



Albany County Chiropractic Center
807 S. 3rd St., Laramie Wyoming 82070
(307) 742-6840
Kendra S. Sims, D.C., P.C.
Darren Bressler, D.C., P.C.



Date _____
 Name _____
 Patient Signature _____

Total Score _____

Functional Rating Index

For use with Neck and/or Back Problems only

In order to properly assess your condition, we must understand how much your neck and/or back problems have affected your ability to manage everyday activities. For each item below, please circle the number which most closely describes your condition right now.

1. Pain Intensity

0	1	2	3	4
No pain	Mild pain	Moderate pain	Severe pain	Worst possible pain

6. Walking

0	1	2	3	4
No pain; any distance	Increased pain after 1 mile	Increased pain after ½ mile	Increased pain after ¼ mile	Increased pain with all walking

2. Sleeping

0	1	2	3	4
Perfect sleep	Mildly disturbed sleep	Moderately disturbed sleep	Greatly disturbed sleep	Totally disturbed sleep

7. Standing

0	1	2	3	4
No pain after several hours	Increased pain after several hours	Increased pain after 1 hour	Increased pain after ½ hour	Increased pain with any standing

3. Personal Care (washing, dressing, etc.)

0	1	2	3	4
No pain no restrictions	Mild pain no restrictions	Moderate pain; need to go slowly	Moderate pain; need some assistance	Severe pain; need 100% assistance

8. Lifting

0	1	2	3	4
No pain with heavy weight	Increased pain with heavy weight	Increased pain with moderate weight	Increased pain with light weight	Increased pain with any weight

4. Travel (driving, etc)

0	1	2	3	4
No pain on long trips	Mild pain on long trips	Moderate pain on long trips	Moderate pain on short trips	Severe pain on short trips

9. Work

0	1	2	3	4
Can do usual work plus unlimited extra work	Can do usual work no extra work	Can do 50% of usual work	Can do 25% of usual work	Cannot work

6. Recreation

0	1	2	3	4
Can do all activities	Can do most activities	Can do some activities	Can do a few activities	Can't do any activities

10. Frequency of Pain

0	1	2	3	4
No pain	Occasional pain 25% of the day	Intermittent pain 50% of the day	Frequent pain 75% of the day	Constant pain 100% of the day

Staff Signature _____



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QUADRUPLE VISUAL ANALOGUE SCALE

Please read carefully:

Instructions: Please circle the number that best describes the question being asked.

Note: If you have more than one complaint, please answer each question for each individual complaint and indicate the score for each complaint.

Example:

	Headache		Neck		Low Back							
No pain	0	1	2	3	4	5	6	7	8	9	10	worst possible pain

1 - What is your pain RIGHT NOW?

	0	1	2	3	4	5	6	7	8	9	10	worst possible pain
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2 - What is your TYPICAL or AVERAGE pain?

	0	1	2	3	4	5	6	7	8	9	10	worst possible pain
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3 - What is your pain level AT ITS BEST (How close to "0" does your pain get at its best)?

	0	1	2	3	4	5	6	7	8	9	10	worst possible pain
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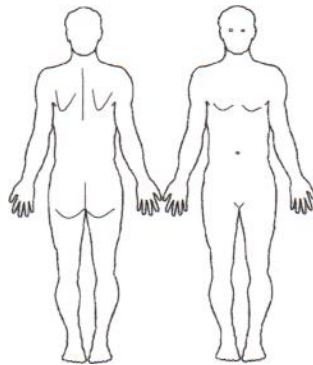
4 - What is your pain level AT ITS WORST (How close to "10" does your pain get at its worst)?

	0	1	2	3	4	5	6	7	8	9	10	worst possible pain
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Mark the diagram as follows:

- A - Ache
- B - Burning
- N - Numbness
- P - Pins & Needles
- S - Stabbing
- O - Other - Describe

OTHER COMMENTS:



Staff Signature _____