

Alaska Health Improvement Center
Improvement Report

Regarding Your Improvement

1. What was it like before you came in to see us?

2. How is it now?

This information is for our files and to help us educate others about what we do.

Name

Date

I authorize AHIC to also share my success/improvement report as follows:

- ☐ Success story that remains in our office at all times;
- ☐ Any promotion by AHIC to help others learn about AHIC's Drug Free Services

You may choose to use ☐ my initials ☐ my full name

Alaska Health Improvement Center
Progress Evaluation & Re Exam

We are excited to do a progress evaluation to ensure that your body is improving, progressing per schedule and that we are making all the gains you desire. Please take a minute to help us evaluate and plan for your next level of care:

Name: _____

Date: _____

1. We've been working on these symptoms. Please tell us how each is doing:

1. _____
2. _____
3. _____
4. _____
5. _____

Really bad _____ **Perfect**

<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
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2. Is there anything else you would like to work on?

1. _____
2. _____
3. _____

Really bad _____ **Perfect**

<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

3. How is your progress coming along?

4. Did you meet your Goals?

5. Do you feel the Dr. understands your situation?

6. How is the staff doing?

7. Did we meet your expectations?

8. What did you think about the required mini health workshop you attended?

9. Is there anything else you would like us to know?

10. Have you recommended us to others?

If "no" any reason why not?

THANK YOU!

Name: _____ Date: _____

Do you currently experience... ?	Intensity Now?			Mark		
WEIGHT	Mild	Moderate	Severe		Office Use	
Binge eating / compulsive eating / drinking	O	O	O			
Craving certain foods (what? _____)	O	O	O			
Overweight or underweight (which?)	O	O	O			
Water retention	O	O	O			
Swollen ankles, legs, etc.	O	O	O			
HEAD						
Headaches	O	O	O			
Migraines	O	O	O			
Faintness	O	O	O			
Dizziness	O	O	O			
EYES						
Watery or itchy eyes	O	O	O			
Swollen, red, or sticky eyelids	O	O	O			
Bags or circles under eyes	O	O	O			
Blurred or tunnel vision (<i>not near or far-sighted</i>)	O	O	O			
EARS						
Itchy ears	O	O	O			
Earaches / ear infections	O	O	O			
Drainage from ear	O	O	O			
Ringing in ears / hearing loss	O	O	O			
NOSE						
Stuffy nose	O	O	O			
Sinus problems	O	O	O			
Sneezing attacks	O	O	O			
Excessive mucous formation	O	O	O			
ALLERGIES						
Animal (which _____)	O	O	O			
Insects (which _____)	O	O	O			
Trees / pollen (which _____)	O	O	O			
Wheat / grains (which _____)	O	O	O			
Nuts (which _____)	O	O	O			
Dairy	O	O	O			
Seasonal / hay fever	O	O	O			
other (what _____)	O	O	O			
MOUTH / THROAT						
Chronic coughing	O	O	O			
Gagging, need to clear through often	O	O	O			
Sore throat, hoarse, loss of voice	O	O	O			
Swollen or discolored tongue, gums, lips	O	O	O			
Canker sores	O	O	O			
SKIN						
Acne	O	O	O			
Hives, rashes	O	O	O			
Itchy, dry skin	O	O	O			
Hair loss	O	O	O			
Flushing, hot flashes	O	O	O			
Excessive sweating	O	O	O			

HEART	Mild	Moderate	Severe	Office use	
Irregular or skipped heartbeat	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>		
Rapid or pounding heartbeat	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>		
Chest pain	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>		
High or Low blood pressure (which?)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>		
LUNGS					
Chest congestion	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>		
Asthma, bronchitis	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>		
Shortness of breath	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>		
Difficulty breathing	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>		
DIGESTIVE TRACT					
Nausea, vomiting	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>		
Diarrhea	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>		
Constipation (# days between stools? _____)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>		
Bloating, belching, gas	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>		
Heartburn, acid reflux	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>		
Intestinal / stomach pain	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>		
JOINTS / MUSCLE					
Pain or aches in joints (where? _____)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>		
Arthritis (where? _____)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>		
Stiffness, limited movement	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>		
Muscle pain or cramps	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>		
Weak, tired muscles	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>		
Numbness	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>		
Bone pain	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>		
Bone demineralizing, osteoporosis	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>		
ENERGY / ACTIVITY					
Fatigue, sluggishness	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>		
Apathy, lethargy	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>		
Hyperactivity	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>		
Restlessness	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>		
MIND / COGNITIVE					
Poor memory	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>		
Brain fog, confusion, poor comprehension	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>		
Poor concentration	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>		
Learning disabilities	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>		
Poor physical coordination	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>		
Stuttering, stammering	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>		
Slurred speech	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>		
EMOTIONS					
Mood swings	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>		
Anxiety, fear, nervousness	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>		
Anger, irritability, aggressiveness	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>		
Depression	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>		
OTHER					
Get sick easily or often	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>		
Frequent urination	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>		
Insomnia (average # hours sleep _____)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>		
MALE / FEMALE					
PMS	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>		
Irregular menses	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>		
Lowered libido	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>		
Erectile dysfunction	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>		

REVISED OSWESTRY CHRONIC LOW BACK PAIN DISABILITY QUESTIONNAIRE

Please Read: This questionnaire is designed to enable us to understand how much your low back pain has affected your ability to manage your everyday activities. Please answer each section by circling the ONE CHOICE that most applies to you. We realize that you may feel that more than one statement may apply to you, but PLEASE JUST CIRCLE THE ONE CHOICE WHICH MOST CLEARLY DESCRIBES YOUR PROBLEM RIGHT NOW.

Section 1 – Pain Intensity

1. The pain comes and goes and is very mild.
2. The pain is mild and does not vary much.
3. The pain comes and goes and is moderate.
4. The pain is moderate and does not vary much.
5. The pain comes and goes and is severe.
6. The pain is severe and does not vary much.

Section 2 – Personal Care

1. I would not have to change my way of washing or dressing in order to avoid pain.
2. I do not normally change my way of washing or dressing even though it causes some pain.
3. Washing and dressing increases the pain, but I manage not to change my way of doing it..
4. Washing and dressing increases the pain and I find it necessary to change my way of doing it.
5. Because of the pain, I am unable to do some washing and dressing without help.
6. Because of the pain, I am unable to do any washing or dressing without help.

Section 3 – Lifting

1. I can lift heavy weights without extra pain.
2. I can lift heavy weights, but it causes extra pain.
3. Pain prevents me from lifting heavy weights off the floor.
4. Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned, e.g. on a table
5. Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
6. I can only lift very light weights, at the most.

Section 4 – Walking

1. Pain does not prevent me from walking any distance.
2. Pain prevents me from walking more than one mile.
3. Pain prevents me from walking more than ½ mile.
4. Pain prevents me from walking more than ¼ mile.
5. I can only walk while using a cane or on crutches.
6. I am in bed most of the time and have to crawl to the toilet.

Section 5 – Sitting

1. I can sit in any chair as long as I like without pain.
2. I can only sit in my favorite chair as long as I like.
3. Pain prevents me from sitting more than one hour.
4. Pain prevents me from sitting more than ½ hour.
5. Pain prevents me from sitting more than ten minutes.
6. Pain prevents me from sitting at all.

Section 6 – Standing

1. I can stand as long as I want without pain.
2. I have some pain while standing, but it does not increase with time.
3. I can not stand for longer than one hour without increasing pain.
4. I can not stand for longer than ½ hour, without increasing pain.
5. I can not stand for longer than ten minutes, without increasing pain.
6. I avoid standing, because it increases the pain straight away.

Section 7 – Sleeping

1. I get no pain in bed.
2. I get pain in bed, but it doesn't prevent me from sleeping well
3. Because of my pain, my normal night's sleep is reduced by less than one-quarter.
4. Because of my pain, my normal night's sleep is reduced by less than one-half.
5. Because of my pain, my normal night's sleep is reduced by less than three-quarters.
6. Pain prevents me from sleeping at all.

Section 8 – Social Life

1. My social life is normal and gives me no pain.
2. My social life is normal, but increases the degree of my pain.
3. Pain has no significant effect on my social life apart from limiting my more energetic interests, e.g. dancing, etc.
4. Pain has restricted my social life and I do not go out very often.
5. Pain has restricted my social life to my home.
6. I have hardly any social life because of the pain.

Section 9 – Traveling

1. I get no pain while traveling.
2. I get some pain while traveling, but none of my usual forms of travel make it any worse.
3. I get extra pain while traveling, but it does not compel me to seek alternate forms of travel.
4. I get extra pain while traveling which compels me to seek alternative forms of travel.
5. Pain restricts all forms of travel.
6. Pain prevents all forms of travel except that done lying down.

Section 10 – Changing Degree of Pain

1. My pain is rapidly getting better.
2. My pain fluctuates, but overall is definitely getting better.
3. My pain seems to be getting better, but improvement is slow at present.
4. My pain is neither getting better or worse.
5. My pain is gradually getting worse.
6. My pain is rapidly worsening

Comments: _____

Patient's Signature: _____ Date: _____

NECK PAIN DISABILITY INDEX QUESTIONNAIRE

Please Read: This questionnaire is designed to enable us to understand how much your neck pain has affected your ability to manage your everyday activities. Please answer each section by circling the ONE CHOICE that most applies to you. We realize that you may feel that more than one statement may apply to you, but PLEASE JUST CIRCLE THE ONE CHOICE WHICH MOST CLEARLY DESCRIBES YOUR PROBLEM RIGHT NOW.

Section 1 – Pain Intensity

1. I have no pain at the moment.
2. The pain is very mild at the moment.
3. The pain is moderate at the moment.
4. The pain is fairly severe at the moment.
5. The pain is very severe at the moment.
6. The pain is the worst imaginable at the moment.

Section 2 – Personal Care

1. I can look after myself normally without causing extra pain.
2. I can look after myself normally, but it causes extra pain.
3. It is painful to look after myself and I am slow and careful.
4. I need some help, but manage most of my personal care.
5. I need help every day in most aspects of self-care.
6. I do not get dressed. I wash with difficulty and stay in bed.

Section 3 – Lifting

1. I can lift heavy weights without extra pain.
2. I can lift heavy weights, but it causes extra pain.
3. Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned, e.g. on a table
4. Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
5. I can lift very light weights.
6. I cannot lift or carry anything at all.

Section 4 – Reading

1. I can read as much as I want to with no pain in my neck.
2. I can read as much as I want to with slight pain in my neck.
3. I can read as much as I want to with moderate pain in my neck.
4. I cannot read as much as I want because of moderate pain in my neck.
5. I cannot read as much as I want because of severe pain in my neck.
6. I cannot read at all.

Section 5 – Headaches

1. I have no headaches at all.
2. I have slight headaches, which come infrequently.
3. I have moderate headaches, which come infrequently.
4. I have moderate headaches, which come frequently.
5. I have severe headaches, which come frequently.
6. I have headaches almost all of the time.

Section 6 – Concentration

1. I can concentrate fully when I want to with no difficulty.
2. I can concentrate fully when I want to with slight difficulty.
3. I have a fair degree of difficulty in concentrating when I want to.
4. I have a lot of difficulty in concentrating when I want to.
5. I have a great deal of difficulty in concentrating when I want to.
6. I cannot concentrate at all.

Section 7 – Work

1. I can do as much work as I want to.
2. I can do only my usual work, but no more.
3. I can do most of my usual work, but no more.
4. I cannot do my usual work.
5. I can hardly do any work at all.
6. I cannot do any work at all.

Section 8 – Driving

1. I can drive my car without any neck pain.
2. I can drive my car as long as I want with slight pain in my neck.
3. I can drive my car as long as I want with moderate pain in my neck.
4. I cannot drive my car as long as I want because of moderate pain in my neck.
5. I can hardly drive at all because of severe pain in my neck.
6. I cannot drive my car at all.

Section 9 – Sleeping

1. I have no trouble sleeping.
2. My sleep is slightly disturbed (less than 1 hour sleepless).
3. My sleep is mildly disturbed (1-2 hours sleepless).
4. My sleep is moderately disturbed (2-3 hours sleepless).
5. My sleep is greatly disturbed (3-5 hours sleepless).
6. My sleep is completely disturbed (5-7 hours sleepless).

Section 10 – Recreation

1. I am able to engage in all of my recreational activities, with no neck pain at all.
2. I am able to engage in all of my recreational activities, with some pain in my neck.
3. I am able to engage in most, but not all of my usual recreational activities because of pain in my neck.
4. I am able to engage in a few of my usual recreational activities because of pain in my neck.
5. I can hardly do any recreational activities because of pain in my neck.
6. I cannot do any recreational activities at all.

Comments: _____

Patient's Signature: _____ Date: _____

RAND 36 ITEM HEALTH SURVEY 1.0

Patient Name: _____

1. In general, would you say your health is:
(Circle One Number)

Excellent	1
Very Good	2
Good	3
Fair.....	4
Poor.....	5

2. Compared to one year ago, how would you rate your:
general health right now ?
(Circle One Number)

Much better than one year ago.....	1
Somewhat better than one year ago	2
About the same	3
Somewhat worse now than one year ago 4	
Much worse now than one year ago	5

The following items are about activities you might do during a typical day: Does your health now limit you in these activities ? If so, how much ? (Circle One Number on Each Line)	Yes, Limited <u>A Lot</u>	Yes, Limited <u>A Little</u>	No, Not Limited <u>at All</u>
3. Vigorous activities , such as running, lifting heavy objects, participating in strenuous sports.....	1	2	3
4. Moderate activities , such as moving a table pushing a vacuum cleaner, bowling or playing golf.....	1	2	3
5. Lifting or carrying groceries	1	2	3
6. Climbing several flights of stairs.....	1	2	3
7. Climbing one flight of stairs	1	2	3
8. Bending, kneeling or stooping	1	2	3
9. Walking more than a mile	1	2	3
10. Walking several blocks	1	2	3
11. Walking one block	1	2	3
12. Bathing or dressing yourself	1	2	3

During the past 4 weeks , have you had any of the following problems with your work or other regular daily activities as a result of your physical health ? : (Circle One Number on Each Line)	<u>Yes</u>	<u>No</u>
13. Cut down the amount of time you spend on work or other activities	1	2
14. Accomplish less than you would like	1	2
15. Were limited in the kind of work or other activities	1	2
16. Had difficulty performing the work or other activities (for example, took extra effort)	1	2

During the past 4 weeks , have you had any of the following problems with your work or other regular daily activities as a result of any emotional problems ? : (depressed, anxious) (Circle One Number on Each Line)	<u>Yes</u>	<u>No</u>
17. Cut down the amount of time you spend on work or other activities	1	2
18. Accomplish less than you would like	1	2
19. Didn't do work or other activities as carefully as usual.....	1	2

20. During the **past 4 weeks**, to what extent has your physical health or emotional:
problems interfered with your normal social activities with family, friends,
neighbors or groups?
(Circle One Number)

Not at all.....	1
Slightly.....	2
Moderate.....	3
Quite a bit.....	4
Good.....	5

21. How much **bodily** pain have you had during the **past 4 weeks**:
(Circle One Number)
- None 1
Very Mild..... 2
Mild..... 3
Moderate 4
Severe..... 5
Very Severe..... 6
22. During the **past 4 weeks**, how much did pain interfere with your normal work (including both work outside the home and housework ?
(Circle One Number)
- Not at all..... 1
Slightly 2
Moderately 3
Quite a bit..... 4
Extremely 5

These questions are about how you feel and how things have been with you **during the past 4 weeks**.
For each question, please give the one answer that comes closest to the way you have been feeling.

How much of the time during the past 4 weeks . . . (Circle One Number on Each Line)	All of the Time	Most of the Time	A Good Bit of the Time	Some of the Time	A Little of the Time	None of the Time
23. Did you feel full of pep ?	1	2	3	4	5	6
24. Have you been a very nervous person ?.....	1	2	3	4	5	6
25. Have you felt so down in the dumps that nothing could cheer you up ?	1	2	3	4	5	6
26. Have you felt calm and peaceful ?	1	2	3	4	5	6
27. Do you have a lot of energy ?	1	2	3	4	5	6
28. Have you felt downhearted and blue ?.....	1	2	3	4	5	6
29. Did you feel worn out ?	1	2	3	4	5	6
30. Have you been a happy person ?.....	1	2	3	4	5	6
31. Did you feel tired ?	1	2	3	4	5	6

32. During the **past 4 weeks**, to what extent has your **physical health or emotional problems** interfered with your normal social activities like visiting with family, friends, relatives, etc.?
(Circle One Number)
- All of the time 1
Most of the time 2
Some of the time 3
A little of the time 4
None of the time..... 5

How TRUE or FALSE is each of the following statements for you ? (Circle One Number on Each Line)	Definitely True	Mostly True	Don't Know	Mostly False	Definitely False
33. I seem to get sick a little easier than other people	1	2	3	4	5
34. I am as healthy as anybody I know	1	2	3	4	5
35. I expect my health to get worse	1	2	3	4	5
36. My health is excellent	1	2	3	4	5

Comments: _____

Patient Signature: _____

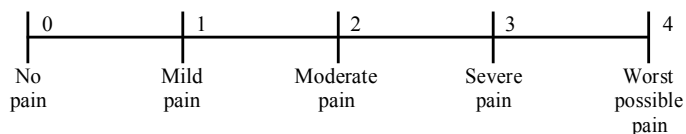
Date _____

Functional Rating Index

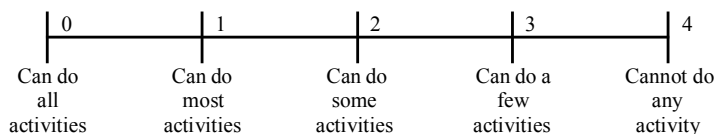
For use with Neck and/or Back Problems only.

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

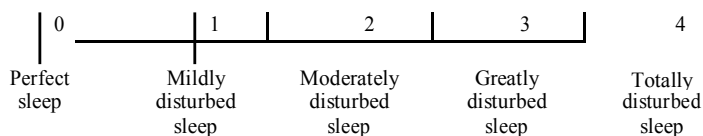
1. Pain Intensity



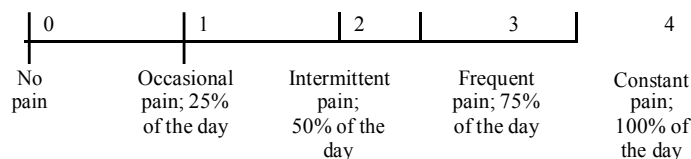
6. Recreation



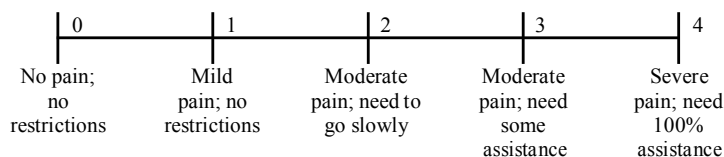
2. Sleeping



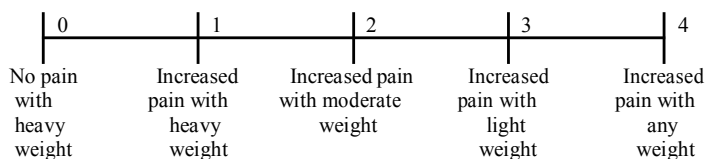
7. Frequency of Pain



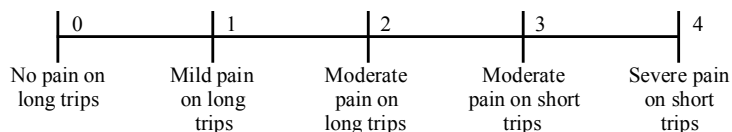
3. Personal Care (washing, dressing, etc.)



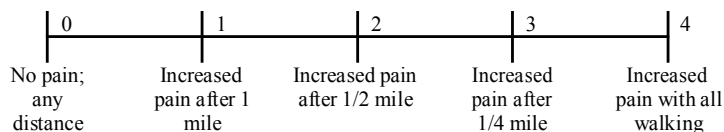
8. Lifting



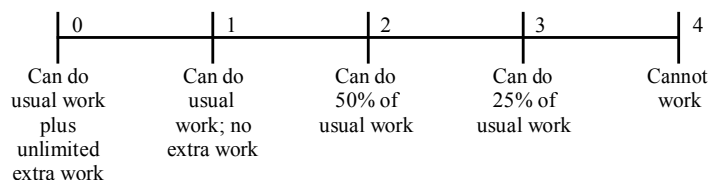
4. Travelling (driving, etc.)



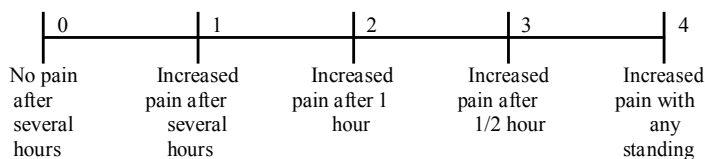
9. Walking



5. Work



10. Standing



Patient's Signature

Date

For Office Use Only:

Practitioner ID#: _____

Total Score _____ / 40

Clinical Diagnosis Codes:

Patient ID#: _____