Name: _____ Date: _____ **Office use**

File No: _____

Practitioner: _____

How many visits have you had with us since your first appointment for this current episode of your problem.
Please include this first appointment and if you are not sure give an approximation: _____

Indicate for each of the statements which number best describes your pain\complaint and how it has affected you **over the past few days:**

1) Over the past few days on average, how would you rate your pain/complaint?

*no pain* **0 1 2 3 4 5 6 7 8 9 10** *worst pain possible*

2) Over the past few days on average, how has your pain/complaint interfered with your daily activities (housework, washing, dressing, and sleeping)?

*no interference* **0 1 2 3 4 5 6 7 8 9 10** *completely unable to carry on*

3) Over the past few days, on average, how has your pain/complaint interfered with your normal social routine including recreational, social and family activities?

*no interference* **0 1 2 3 4 5 6 7 8 9 10** *completely unable to participate in any activity*

4) Over the past few days, on average, how anxious (uptight, tense, irritable, difficulty in relaxing/concentrating) have you been feeling?

*not at all anxious* **0 1 2 3 4 5 6 7 8 9 10** *extremely anxious*

5) Over the past few days, on average, how depressed (down-in-the-dumps, sad, low in spirits, pessimistic, lethargic) have you been feeling?

*not depressed* **0 1 2 3 4 5 6 7 8 9 10** *extremely depressed*

6) Over the past few days, on average, how do you think your work (both inside the home and/or employed work) have affected your pain/complaint?

*make it no worse* **0 1 2 3 4 5 6 7 8 9 10** *make it very much worse*



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**7)** Over the past few days, on average, how have you been able to control (help/reduce) and cope with your pain/complaint on your own?

*I can control it completely* **0 1 2 3 4 5 6 7 8 9 10** *I have no control whatsoever*

**Please use the space below to add any further comments you would like to make.**

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How would you describe your pain/complaint now, compared to how you were when you completed the questionnaire before your first visit to this clinic?
Please select one of the following:

**1)** Completely recovered.
**2)** Much improved.
**3)** Slightly improved.
**4)** No change.
**5)** Slightly worsened.
**6)** Much worsened.
**7)** Worse than ever.

**if there is anything else you would like to tell us, either about how your problem has progressed or about the care or service you received from us please use the space below.**