baseline  
 ID Number: 000000000029 Age: 43  
 Date Tested: 5/18/2006



Functional Status Component



Psychosocial Status Component



Total PDQ Score

### Legend

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### Pain Disability Questionnaire Responses:

1.	Does your pain interfere with your normal work inside and outside the home?	7
2.	Does your pain interfere with personal care (such as washing, dressing, etc.)?	7
3.	Does your pain interfere with your traveling?	5
4.	Does your pain affect your ability to sit or stand?	7
5.	Does your pain affect your ability to lift overhead, grasp objects, or reach for things?	8
6.	Does your pain affect your ability to lift objects off the floor, bend, stoop, or squat?	8
7.	Does your pain affect your ability to walk or run?	6
8.	Has your income declined since your pain began?	2
9.	Do you have to take pain medication every day to control your pain?	1
10.	Does your pain force you to see doctors much more often than before your pain began?	6
11.	Does your pain interfere with your ability to see the people who are important to you as much as you would like?	2
12.	Does your pain interfere with recreational activities and hobbies that are important to you?	7
13.	Do you need the help of your family and friends to complete everyday tasks (including both work outside the home and housework) because of your pain?	6
14.	Do you now feel more depressed, tense, or anxious than before your pain began?	5
15.	Are there emotional problems caused by your pain that interfere with your family, social, or work activities?	7

## RAND 36 Intake Report

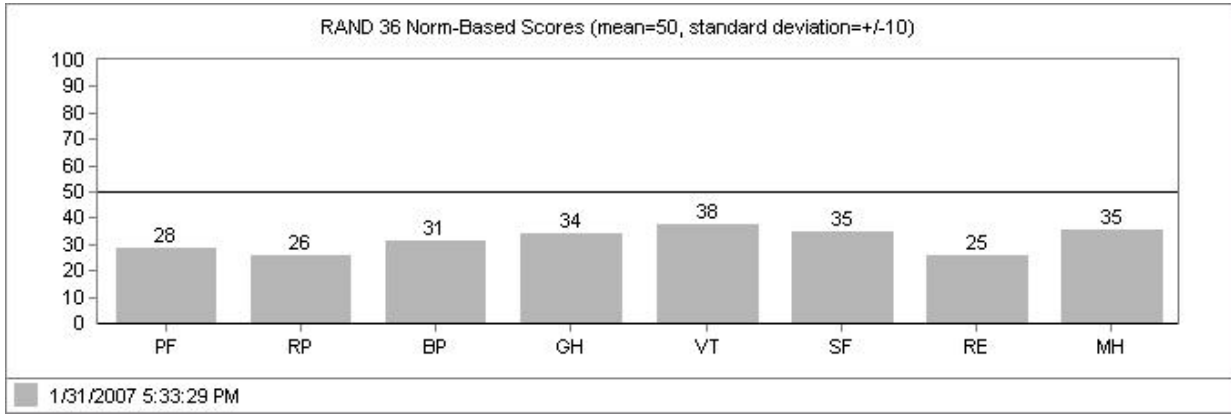
Name: \_\_\_\_\_

ID Number: 000000000029

Age: 43

Date Tested: 5/18/2006 5:33:29 PM

Gender: Female



### RAND 36 Item Responses:

<b>Health in general</b>	Fair	<b>EP - Did activities less carefully</b>	Yes
<b>Health compare to year ago</b>	Somewhat worse now than one year ago	<b>Physical or emotional interfered</b>	Quite a bit
<b>Vigorous activities</b>	Yes, limited a lot	<b>Bodily pain past 4 weeks</b>	Moderate
<b>Moderate activities</b>	Yes, limited a lot	<b>Pain interfere with normal work</b>	Quite a bit
<b>Lifting or carrying groceries</b>	Yes, limited a little	<b>Did you feel full of pep</b>	Some of the time
<b>Climbing several flights</b>	Yes, limited a little	<b>Have you been very nervous</b>	Most of the time
<b>Climbing one flight of stairs</b>	Yes, limited a little	<b>Down in the dumps</b>	Some of the time
<b>Bending, kneeling, or stooping</b>	Yes, limited a lot	<b>Have you felt calm and peaceful</b>	Some of the time
<b>Walking more than a mile</b>	Yes, limited a little	<b>Did you have a lot of energy</b>	A little of the time
<b>Walking several blocks</b>	Yes, limited a little	<b>Have you felt downhearted/depressed</b>	A little of the time
<b>Walking one block</b>	Yes, limited a little	<b>Did you feel worn out</b>	Most of the time
<b>Bathing or dressing yourself</b>	Yes, limited a little	<b>Have you been happy</b>	Some of the time
<b>PH - Cut down the amount of time</b>	Yes	<b>Did you feel tired</b>	Some of the time
<b>PH - Accomplished less would like</b>	Yes	<b>Physical/emotional interfer social</b>	A little of the time
<b>PH - Were limited in the kind of work</b>	Yes	<b>Get sick a little easier than others</b>	Mostly false
<b>PH - Had difficulty performing</b>	Yes	<b>I am as healthy as anybody I know</b>	Don't know
<b>EP - Cut down the amount of time</b>	Yes	<b>I expect my health to get worse</b>	Mostly true
<b>EP - Accomplished less would like</b>	Yes	<b>My health is excellent</b>	Mostly false

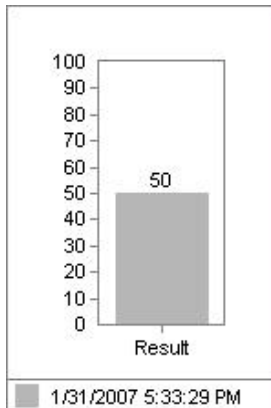
## Oswestry Intake Report

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

ID Number: 000000000029

Date Tested: 5/18/2006 5:22:00 PM

Reviewed by: \_\_\_\_\_



### Oswestry Item Responses:

<b>Pain Intensity</b>	Pain medication provides me with moderate relief from pain.
<b>Personal Care</b>	I can take care of myself normally, but it increases my pain.
<b>Lifting</b>	I can lift only very light weights.
<b>Walking</b>	Pain prevents me from walking more than 1/4 mile.
<b>Sitting</b>	Pain prevents me from sitting for more than 1 hour.
<b>Standing</b>	Pain prevents me from standing for more than 1 hour.
<b>Sleeping</b>	Even when I take medication, I sleep less than 4 hours.
<b>Social Life</b>	Pain prevents me from going out very often.
<b>Traveling</b>	I can travel anywhere, but it increases my pain.
<b>Employment / Homemaking</b>	Pain prevents me from doing anything but light duties.

Note: Item responses are from the most recent test administration.