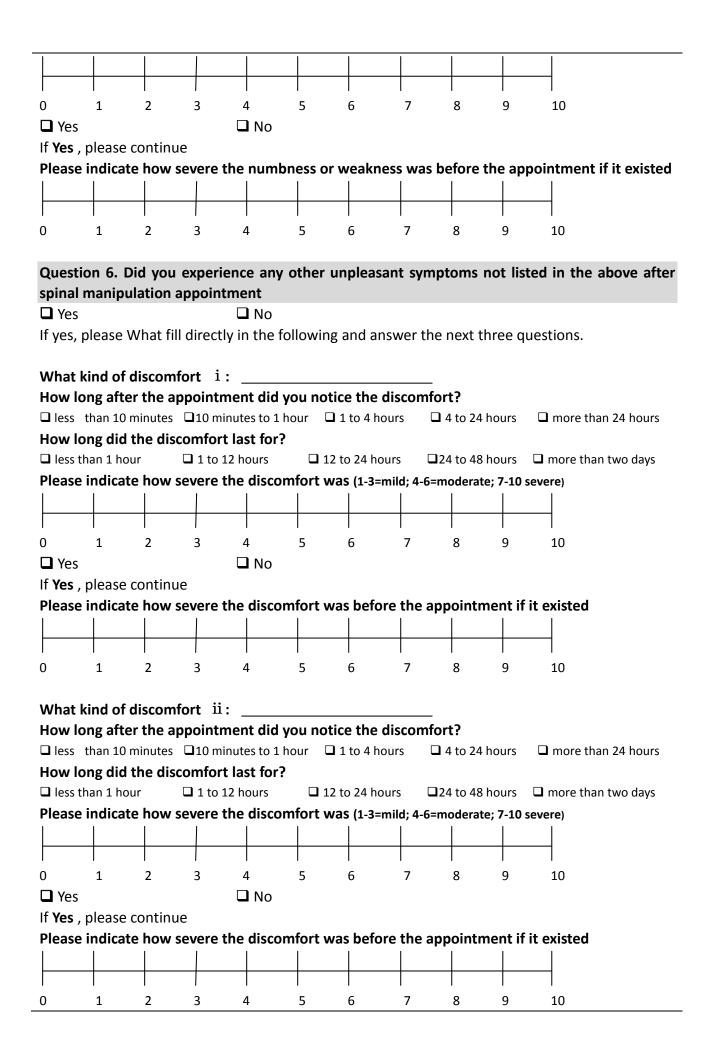
Accompanying Unpleasant Reactions Questionnaire

Apart from measuring any improvement of your condition we are seeking to develop an understanding of unpleasant reactions that people may experience accompanying with spinal manipulation treatment. Unpleasant reactions in this study may include anticipated reactions such as pain, numbness or muscle tightness, and some other unanticipated events. Your support in completing this questionnaire would be greatly appreciated as it will provide valuable information about the types of adverse events people may experience accompanying with spinal manipulation treatment. We estimate that this questionnaire will take 10-15 minutes to complete. Thank you for taking the time to complete this questionnaire.

Part A										
Question 1. Did you experience any new unwelcome symptoms or an increase of your presenting symptoms during the first 48 hours (two days) after treatment? This includes pain numbness, tightness or restrictions in daily activities										
Yes				☐ No						
If you answered No to Question 1 , please stop here. If you answered Yes to Question 1 , please continue										
Part B										
If you e	xperien	ced any	y comp	laints af	ter spina	al manip	ulation	treatme	nt, plea	ase mark the boxes
and sca	and scales below to indicate how long the complaint started, how long the complaint lasted, and									
how severe the complaint was.										
Question 2. Did you feel any lumbar muscle tightness or stiffness after spinal manipulation										
appointment										
☐ Yes				☐ No						
If yes, please answer the next three questions.										
How long after the appointment did you notice the stiffness?										
□ less than 10 minutes □ 10 minutes to 1 hour □ 1 to 4 hours □ 4 to 24 hours □ more than 24 hours										
How long did the stiffness last for?										
□ less than 1 hour □ 1 to 12 hours □ 12 to 24 hours □ 24 to 48 hours □ more than two days										
Please i	ndicate	how se	evere th	ne stiffne	ss was (1-3=mild;	4-6=mod	erate; 7-1	0 severe)	
										1
0	1	2	3	4	5	6	7	8	9	10
Yes				☐ No						
If Yes , please continue										
Please i	ndicate	how se	evere th	ne stiffne	ss was b	efore th	e appoi	ntment	if it exis	sted
										I
0	1	2	3	4	5	6	7	8	9	10

Question 3. Did you feel increased pain on waist, hip or leg, foot regionally after spinal

manıp	ulation	appoin	tment							
☐ Yes				☐ No						
If yes, please answer the next three questions.										
How long after the appointment did you notice the increased pain?										
□ less than 10 minutes □ 10 minutes to 1 hour □ 1 to 4 hours □ 4 to 24 hours □ more than 24 hours										
How le	ong did	the inc	reased p	oain last	for?					
☐ less t	than 1 ho	ur	☐ 1 to 1	2 hours	1 2	2 to 24 h	ours [⊒ 24 to 48	hours	☐ more than two days
Please	e indicat	e how	severe t	he pain v	was (1-3	=mild; 4-	-6=moder	ate; 7-10	severe)	
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☐ Yes				□ No						
	, please	continu	ıe							
				he pain v	was bef	ore the	appoin	tment if	it existe	ed
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0	1	2	3	4	5	6	7	8	9	10
-	_	_		•			-			
Quest	ion 4. D	id vou	feel inc	reased ra	adiating	nain c	on hin. I	eg. or fo	oot after	r spinal manipulation
	ntment	ia you		reasea i	uu.u	, p a c	эн нь р , н	c _B , c	or arte.	opinal mampalation
☐ Yes				□ No						
		ncwar	the nev	t three qu	uestions	2				
•	•			•			increas	ed radia	ting naiı	n?
How long after the appointment did you notice the increased radiating pain? ☐ less than 10 minutes ☐ 10 minutes to 1 hour ☐ 1 to 4 hours ☐ 4 to 24 hours ☐ more than 24 hours										
How long did the increased radiating pain last for?								□ 4 to 24	hours	☐ more than 24 hours
							ours	☐ 4 to 24	hours	☐ more than 24 hours
How l	ong did	the inc	reased r	adiating	pain la	st for?				
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How less to Please O Yes If Yes , Please O Quest manip Yes If yes, How less How less	ong did than 1 hoo e indicat 1 , please e e indicat 1 ion 5. culation please a ong afte than 10 ong did ong did	the incur e how s 2 continue how s 2 Did you appoint	reased reservere to 1 to 1 severe to 3 le severe to 3 ou feel the next ppointmum 10 min reased rea	radiating 2 hours he radiat 4 No he radiat 4 increase U No t three quality nutes to 1 increase	pain la: 12 ting pail 5 ting pail 5 ting pail 4 ting pail 5 ting pail 6 ting pail 6 ting pail 7 ting pail 7 ting pail 8 ting p	st for? 2 to 24 ho n was (3 6 n was b 6 sbness ice the 1 to 4 ho hakness	ours [1-3=mild; 7 pefore the state of the	akness of the desired numler of the 24 to	hours (left) erate; 7-1 9 intment 9 on leg oness or hours	more than two days 0 severe) 10 if it existed 10 or foot after spinal weakness? more than 24 hours
How less to Please	than 1 hore indicat 1 please a indicat 1 ion 5. pulation please a ong afte than 10 mong did than 1 hore	the incur e how s 2 continue e how s 2 Did you appoint answer or the a minutes the incur	reased reserver to 1 to 1 severe to 3 severe to 3 severe to 4 3 bu feel the next ppointm 10 min reased	radiating 2 hours he radiat 4 No he radiat 4 increase No t three quantities to 1 numbnes 2 hours	pain la: 12 ting pail 5 ting pail 6 ting pail 7 ting pail 8 ting pail 12 ting pail 13 ting pail 14 ting pail 15 ting pail 16 ting pail 17 ting pail 17 ting pail 18 ting pail 18 ting pail 18 ting pail 19 ting pa	st for? 2 to 24 ho n was (3 6 n was b 6 sice the 1 to 4 ho rakness 2 to 24 ho	ours 1-3=mild; 7 pefore the state of the	24 to 48 4-6=mod 8 ne appoi 8 akness (24 24 to 24 ?	hours (learning) 9 Intment 9 On leg hours hours	more than two days 0 severe) 10 if it existed 10 or foot after spinal weakness?



What kind of discomfort iii:										
How long after the appointment did you notice the discomfort?										
	□ less than 10 minutes □ 10 minutes to 1 hour □ 1 to 4 hours □ 4 to 24 hours □ more than 24 hours									
	How long did the discomfort last for?									
	han 1 ho			12 hours		2 to 24 h				☐ more than two days
Please	indicat	e how s	severe	the disco	mfort v	was (1-3=	mild; 4-6	=moderat	te; 7-10	severe)
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0	1	2	3	4	5	6	7	8	9	10
Yes				☐ No						
	please				_					
Please	indicat	e how s	severe	the disco	mfort v	was befo	ore the a	ppointr	nent if	it existed
I	I		ı	I	ı	I	ı		I	
0	1	2	3	4	5	6	7	8	9	10
Part C							_			
=	If you had any additional problems or increasing difficulties with the activities of daily living after									
spinal manipulation appointment										
Yes				☐ No						
if yes,	please i	ndicate								
Questi	Question 7. Did you have more difficulty with getting up, or maintaining posture, or changing									
posture in bed										
Yes				☐ No						
Questi	on 8. Di	id you ł	nave m	ore diffic	ulty wi	th sittin	g , or ris	ing fron	n a cha	ir
Yes				☐ No						
Questi	on 9. Di	id you h	nave m	ore diffic	ulty wi	th stand	ling			
Yes				☐ No						
Question 10. Did you have more difficulty with walking										
Yes				☐ No						
Question 11. Did you have more difficulty with dressing such as wearing trousers, socks, shoes										
☐ Yes				☐ No						
Question 12. Did you have more difficulty with personal hygiene such as washing your face, or										
brushing your teeth										
☐ Yes				☐ No						
Question 13. Did you have more difficulty with sleep disorders such as falling asleep with										
difficulty, or waking up easily because of pain										
☐ Yes	.,,		, J.	□ No	Pu	-				

Question 14. Did you have m	nore difficulty with defecating because of pain
☐ Yes	□ No
If there were any other problist on the space below	lems you experienced after spinal manipulation appointment, please
Part D If you experienced severe active following questions	dverse reactions after spinal manipulation treatment, please sign in
Question 15. Did you experie	ence saddle anesthesia, or defecation dysfunction
☐ Yes	□ No
Question 16. Did you exper suddenly missing	ience severely radicular pain, or ankle-foot sensorimotor function
☐ Yes	□ No
Part E	
-	e any additional therapy apart from doctor's treatment for your veeks of spinal manipulation treatment
☐ Yes	□ No

Thank you for taking the time to complete this questionnaire