

## 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 experienced any complaints after spinal manipulation treatment, please mark the boxes 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 indicate how severe the stiffness was (1-3=mild; 4-6=moderate; 7-10 severe)**



Yes  No

If **Yes**, please continue

**Please indicate how severe the stiffness was before the appointment if it existed**



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

**manipulation appointment**

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 long did the increased pain last for?**

less than 1 hour  1 to 12 hours  12 to 24 hours  24 to 48 hours  more than two days

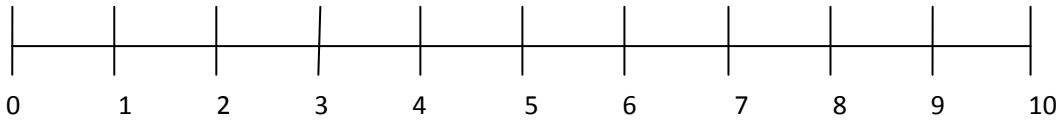
**Please indicate how severe the pain was (1-3=mild; 4-6=moderate; 7-10 severe)**



Yes  No

If Yes , please continue

**Please indicate how severe the pain was before the appointment if it existed**



**Question 4. Did you feel increased radiating pain on hip, leg, or foot after spinal manipulation appointment**

Yes  No

If yes, please answer the next three questions.

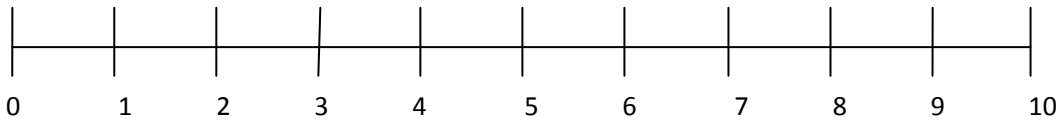
**How long after the appointment did you notice the increased radiating pain?**

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?**

less than 1 hour  1 to 12 hours  12 to 24 hours  24 to 48 hours  more than two days

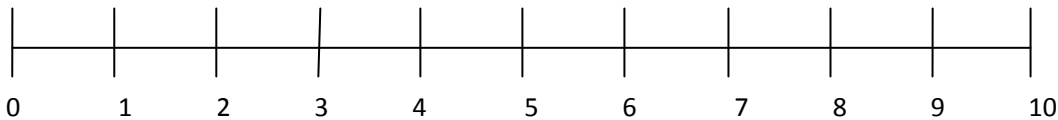
**Please indicate how severe the radiating pain was (1-3=mild; 4-6=moderate; 7-10 severe)**



Yes  No

If Yes , please continue

**Please indicate how severe the radiating pain was before the appointment if it existed**



**Question 5. Did you feel increased numbness or weakness on leg or foot after spinal manipulation appointment**

Yes  No

If yes, please answer the next three questions.

**How long after the appointment did you notice the increased numbness or weakness?**

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 numbness or weakness last for?**

less than 1 hour  1 to 12 hours  12 to 24 hours  24 to 48 hours  more than two days

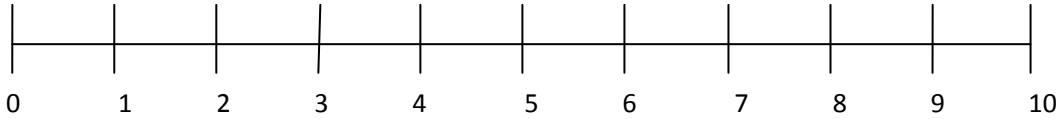
**Please indicate how severe the numbness or weakness was (1-3=mild; 4-6=moderate; 7-10 severe)**



Yes  No

If **Yes** , please continue

**Please indicate how severe the numbness or weakness was before the appointment if it existed**



**Question 6. Did you experience any other unpleasant symptoms not listed in the above after spinal manipulation appointment**

Yes  No

If yes, please What fill directly in the following and answer the next three questions.

**What kind of discomfort i :** \_\_\_\_\_

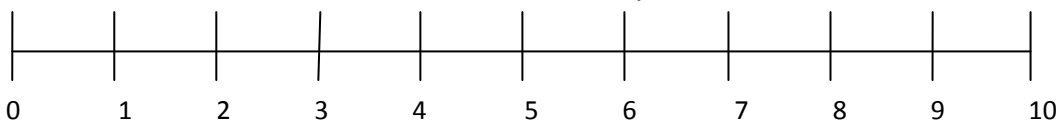
**How long after the appointment did you notice the discomfort?**

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?**

less than 1 hour  1 to 12 hours  12 to 24 hours  24 to 48 hours  more than two days

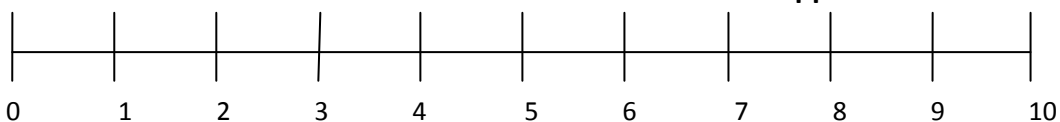
**Please indicate how severe the discomfort was (1-3=mild; 4-6=moderate; 7-10 severe)**



Yes  No

If **Yes** , please continue

**Please indicate how severe the discomfort was before the appointment if it existed**



**What kind of discomfort ii :** \_\_\_\_\_

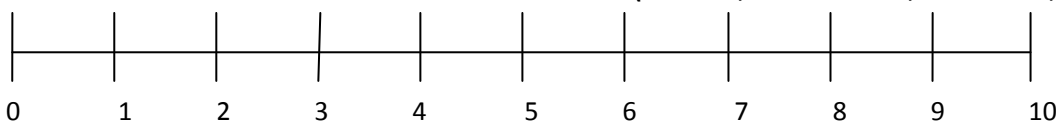
**How long after the appointment did you notice the discomfort?**

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?**

less than 1 hour  1 to 12 hours  12 to 24 hours  24 to 48 hours  more than two days

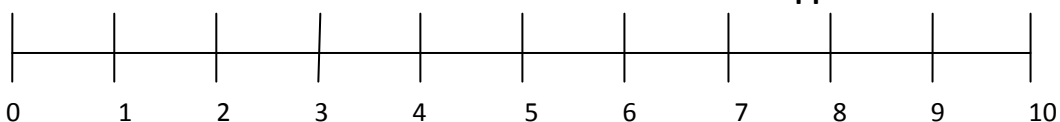
**Please indicate how severe the discomfort was (1-3=mild; 4-6=moderate; 7-10 severe)**



Yes  No

If **Yes** , please continue

**Please indicate how severe the discomfort was before the appointment if it existed**



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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?

less than 1 hour    1 to 12 hours    12 to 24 hours    24 to 48 hours    more than two days

Please indicate how severe the discomfort was (1-3=mild; 4-6=moderate; 7-10 severe)

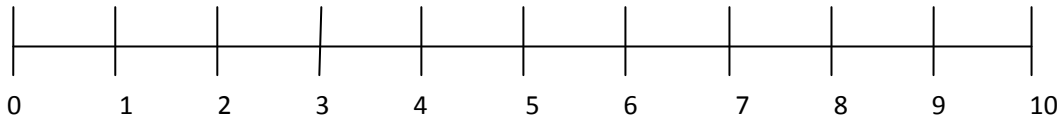


Yes

No

If Yes, please continue

Please indicate how severe the discomfort was before the appointment if it existed



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### 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 indicate

**Question 7. Did you have more difficulty with getting up, or maintaining posture, or changing posture in bed**

Yes

No

**Question 8. Did you have more difficulty with sitting, or rising from a chair**

Yes

No

**Question 9. Did you have more difficulty with standing**

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

No

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**Question 14. Did you have more difficulty with defecating because of pain**

Yes

No

If there were any other problems you experienced after spinal manipulation appointment, please list on the space below

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**Part D**

If you experienced severe adverse reactions after spinal manipulation treatment, please sign in the following questions

**Question 15. Did you experience saddle anesthesia, or defecation dysfunction**

Yes

No

**Question 16. Did you experience severely radicular pain, or ankle-foot sensorimotor function suddenly missing**

Yes

No

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**Part E**

**Question 17. Did you have any additional therapy apart from doctor's treatment for your complaints during the two weeks of spinal manipulation treatment**

Yes

No

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**Thank you for taking the time to complete this questionnaire**