



Supplemental Report Questionnaire

Please Print

Last Name _____ First Name _____ Date _____ Acct# _____

Your number-one problem at the time of your last exam was: Neck Pain Mid-back Pain Low back Pain
 Headache Leg Pain (R L) Arm Pain (R L) Other: _____

At that time you rated the level of pain as: 0 1 2 3 4 5 6 7 8 9 10

1. What is your number-one problem or the one area of greatest pain NOW? _____
2. Please rate the CURRENT level of this pain on the following scale: 0 is no pain, 10 is severe pain or the worst pain you have ever felt. If your pain varies from day-to-day, please circle two numbers to indicate a range of your pain. 0 1 2 3 4 5 6 7 8 9 10
3. How often do you experience the pain? 1-2 hours per day About half of the day Most of the day The pain never goes away
4. How does the pain effect your daily activities?
 It does not affect my daily activities I have had to change how I do things
 I have had to stop doing some of my daily activities I am unable to perform daily activities
5. If you have changed the way you do things or have stopped doing any of your daily activities due to the pain please explain: _____

6. What increases your pain? _____
7. What decreases your pain? _____

8. At the time of your last exam you listed other complaint(s) with the follow level(s) of pain:
- a. _____ 0 1 2 3 4 5 6 7 8 9 10
 - b. _____ 0 1 2 3 4 5 6 7 8 9 10
 - c. _____ 0 1 2 3 4 5 6 7 8 9 10
 - d. _____ 0 1 2 3 4 5 6 7 8 9 10

- Please list any other complaints you have NOW and rate your pain level for each.
- a. _____ 0 1 2 3 4 5 6 7 8 9 10
 - b. _____ 0 1 2 3 4 5 6 7 8 9 10
 - c. _____ 0 1 2 3 4 5 6 7 8 9 10
 - d. _____ 0 1 2 3 4 5 6 7 8 9 10

9. How much improvement have you noticed since your last examination?
 Unchanged Less than 50% More than 50% I feel excellent!

Have you noticed any positive change(s) since your last examination? Y N
Please explain: _____

10. Is there anything the doctor has not addressed that you would like him to evaluate further? _____

11. Are you pleased with your treatment here? Y N
Please explain: _____

12. Please add anything else you would like the doctor to know: _____

Patient's Signature _____ Date _____