Springbrook Chiropractic/ Dr. John J. Collins 420 Villa Road Newberg, OR 97132
www.LifeRealigned.com 503-538-0618 fax: 503-537-2539

***Wellness Behaviors Questionnaire:*** *Select the answer that seems most correct.*

1-I **regularly eat** home-cooked meals with fruit, organic vegetables and meats, poultry or seafood.

100% Disagree ○ ○ ○ ○ ○ ○ ○ ○ ○ ○ ○ 100% Agree

2-I **rarely eat** fast food, processed food, added sugar, desserts, alcohol, caffeine or preservatives.

100% Disagree ○ ○ ○ ○ ○ ○ ○ ○ ○ ○ ○ 100% Agree

3- **Most days**, I walk, jog or run at least 10,000 steps/5 miles per day.

100% Disagree ○ ○ ○ ○ ○ ○ ○ ○ ○ ○ ○ 100% Agree

4- **At least a few times per week**: I move my entire body through its full range of motion and lift, carry, push or pull heavy objects/items/weights in ways that require much of my physical strength.

100% Disagree ○ ○ ○ ○ ○ ○ ○ ○ ○ ○ ○ 100% Agree

5- **Most nights**, I go to bed 'on time' and rarely need an alarm clock to wake me in time to start my day.

100% Disagree ○ ○ ○ ○ ○ ○ ○ ○ ○ ○ ○ 100% Agree

6- I have multiple supportive relationships with family, friends and others. I have one or more supportive social communities/networks (include extended family) and feel a strong sense of belonging.

100% Disagree ○ ○ ○ ○ ○ ○ ○ ○ ○ ○ ○ 100% Agree

7- I **do NOT smoke or use tobacco products**.

100% Disagree ○ ○ ○ ○ ○ ○ ○ ○ ○ ○ ○ 100% Agree

0 1 2 3 4 5 6 7 8 9 10

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**General Physical Function Questionnaire:** Please choose the answer that seems most correct.

**"Recently, because of my pain (or other symptoms for which I am seeking treatment) my ability to:**

SIT is:
- ❑ Not Limited 0
- ❑ Mildly Limited 1
- ❑ Moderately Limited 2
- ❑ Severely Limited 3

HOLD or CARRY things is:
- ❑ Not Limited
- ❑ Mildly Limited
- ❑ Moderately Limited
- ❑ Severely Limited

CARE FOR MYSELF is:
- ❑ Not Limited
- ❑ Mildly Limited
- ❑ Moderately Limited
- ❑ Severely Limited

STAND or WALK is:
- ❑ Not Limited
- ❑ Mildly Limited
- ❑ Moderately Limited
- ❑ Severely Limited

BEND or REACH is:
- ❑ Not Limited
- ❑ Mildly Limited
- ❑ Moderately Limited
- ❑ Severely Limited

SLEEP is:
- ❑ Not Limited
- ❑ Mildly Limited
- ❑ Moderately Limited
- ❑ Severely Limited

Print Patient Name:________________________ Signature:_________________________ Date: ___/___/___

This form is 2-sided

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Staff use only: WBQ Score ____/70 (0-70, 70=Perfect wellness behavior score)
GPFQ Score ____/18 (0=No functional limitation, 18=Highest possible functional limitation)

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Welcome!

Reason for visit (check one or more):

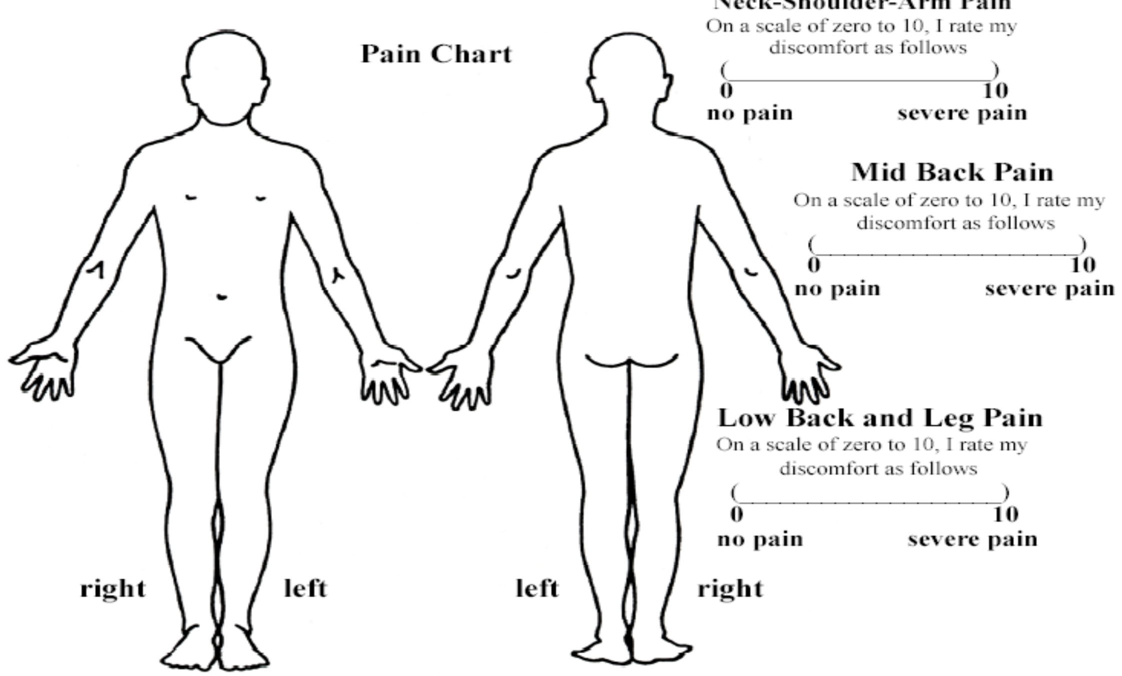
1- __ I am a new patient.
2- __ I am a former patient returning with a new problem (or reoccurrence of an old problem).
3- __ I am a current patient and this is a scheduled re-evaluation.

If you checked #1 or #2 briefly describe your reason for this visit: ______________________________
______________________________________________________________________________

If you checked #3, has your condition improved since your last exam? __Yes; __No; __ Don't know

Please mark, draw or fill in areas on the body picture (below) **where** you feel any PAIN OR OTHER SYMPTOMS. Mark areas of shooting pain too. Include headaches and any other symptoms that you might have. You can also write words and use arrows to describe your symptoms.

| Numbness | Pins & Needles | Burning | Aching | Stabbing |
|---|---|---|---|---|
| - - - - - | OOOOO | xxxxx | ***** | / / / / / |
| - - - - - | OOOOO | xxxxx | ***** | / / / / / |
| - - - - - | OOOOO | xxxxx | ***** | / / / / / |




Are you taking medications (prescription or non-prescription) to alleviate your symptoms? No. Yes.

If yes, what are you taking and how much? _______________________________________________.

In general, your MAIN symptoms are (circle one): Infrequent Occasional Frequent Constant

Print Patient Name: ______________________ Signature: ________________________ Date: ___/___/___

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# Revised Oswestry Pain Disability Questionnaire

Patient Name: ___________________________________ Date of birth: ___/___/_____ Date: ___/___/_____

**Please Read:**
This questionnaire has been designed to give your doctor/therapist information as to how your back pain has affected your ability to manage everyday life. Please answer every section, and mark in each section only the **one** box that best describes your condition today.

We realize you may feel that two of the statements in any one section relate to you, but please just mark the box which most closely describes your current condition.

***Section 1 – Pain Intensity***
- ☐ I can tolerate the pain I have without having to use pain medication.
- ☐ The pain is bad but I manage without having to take pain medication.
- ☐ Pain medication provides me complete relief from pain.
- ☐ Pain medication provides me moderate relief from pain.
- ☐ Pain medication provides me little relief from pain.
- ☐ Pain medication has no effect on the pain.

***Section 2 – Personal Care (Washing, Dressing, etc.)***
- ☐ I can take care of myself normally without causing increased pain.
- ☐ I can take care of myself normally but it increases my pain.
- ☐ It is painful to take care of myself and I am slow and careful.
- ☐ I need help but I am able to manage most of my personal care.
- ☐ I need help every day in most aspects of my care.
- ☐ I do not get dressed, wash with difficulty, and stay in bed.

***Section 3 – Lifting***
- ☐ I can lift heavy weights without increased pain.
- ☐ I can lift heavy weights but it causes increased pain.
- ☐ Pain prevents me from lifting heavy weights off the floor, but I can manage if weights are conveniently positioned, e.g. on a table.
- ☐ Pain prevents me from lifting heavy weights but I can manage light to medium weights if they are conveniently positioned.
- ☐ I can lift only very light weights.
- ☐ I cannot lift or carry anything at all.

***Section 4 – Walking***
- ☐ Pain does not prevent me walking any distance.
- ☐ Pain prevents me walking more than 1 mile.
- ☐ Pain prevents me walking more than ½ mile
- ☐ Pain prevents me walking more than ¼ mile
- ☐ I can only walk using crutches or a cane.
- ☐ I am in bed most of the time and have to crawl to the toilet.

***Section 5 – Sitting***
- ☐ I can sit in any chair as long as I like.
- ☐ I can only sit in my favorite chair as long as I like.
- ☐ Pain prevents me sitting more than 1 hour.
- ☐ Pain prevents me from sitting more than ½ hour.
- ☐ Pain prevents me from sitting more than 10 minutes.
- ☐ Pain prevents me from sitting at all.

***Section 6 – Standing***
- ☐ I can stand as long as I want without increased pain.
- ☐ I can stand as long as I want but it increases my pain.
- ☐ Pain prevents me from standing for more than 1 hour.
- ☐ Pain prevents me from standing for more than ½ hour.
- ☐ Pain prevents me from standing for more than 10 minutes.
- ☐ Pain prevents me from standing at all.

***Section 7 – Sleeping***
- ☐ Pain does not prevent me from sleeping well.
- ☐ I can sleep well only by using pain medication.
- ☐ Even when I take pain medication, I sleep less than 6 hours.
- ☐ Even when I take pain medication, I sleep less than 4 hours.
- ☐ Even when I take pain medication, I sleep less than 2 hours.
- ☐ Pain prevents me from sleeping at all.

***Section 8 – Social Life***
- ☐ My social life is normal and does not increase my pain.
- ☐ My social life is normal, but it increases my level of pain.
- ☐ Pain prevents me from participating in more energetic activities (ex. sports, dancing, etc.)
- ☐ Pain prevents me from going out very often.
- ☐ Pain has restricted my social life to my home.
- ☐ I have hardly any social life because of my pain.

***Section 9 – Traveling***
- ☐ I can travel anywhere without increased pain.
- ☐ I can travel anywhere but it increases my pain.
- ☐ Pain restricts travel over 2 hours.
- ☐ Pain restricts travel over 1 hour.
- ☐ Pain restricts my travel to short necessary journeys under ½ hour.
- ☐ Pain prevents all travel except for visits to the doctor/therapist or hospital.

***Section 10 – Employment/Homemaking***
- ☐ My normal homemaking/job activities do not cause pain.
- ☐ My normal homemaking/job activities increase my pain, but I can still perform all that is required of me.
- ☐ I can perform most of my homemaking/job duties, but pain prevents me from performing more physically stressful activities (ex. lifting, vacuuming).
- ☐ Pain prevents me from doing anything but light duties.
- ☐ Pain prevents me from doing even light duties.
- ☐ Pain prevents me from performing any job/homemaking chores.

Score (filled out by doctor/clinician): _________%