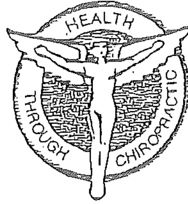
SCOMA CHIROPRACTIC, P.A.

DR. LOUIS SCOMA



1113 SE 47th Terr. #1
Cape Coral, FL 33904

(239) 945-1717
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HOURS BY APPOINTMENT

HEALTH AND WELLNESS CENTER

Patient name ______________________ Patient signature ____________________ Date ______

The BACK Bournemouth Questionnaire

The following scales have been designed to find out about your back pain and how it is affecting you. Please answer ALL the scales by circling ONE number on EACH scale that best describes how you feel:

1. Over the past week, on average, how would you rate your back pain?

   No pain 0 1 2 3 4 5 6 7 8 9 10 Worst pain possible

2. Over the past week, how much has your back pain interfered with your daily activities (housework, washing, dressing, walking, climbing stairs, getting in/out of bed/chair)?

   No interference 0 1 2 3 4 5 6 7 8 9 10 Unable to carry out activity

3. Over the past week, how much has your back pain interfered with your ability to take part in recreational, social, and family activities?

   No interference 0 1 2 3 4 5 6 7 8 9 10 Unable to carry out activity

4. Over the past week, how anxious (tense, uptight, irritable, difficulty in concentrating/relaxing) have your been feeling?

   Not at all anxious 0 1 2 3 4 5 6 7 8 9 10 Extremely anxious

5. Over the past week, how depressed (down-in-the-dumps, sad, in low spirits, pessimistic, unhappy) have you been feeling?

   Not at all depressed 0 1 2 3 4 5 6 7 8 9 10 Extremely depressed

6. Over the past week, how have you felt your work (both inside and outside the home) has affected (or would affect) your back pain?

   Have made it no worse 0 1 2 3 4 5 6 7 8 9 10 Have made it much worse

7. Over the past week, how much have you been able to control (reduce/help) your back pain on your own?

   Completely control it 0 1 2 3 4 5 6 7 8 9 10 No control whatsoever

Patient name ______________ Patient signature ______________ Date ______________

The NECK Bournemouth Questionnaire

The following scales have been designed to find out about your neck pain and how it is affecting you. Please answer ALL the scales by circling ONE number on EACH scale that best describes how you feel:

1. Over the past week, on average, how would you rate your neck pain?

No pain — Worst pain possible

0 1 2 3 4 5 6 7 8 9 10

2. Over the past week, how much has your neck pain interfered with your daily activities (housework, washing, dressing, lifting, reading, driving)?

No interference — Unable to carry out activity

0 1 2 3 4 5 6 7 8 9 10

3. Over the past week, how much has your neck pain interfered with your ability to take part in recreational, social, and family activities?

No interference — Unable to carry out activity

0 1 2 3 4 5 6 7 8 9 10

4. Over the past week, how anxious (tense, uptight, irritable, difficulty in concentrating/relaxing) have your been feeling?

Not at all anxious — Extremely anxious

0 1 2 3 4 5 6 7 8 9 10

5. Over the past week, how depressed (down-in-the-dumps, sad, in low spirits, pessimistic, unhappy) have you been feeling?

Not at all depressed — Extremely depressed

0 1 2 3 4 5 6 7 8 9 10

6. Over the past week, how have you felt your work (both inside and outside the home) has affected (or would affect) your neck pain?

Have made it no worse — Have made it much worse

0 1 2 3 4 5 6 7 8 9 10

7. Over the past week, how much have you been able to control (reduce/help) your neck pain on your own?

Completely control it — No control whatsoever

0 1 2 3 4 5 6 7 8 9 10

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Health and Wellness Center

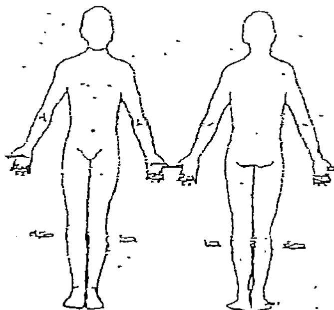
ACTIVITIES OF DAILY LIVING COMMONLY MEASURED IN ACTIVITIES OF DAILY LIVING (ADL)

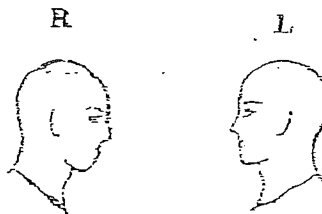
Name of Applicant:______________________ Date of Birth:__________ Date:__________

APPLICANT HAS DIFFICULTY WITH: (Mark with an "X" and explain where indicated)

	CATEGORY	ACTIVITY	Without Difficulty	With Some Difficulty	With Much Difficulty	Almost Unable To Do
1.	Self-care, Personal Hygene: (Urinating Defecating Brushing teeth Combing hair Bathing Dressing oneself Eating)	Take a shower				
		Take a bath				
		Wash & dry body				
		Wash & dry face				
		Turn on/off faucets				
		Brush teeth				
		Get on/off toilet				
		Comb/brush hair				
		Dress self				
		Put on/off shoes/socks				
		Open carton of milk				
		Open a jar				
		Lift glass/cup to mouth				
		Make a meal				
		Lift fork/spoon to mouth				
		Describe other: (bladder and bowel function difficulties, incontinence, retention, constipation)				
2.	**Physical Activity:** (Standing Sitting Reclining Walking Climbing stairs	Stand Sit				
		Recline				
		Rise from a chair				
		Get in/out of bed				
		Climb flight of 10 stairs				
		Work outdoors				
		Light house work				
		Shop/do errands				
		Carry groceries				
		Lift 5 lbs.				
		Lift 10 lbs.				
		Lift 20 lbs.				
		Lift 30 lbs.				
		Walk				
		Describe other: (eating/chewing difficulty: TMJ)				

APPLICANT HAS DIFFICULTY WITH: (Mark with an "X" and explain where indicated)						
	CATEGORY	ACTIVITY	Without Difficulty	With Some Difficulty	With Much Difficulty	Almost Unable To Do
3.	Communication: (Writing, typing, seeing, hearing, speaking)	Write a note				
		Type a message on A computer/typewriter				
		See a television screen				
		Use a telephone				
		Speak clearly				
		Hear clearly				
		Describe other				
4.	**Non-specified Hand activities** (Grasping, lifting, tactile, discrimination)	Pick up small items				
		Turn a knob on a door				
		Write with pen/pencil				
		Turn steering wheel in a car				
		Describe other:				
5.	**Sensory function** (Hearing, seeing, tactile feeling, tasting, smelling)	Feel what you touch				
		Taste what you eat				
		Smell what you eat				
		Describe other:				
6.	**Travel** (Riding, flying, driving))	Get in/out of a car				
		Drive a car				
		Ride in a car				
		Fly on a plane				
		Ride a bicycle				
		Describe other:				
7.	**Sleep** (Restful sleep, nocturnal sleep pattern)	Get to sleep				
		Sleep through the night				
		Have restful sleep				
		Feel refreshed after sleep				
		Describe specific difficulty; (teeth grinding at night, excessive daytime fatigue, irritability, etc.):				





Shade and Code Area(s) to indicate the location of pain or discomfort:

RATE YOUR PAIN: 1 – 10 (1-3 MINIMAL, SLIGHT 4-6, MODERATE 7-9, MARKED 10)

CIRCLE YOUR PAIN LEVEL 1 2 3 4 5 6 7 8 9 10