Lifeline

CHIROPRACTIC & APPLIED KINESIOLOGY P.C.

Pain Intensity Scales

Patient Name ____ Date _____________

Location of condition: ❑ neck ❑ upper back ❑ lower back ❑ head ❑ other ________
Please circle the number which most closely describes your condition right now.

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

Location of condition: ❑ neck ❑ upper back ❑ lower back ❑ head ❑ other ________
Please circle the number which most closely describes your condition right now.

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

Location of condition: ❑ neck ❑ upper back ❑ lower back ❑ head ❑ other ________
Please circle the number which most closely describes your condition right now.

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

Location of condition: ❑ neck ❑ upper back ❑ lower back ❑ head ❑ other ________
Please circle the number which most closely describes your condition right now.

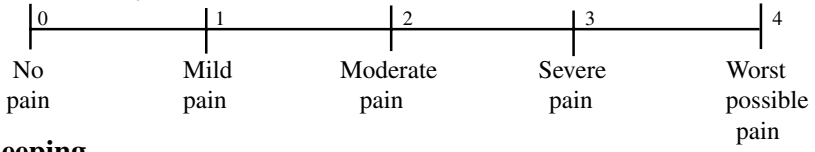
0	1	2	3	4	5	6	7	8	9	10
No pain					Moderate pain					Worst possible

Functional Rating Index

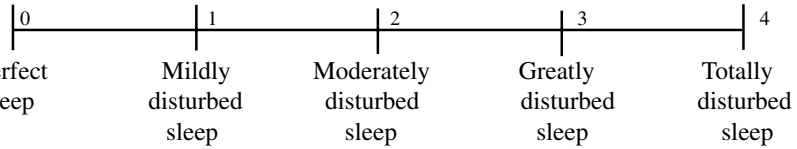
For use with **Neck and/or Back Problems** only.

In order to properly assess your condition, we must understand how much your **neck and/or back problems** have affected your ability to manage everyday activities.
For each item below, **please circle the number which most closely describes your condition right now.**

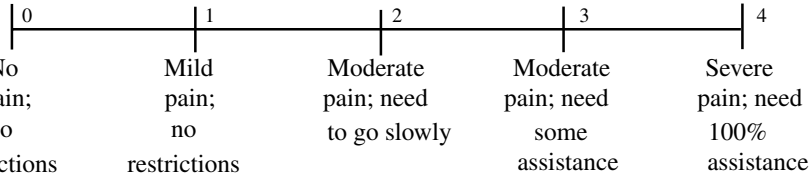
1. Pain Intensity



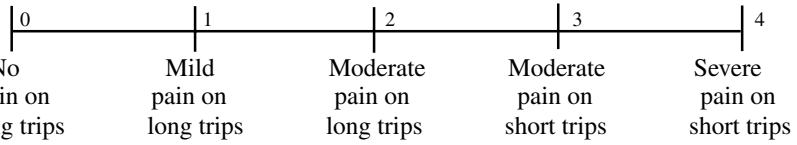
2. Sleeping



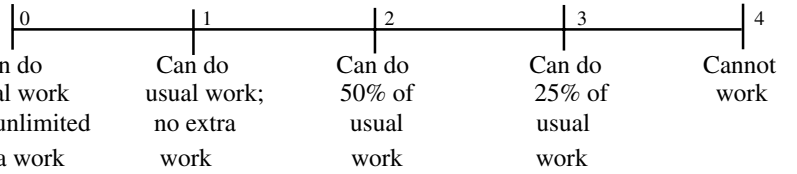
3. Personal Care (washing, dressing, etc.)



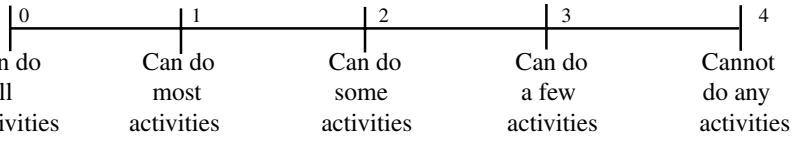
4. Travel (driving, etc.)



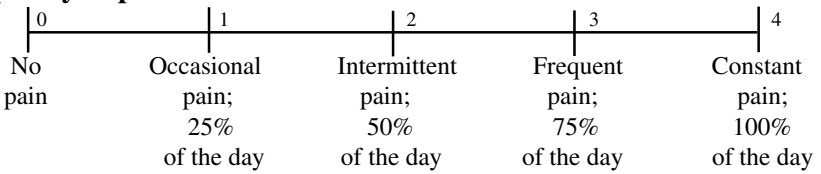
5. Work



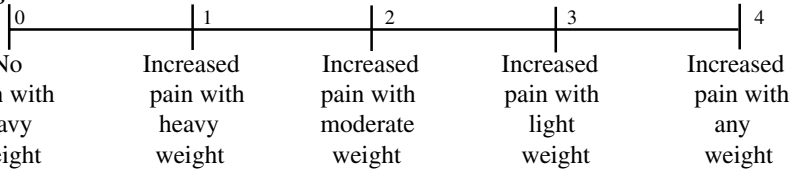
6. Recreation



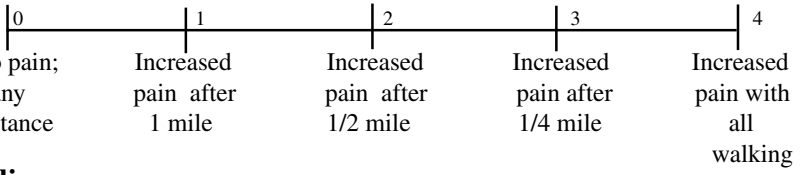
7. Frequency of pain



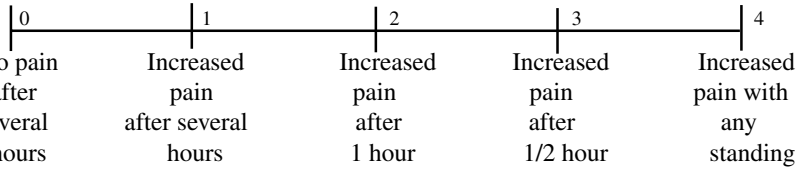
8. Lifting



9. Walking



10. Standing



Name _____
PRINTED

_____
Signature

_____
Date

Total Score _____

1st follow-up: E-B info ❒