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: ____________

You previously recorded symptom 1 (as written below) as the most important in relation to your condition. Please circle on a score below to indicate how bad this symptom has been **over the last week** on a scale of 0 to 6, with **0** being **'as good as it can be'** and **6** being as **'bad as it can be'**.

Symptom 1 ___________________________

as good as it can be **0 1 2 3 4 5 6** *as bad as it can be*

You previously recorded symptom 2 (as written below) as a second symptom associated with your condition. Please circle on a score below to indicate how bad this symptom has been **over the last week** on a scale of 0 to 6, with **0** being **'as good as it can be'** and **6** being as **'bad as it can be'**.

Symptom 2 ___________________________

as good as it can be **0 1 2 3 4 5 6** *as bad as it can be*

If another symptomhas arisen (physical or mental) which you feel is associated with your condition, Please circle on a score below to indicate how bad this symptom has been **over the last week**.

Additional Symptom ___________________________

as good as it can be **0 1 2 3 4 5 6** *as bad as it can be*

You previously recorded the activity (as written below) as something your symptom/s prevent or interfere with. Please circle on a score below to indicate how badly this activity has been affected **over the last week** on a scale of 0 to 6, with **0** being **'as good as it can be'** and **6** being as **'bad as it can be'**.

Activity ___________________________

as good as it can be **0 1 2 3 4 5 6** *as bad as it can be*

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Finally. please circle on a score below to indicate your general wellbeing i.e. how you feel in yourself.

as good as it can be **0 1 2 3 4 5 6** *as bad as it can be*

The treatment you are receiving may not be the only thing affecting your problem. If there is anything else that you think is improtant, such as changes you have made yourself, or other things happening in your life, **Please enter in the space below.**

Are you taking medication **for this problem?** **Yes / No**

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.