Patient Follow-up Questionnaire

American Chiropractic Network

ACN Use Only rev 5/10/99

Patient Name _____ **Date** _____

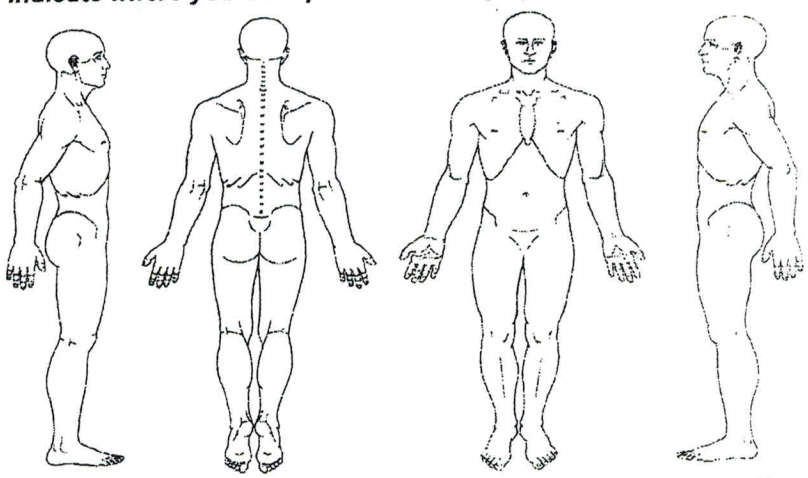
1. *Describe your current symptoms* _____

2. *How often do you experience your symptoms?*
   - ① Constantly (76-100% of the day)
   - ② Frequently (51-75% of the day)
   - ③ Occasionally (26-50% of the day)
   - ④ Intermittently (0-25% of the day)

3. *What describes the nature of your symptoms?*
   - ① Sharp
   - ② Dull ache
   - ③ Numb
   - ④ Shooting
   - ⑤ Burning
   - ⑥ Tingling

4. *How are your symptoms changing?*
   - ① Getting Better
   - ② Not Changing
   - ③ Getting Worse

Indicate where you have pain or other symptoms



5. *How bad are your symptoms at their:*

	None										Unbearable
a. worst:	⓪	①	②	③	④	⑤	⑥	⑦	⑧	⑨	⑩
b. best:	⓪	①	②	③	④	⑤	⑥	⑦	⑧	⑨	⑩

6. *How do your symptoms affect your ability to perform daily activities?*

⓪	①	②	③	④	⑤	⑥	⑦	⑧	⑨	⑩
No complaints		*Mild, forgotten with activity*		*Moderate, interferes with activity*		*Limiting, prevents full activity*		*Intense, preoccupied with seeking relief*		*Severe, no activity possible*

7. *What do you hope to get from your visit/treatment (select all that apply)*
   - ① Reduce symptoms
   - ② Resume/increase activity
   - ③ Explanation of condition/treatment
   - ④ Learn how to take care of this on my own
   - ⑤ How to prevent this from occurring again
   - ⑥

8. *Additional comments*

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Patient Signature _____ **Date** _____