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: _____

CORNERSTONE HEALTH
CHIROPRACTIC · ACUPUNCTURE · NUTRITION

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***

CORNERSTONE HEALTH
CHIROPRACTIC · ACUPUNCTURE · NUTRITION

Here are some of the things other patients have told us about their pain. For each statement, please circle the number from 0 to 6 to indicate how much physical activities such as bending, lifting, walking or driving affect or would affect your back pain.

	Completely Disagree			Unsure			Completely Agree
1. My pain was caused by physical activity.	0	1	2	3	4	5	6
2. Physical activity makes my pain worse.	0	1	2	3	4	5	6
3. Physical activity might harm my back.	0	1	2	3	4	5	6
4. I should not do physical activities which (might) make my pain worse.	0	1	2	3	4	5	6
5. I cannot do physical activities which (might) make my pain worse.	0	1	2	3	4	5	6

The following statements are about how your normal work affects or would affect your back pain.

	Completely Disagree			Unsure			Completely Agree
6. My pain was caused by my work or by an accident at work.	0	1	2	3	4	5	6
7. My work aggravated my pain	0	1	2	3	4	5	6
8. I have a claim for compensation for my pain	0	1	2	3	4	5	6
9. My work is too heavy for me.	0	1	2	3	4	5	6
10. My work makes or would make my pain worse.	0	1	2	3	4	5	6
11. My work might harm my back.	0	1	2	3	4	5	6
12. I should not do my regular work with my present pain.	0	1	2	3	4	5	6
13. I cannot do my normal work with my present pain.	0	1	2	3	4	5	6
14. I cannot do my normal work until my pain is treated.	0	1	2	3	4	5	6
15. I do not think that I will be back to my normal work within 3 months.	0	1	2	3	4	5	6
16. I do not think that I will ever be able to go back to that work.	0	1	2	3	4	5	6

CORNERSTONE HEALTH
CHIROPRACTIC · ACUPUNCTURE · NUTRITION

CERVICAL POSITIONAL TOLERANCE QUESTIONNAIRE (CPTQ)

1. Do you avoid looking up as if into a high cabinet shelf because do so causes:

a) Visual Problems or Dizziness YES / NO / SOMETIMES
b) Sudden Drop to the Floor YES / NO / SOMETIMES
c) Unsteadiness YES / NO / SOMETIMES
d) Extremity Weakness YES / NO / SOMETIMES
e) Confusion YES / NO / SOMETIMES
f) Headaches YES / NO / SOMETIMES
g) Hearing Loss YES / NO / SOMETIMES
h) Loss of Consciousness YES / NO / SOMETIMES
i) Arm or Leg Numbness YES / NO / SOMETIMES
j) Problems with Speech YES / NO / SOMETIMES
k) Ringing in the Ear YES / NO / SOMETIMES
l) Numbness around Mouth YES / NO / SOMETIMES

2. Do you avoid looking over your LEFT shoulder as if backing up to your car because of:

a) Visual Problems or Dizziness YES / NO / SOMETIMES
b) Sudden Drop to the Floor YES / NO / SOMETIMES
c) Unsteadiness YES / NO / SOMETIMES
d) Extremity Weakness YES / NO / SOMETIMES
e) Confusion YES / NO / SOMETIMES
f) Headaches YES / NO / SOMETIMES
g) Hearing Loss YES / NO / SOMETIMES
h) Loss of Consciousness YES / NO / SOMETIMES
i) Arm or Leg Numbness YES / NO / SOMETIMES
j) Problems with Speech YES / NO / SOMETIMES
k) Ringing in the Ear YES / NO / SOMETIMES
l) Numbness around Mouth YES / NO / SOMETIMES

3. Do you avoid looking over your RIGHT shoulder as if backing up to your car because of:

a) Visual Problems or Dizziness YES / NO / SOMETIMES
b) Sudden Drop to the Floor YES / NO / SOMETIMES
c) Unsteadiness YES / NO / SOMETIMES
d) Extremity Weakness YES / NO / SOMETIMES
e) Confusion YES / NO / SOMETIMES
f) Headaches YES / NO / SOMETIMES
g) Hearing Loss YES / NO / SOMETIMES
h) Loss of Consciousness YES / NO / SOMETIMES
i) Arm or Leg Numbness YES / NO / SOMETIMES
j) Problems with Speech YES / NO / SOMETIMES
k) Ringing in the Ear YES / NO / SOMETIMES
l) Numbness around Mouth YES / NO / SOMETIMES

_____ *TOTAL SCORE = "YES" Responses + "Sometimes" Responses.*
Scores ≥ 1 constitute a positive CPTQ.

CORNERSTONE HEALTH
CHIROPRACTIC · ACUPUNCTURE · NUTRITION

TMJ DISABILITY INDEX (TDI)

We are interested in knowing whether you are having any difficulty with the activities listed below because of your jaw problem. Please provide answers for each activity for today.

Do you or would you have difficulty with	No Difficulty			Some Difficulty			Complete Inability
Eating	0	1	2	3	4	5	6
Eating chewy foods (steak, bagels, gum)	0	1	2	3	4	5	6
Eating hard foods (nuts, carrots, apple, corn-on-the-cob)	0	1	2	3	4	5	6
Eating moderately soft foods (fish, noodles, peas)	0	1	2	3	4	5	6
Eating soft foods (mashed potatoes, pudding, creamed corn, porridge)	0	1	2	3	4	5	6
Eating/drinking liquids (soups, tea, milk)	0	1	2	3	4	5	6
Talking or carry on a conversation	0	1	2	3	4	5	6

Do you or would you	None of the Time			Some of the Time			All of the Time
Limit how often you eat	0	1	2	3	4	5	6
Avoid talking or carrying on a conversation	0	1	2	3	4	5	6
Limit how long you eat	0	1	2	3	4	5	6
Change how you communicate (i.e., gesture, write notes)	0	1	2	3	4	5	6
Change the way in which your jaw moves during eating (i.e., chewing mostly on one side, avoid biting large foods)	0	1	2	3	4	5	6
Limit how often you talk or carry on a conversation	0	1	2	3	4	5	6
Limit how long you talk or carry on a conversation	0	1	2	3	4	5	6
Avoid eating certain foods	0	1	2	3	4	5	6
Change the way in which your jaw moves while talking (i.e., talk with little/no jaw movement or clenched teeth)	0	1	2	3	4	5	6

Are you satisfied with your ability to	Yes Absolutely			Some What			Not at All
Talk or carry on a conversation even though you have a jaw problem	0	1	2	3	4	5	6
Eat even though you have a jaw problem	0	1	2	3	4	5	6

Do you or would your jaw muscles get tight when	None of the Time			Some of the Time			All of the Time
Talking	0	1	2	3	4	5	6
Eating	0	1	2	3	4	5	6

Total Score: _____