### Chiropractic ongoing treatment questionnaire

**Player Name:** __________________  □ Male □ Female  □ Age: ___  □ Treatment no.: ___

**Diagnosis of condition treated / reason for consultation:** __________________________________

**If applicable, diagnosis of secondary condition treated:** ____________________________

**Please rate the degree of pain the player currently has for the primary condition:**

<table>
<thead>
<tr>
<th>No pain</th>
<th>0</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
<th>8</th>
<th>9</th>
<th>10</th>
<th>Worst possible pain</th>
</tr>
</thead>
</table>

**Reason for treatment (primary condition only):** (please ✓ one box)

- □ Treatment of acute pain/symptoms – injury occurred/recurred in past 0-3 months
- □ Treatment of chronic pain/symptoms – injury continuously present for >3 months
- □ Non-symptomatic/functional improvement/wellness/performance

**Where was treatment provided:** (please ✓ one box)

- □ Training location
- □ Match location
- □ Other: ______________________

**When was treatment provided:** (please ✓ one box)

- □ Pre training
- □ During scheduled training
- □ Post training
- □ Pre match
- □ During match
- □ Post match
- □ Other: ______________________

**How much time did you spend treating this patient (minutes)?** (please ✓ one box)

- □ Less than 5
- □ 6-10
- □ 11-15
- □ 16-20
- □ 20-30
- □ 31-45
- □ 45-60
- □ >60

**Treatment modalities:** (please ✓ one box)

- □ Passive (delivered by the chiropractor/practitioner)
- □ Active (home advice including exercises / to be performed by the player)
- □ Active and Passive

**Which techniques did you use / advise?** (please ✓ all)

- □ High velocity spinal manipulation
- □ High velocity peripheral manipulation
- □ Activator/instrument
- □ Orthopaedic blocking
- □ Stretching techniques
- □ Rehabilitation/therapeutic exercises
- □ Range of motion exercises
- □ Advised pharmacological agents (Please specify): __________________________

**Type and location of treatment:** (please ✓ the type of treatment and all regions)

- □ Joint based therapies
- □ Soft tissue based therapies
- □ Exercise / active therapies
- □ Head/neck
- □ Thoracic/ribs/trunk
- □ Lumbar/pelvis
- □ Hip
- □ Knee
- □ Ankle/foot
- □ Shoulder
- □ Elbow
- □ Wrist/hand

**Was co-management with another health care provider required?** (please ✓ all)

- □ No
- □ Yes

**Medical practitioner** □ Physiotherapist □ Massage therapist / Myotherapist □ Other ______________________

If applicable, was this provided/available at the event? (please ✓) □ No □ Yes