Sellari Chiropractic Center, P.C. ▪ 1594 Route 130, North Brunswick, NJ 08902 ▪ 732 821-5900

# PATIENT FOLLOW-UP QUESTIONNAIRE

Name: _____ No.: _____ Date: _____

Initial Exam Date: _____ Most Recent Re-examination: _____

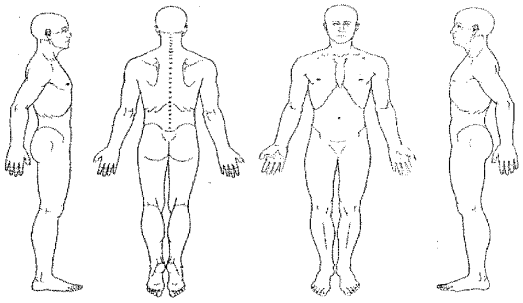
***TO BE COMPLETED BY PATIENT:***

What percentage (%) of you original symptoms do you still have?

□ 10% □ 30% □ 50% □ 70 % □ 90%
□ 20% □ 40% □ 60 % □ 80% □ 100%

What are your present complaints? _____

Please mark the location of your pain on the figures below:



On the scale below, rate your pain intensity by circling the appropriate number: 0= no pain, 10 = unbearable pain.

| 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
|---|---|---|---|---|---|---|---|---|---|

How often do you experience your symptoms?

□ Constantly (76-100% of the day) □ Frequently (51-75% of the day)
□ Occasionally (26-50% of the day) □ Intermittently (0-25% of the day)

To what degree do your symptoms interfere with your daily activities?

| 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
|---|---|---|---|---|---|---|---|---|---|---|
| No Symptoms | | Mild Forgotten with activity | | Moderate interferes with activity | | Limiting Prevents Full activity | | Intense preoccupied with pain | | Severe no activity possible |

My symptoms interfere with my: □ Sleep □ Work □ Personal Care □ Social life □ Recreation □ None of these

Currently your pain is aggravated by:

□ Coughing □ Neck Movements □ Bending □ Walking
□ Sneezing □ Reaching □ Lifting □ other:_____
□ Straining at Stool □ Sitting □ Standing □ None of these

Since your symptoms began, have you noticed a change in:
□ Bowel function □ Bladder Function □ Ability to maintain and erection □ None of these

Since your last examination, have you had any?
□ Accidents □ Illnesses □ Treatments or examination elsewhere □ None of these
If so, what/where? _____

Do you have any questions regarding your care? □ Yes □ No

_____
Patient's Signature