PMIQ Follow Up Appointment

NAME:

DATE:

DOB:

New York Spine & Wellness Center

Please read each statement:

If the statement is false do nothing, **IF TRUE, WRITE IN WHAT HAS IMPROVED**

Circle the level of improvement: 5 represents the most improvement

Since I have been receiving:

(circle one)

ACUPUNCTURE **CHIROPRACTIC** **MASSAGE**

I have had a _____ % decrease in pain.

1	My walking has improved: *i.e. I can walk longer distances*	1 2 3 4 5 No improvement
2	My ability to wash/clean/bath myself has improved :	1 2 3 4 5 No improvement
3	My ability to dress myself has improved :	1 2 3 4 5 No improvement
4	I am able to spend more time doing the following house work:	1 2 3 4 5 No improvement
5	My sleep has improved :	1 2 3 4 5 No improvement
6	My range of motion/movement has increased allowing me to:	1 2 3 4 5 No improvement
7	I am able to concentrate more clearly on or while I am:	1 2 3 4 5 No improvement
8	I take less of my medication ,Name and dose: How often are you taking it per day/week/or month?	1 2 3 4 5 No improvement
9	I participate in strengthening and aerobic exercise at home or elsewhere:	1 2 3 4 5 Not participating
10	Other:	1 2 3 4 5

Total:

Please circle your pain at this moment on a 0 to 10 scale