CORNERSTONE HEALTH
CHIROPRACTIC · ACUPUNCTURE · NUTRITION

NAME _____ Primary Complaint: _____

Preferred Pronoun: *He/Him/His* *She/Her/Hers* *They/Them/Theirs* *Other*

1. Please indicate your usual level of pain during the past week:
   No pain **0 1 2 3 4 5 6 7 8 9 10** ***Worst possible pain***
2. Does pain, numbness, tingling or weakness extend into your leg (from low back) and/or arm (from neck)?
   None of the time **0 1 2 3 4 5 6 7 8 9 10** ***All of the time***
3. How would you rate your general health? (10-x)
   Poor **0 1 2 3 4 5 6 7 8 9 10** ***Excellent***
4. If you had to spend the rest of your life with your condition as it is right now, how would you feel?
   Delighted **0 1 2 3 4 5 6 7 8 9 10** ***Terrible***
5. How anxious (i.e., tense, uptight, irritable, fearful, difficulty in concentrating/relaxing) have you been feeling during the past week?
   Not at all **0 1 2 3 4 5 6 7 8 9** ***10*** ***Extremely anxious***
6. How much have you been able to control (i.e., reduce/help) your pain/complaint on your own during the past week?
   I can reduce it **0 1 2 3 4 5 6 7 8 9** ***10*** ***I can't reduce it all***
7. Please indicate how depressed (e.g., blue, downhearted, sad, in low spirits, pessimistic, hopeless feeling) you have been feeling in the past week
   Not depressed at all **0 1 2 3 4 5 6 7 8 9 10** ***Extremely depressed***
8. On a scale of 0 to 10, how certain are you that you will be doing normal activities or working within six months?
   Very certain **0 1 2 3 4 5 6 7 8 9 10** ***Not certain at all***
9. I can do light work for an hour:
   Completely agree **0 1 2 3 4 5 6 7 8 9 10** ***Completely disagree***
10. I can sleep at night:
    Completely agree **0 1 2 3 4 5 6 7 8 9 10** ***Completely disagree***
11. An increase in pain is an indication that I should stop what I am doing until the pain decreases:
    Completely agree **0 1 2 3 4 5 6 7 8 9 10** ***Completely disagree***
12. Physical activity makes my pain worse:
    Completely disagree **0 1 2 3 4 5 6 7 8 9 10** ***Completely agree***
13. I should not do my normal activities, including work, with my present pain:
    Completely disagree **0 1 2 3 4 5 6 7 8 9 10** ***Completely agree***

Patient Signature _____ Date: _____

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Patient Specific Functional Scale (PSFS):

Identify 2-3 activities that you are not able to do or have difficulty with as a result of your chief complaint.

Write the activity that you are having trouble with in the space provided below (e.g., running, sitting, standing, etc.), then circle the number that corresponds to that activity.

1. How difficult is _____ for you?

   Unable to perform **0 1 2 3 4 5 6 7 8 9 10** ***Able to perform fully***

2. How difficult is _____ for you?

   Unable to perform **0 1 2 3 4 5 6 7 8 9 10** ***Able to perform fully***

3. How difficult is _____ for you?

   Unable to perform **0 1 2 3 4 5 6 7 8 9 10** ***Able to perform fully***

Pain Limitation: Over the past 24 hours, how much has your pain limited you from performing any of your normal, daily activities?

Activities severely limited **0 1 2 3 4 5 6 7 8 9 10** ***Activities not limited***

Pain Intensity: Over the past 24 hours, how bad has your pain been?

No Pain **0 1 2 3 4 5 6 7 8 9 10** ***Pain as bad as it can be***