

Patient Information

Date: ___/___/___
 Social Sec. # _____
 Patient Name _____
Last Name First Name Middle Initial
 Address _____
 City _____
 State _____ Zip _____
 E-mail _____
 Sex Male Female Age _____
 Birthdate ___/___/___
 Married Widowed Single Minor
 Separated Divorced Partnered
 Occupation _____
 Patient Employer/School _____
 Employer/School Address _____
 City _____
 State _____ Zip _____
 Employer/School Phone _____
 How did you hear about us? _____

Spouse's Name _____
 Birthdate _____
 SS# _____
 Spouses Employer _____

Staff Use Only

- Patient Chief Complaint Summary: _____

- SP Symptom Survey Form: _____

- Wellness Wheel Total Score: _____ Lowest: _____
- Toxicity Form - Section I: _____ Section II: _____ Total: _____
- Acidity Form - Section I: _____ Section II: _____ Total: _____
- Posture Exam Notes: _____

- Thermography Notes: _____

- X-Rays Taken: C-SP T-Sp L-Sp ___ Shoulder
 ___ Elbow ___ Knee ___ Foot
- Diagnosis Codes: _____

Phone Numbers

Home Phone (____) _____
 Cell Phone (____) _____
 Best time and place to reach you _____
 In Case of Emergency Contact _____
 Name _____
 Relationship _____
 Home Phone _____
 Work Phone _____

Accident Information

Is condition due to an accident or injury? Yes No
 Date of Accident ___/___/___
 Type of accident Auto Work Home Other
 Who have you made a report of your accident?
 Auto Insurance Employer Work Comp. Attorney Other
 Attorney Name (if applicable) _____
 Claim Adjuster (if applicable) _____
 Case Manager (if applicable) _____
 Case # _____

Informed Consent

- We invite you to discuss with us any questions regarding our services. The best health services are based on a friendly, mutual understanding between the provider and the patient.
- Our policy requires payment in full for all services rendered at the time of visit, unless other arrangements have been made with the business manager. If account is not paid within 90 days of the date of service and no financial arrangements have been made, you will be responsible for legal fees, collection agency fees, and any other expenses incurred in collecting your account.
- I authorize the staff of Lake Cities Chiropractic Center to perform any and all necessary services needed during diagnosis and treatment. I also authorize the provider and or managed care organization, to release any information required to process insurance claims.
- I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes to the information provided.

Signature _____ Date ___/___/___ Adult Guardian Spouse Representative

Consent for X-Ray Examination

I _____ do hereby give my permission to Lake Cities Chiropractic Center and its representatives to take X-RAYS as deemed appropriate by the examining doctor. I also hereby declare that to my knowledge, I am not pregnant.

Signature _____ Date _____

Health History

What treatment have you already received for your condition? Medication Surgery Physical Therapy Chiropractor Other:

Name and address of other doctor(s) who have treated you for your condition? _____

Date of your last: Physical Exam _____ Spinal X-Ray _____ Blood Test _____ Bone Density _____
MRI, CT-Scan, Bone Scan _____ Urine Test _____ Posture Exam: _____

Place a mark on Y or N to indicate if you have had any of the following:

AIDS	<input type="checkbox"/> Y <input type="checkbox"/> N	Emphysema	<input type="checkbox"/> Y <input type="checkbox"/> N	Miscarriage	<input type="checkbox"/> Y <input type="checkbox"/> N	Stroke	<input type="checkbox"/> Y <input type="checkbox"/> N
Alcoholism	<input type="checkbox"/> Y <input type="checkbox"/> N	Epilepsy	<input type="checkbox"/> Y <input type="checkbox"/> N	Mononucleosis	<input type="checkbox"/> Y <input type="checkbox"/> N	Suicide Attempt	<input type="checkbox"/> Y <input type="checkbox"/> N
Allergies	<input type="checkbox"/> Y <input type="checkbox"/> N	Fractures	<input type="checkbox"/> Y <input type="checkbox"/> N	Multiple Sclerosis	<input type="checkbox"/> Y <input type="checkbox"/> N	Thyroid Problems	<input type="checkbox"/> Y <input type="checkbox"/> N
Anemia	<input type="checkbox"/> Y <input type="checkbox"/> N	Glaucoma	<input type="checkbox"/> Y <input type="checkbox"/> N	Mumps	<input type="checkbox"/> Y <input type="checkbox"/> N	Tonsillitis	<input type="checkbox"/> Y <input type="checkbox"/> N
Anorexia	<input type="checkbox"/> Y <input type="checkbox"/> N	Goiter	<input type="checkbox"/> Y <input type="checkbox"/> N	Osteoporosis	<input type="checkbox"/> Y <input type="checkbox"/> N	Tuberculosis	<input type="checkbox"/> Y <input type="checkbox"/> N
Appendicitis	<input type="checkbox"/> Y <input type="checkbox"/> N	Gonorrhea	<input type="checkbox"/> Y <input type="checkbox"/> N	Osteopenia	<input type="checkbox"/> Y <input type="checkbox"/> N	Tumors	<input type="checkbox"/> Y <input type="checkbox"/> N
Arthritis	<input type="checkbox"/> Y <input type="checkbox"/> N	Gout	<input type="checkbox"/> Y <input type="checkbox"/> N	Pacemaker	<input type="checkbox"/> Y <input type="checkbox"/> N	Growths	<input type="checkbox"/> Y <input type="checkbox"/> N
Asthma	<input type="checkbox"/> Y <input type="checkbox"/> N	Heart Disease	<input type="checkbox"/> Y <input type="checkbox"/> N	Parkinson's	<input type="checkbox"/> Y <input type="checkbox"/> N	Typhoid	<input type="checkbox"/> Y <input type="checkbox"/> N
Bleeding Disorders	<input type="checkbox"/> Y <input type="checkbox"/> N	Hepatitis	<input type="checkbox"/> Y <input type="checkbox"/> N	Pinched Nerve	<input type="checkbox"/> Y <input type="checkbox"/> N	Ulcers	<input type="checkbox"/> Y <input type="checkbox"/> N
Breast Lump	<input type="checkbox"/> Y <input type="checkbox"/> N	Hernia	<input type="checkbox"/> Y <input type="checkbox"/> N	Pneumonia	<input type="checkbox"/> Y <input type="checkbox"/> N	Vaginal Infections	<input type="checkbox"/> Y <input type="checkbox"/> N
Bronchitis	<input type="checkbox"/> Y <input type="checkbox"/> N	Herniated Disc	<input type="checkbox"/> Y <input type="checkbox"/> N	Polio	<input type="checkbox"/> Y <input type="checkbox"/> N	Whooping Cough	<input type="checkbox"/> Y <input type="checkbox"/> N
Bulimia	<input type="checkbox"/> Y <input type="checkbox"/> N	Herpes	<input type="checkbox"/> Y <input type="checkbox"/> N	Prostate Problem	<input type="checkbox"/> Y <input type="checkbox"/> N	Other ▶	
Cancer	<input type="checkbox"/> Y <input type="checkbox"/> N	High Cholesterol	<input type="checkbox"/> Y <input type="checkbox"/> N	Prosthesis	<input type="checkbox"/> Y <input type="checkbox"/> N		
Cataracts	<input type="checkbox"/> Y <input type="checkbox"/> N	Kidney Disease	<input type="checkbox"/> Y <input type="checkbox"/> N	Psychiatric Care	<input type="checkbox"/> Y <input type="checkbox"/> N		
Drug Dependency	<input type="checkbox"/> Y <input type="checkbox"/> N	Liver Disease	<input type="checkbox"/> Y <input type="checkbox"/> N	Rheumatoid Arthritis	<input type="checkbox"/> Y <input type="checkbox"/> N		
Chicken Pox	<input type="checkbox"/> Y <input type="checkbox"/> N	Measles	<input type="checkbox"/> Y <input type="checkbox"/> N	Rheumatic Fever	<input type="checkbox"/> Y <input type="checkbox"/> N		
Diabetes	<input type="checkbox"/> Y <input type="checkbox"/> N	Migraines	<input type="checkbox"/> Y <input type="checkbox"/> N	Scarlet Fever	<input type="checkbox"/> Y <input type="checkbox"/> N		

Exercise	Work Activity	Habits	Please List Any Significant Injuries	Date
<input type="checkbox"/> None	<input type="checkbox"/> Sitting	<input type="checkbox"/> Smoking	<input type="checkbox"/> Falls	
<input type="checkbox"/> Moderate	<input type="checkbox"/> Standing	<input type="checkbox"/> Alcohol	<input type="checkbox"/> Head Injuries	
<input type="checkbox"/> Daily	<input type="checkbox"/> Light Labor	<input type="checkbox"/> Drug Use	<input type="checkbox"/> Broken Bones	
<input type="checkbox"/> Heavy	<input type="checkbox"/> Moderate Labor	<input type="checkbox"/> Caffeine	<input type="checkbox"/> Dislocations	
<input type="checkbox"/> Training	<input type="checkbox"/> Heavy Labor	<input type="checkbox"/> High Stress	<input type="checkbox"/> Sprain/Strains	

Medications	Allergies	Vitamins/Herbs/Minerals	Please list Any Surgeries	Date
1.	1.	1.	1.	
2.	2.	2.	2.	
3.	3.	3.	3.	
4.	4.	4.	4.	

PLEASE ANSWER THE FOLLOWING QUESTIONS TO THE BEST OF YOUR ABILITY

- What would you like to achieve from seeking care at our office? (eg.. better health, better range of motion, get out of pain...) _____
- What do you feel is or has been hindered by the condition(s) you are seeking help for? (eg.. golf game, driving, sitting, play with kids) _____
- What, if any are your previous experiences with chiropractic care? (eg.. good, bad, certain adjustment technique) _____
- Would you be interested in utilizing Clinical Aromatherapy/Essential Oil Therapy in conjunction with your treatment at our office?
 Yes No Comments: _____
- Do we have permission to communicate with you through e-mail? Typically we may use e-mail for the following: Sending and receiving forms, exercise plans, goal worksheets, information updates, monthly newsletters, clinic specials on products ect...This authorization is effective through 01-01-2015 unless written revocation to this office is received. _____ Initial Please.
 Yes No E-mail you would like us to use: _____

Chief Complaint: _____

Where did the problem begin? Home Work Play Travel

Date of Onset: _____

Mode of Onset: Sudden Gradual Worsening Chronic

Location: Neck Mid-Back Low Back Pelvis Other: _____

Consulted any other Dr.'s for this condition? Yes No

Name: _____

Address: _____

Still under care? Yes No | PCP Ortho Neuro

Prescription(s): _____

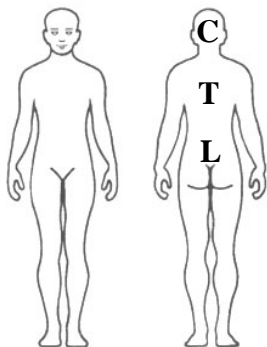
Remarks: _____

Was surgery recommended? Yes No : _____

Result of Treatment? Good Condition worse No Change

FRONT

BACK



Have you had previous chiropractic care? Yes No

Location: _____

When: _____ Last Adjustment ____/____/____

Why: _____

X-rays on file: Yes No Loc: C T L P E

Result of Treatment: Good Condition worse No Change

Do you have any secondary complaints? _____

Pain: C 1 2 3 4 5 6 7 8 9 10 T 1 2 3 4 5 6 7 8 9 10 L 1 2 3 4 5 6 7 8 9 10

Quality: Dull Sharp Stabbing Ache Tingle Numb
 Burn Tight Locked Soreness Annoying

Frequency: Constant Intermittent Intensity Fluctuates

Hindered: ADL Sports Kids Work

Radiate? R L Shoulder Arm Hand Leg Foot

Has it gotten progressively? Worse Better No Change

Aggravating Factors? Walking Sitting Standing Sleep

Worse w/ Activity? Yes No: _____

Reliving Factors? _____ Pt. Denies

Do any positions relieve the pain? Yes No No Change

Sitting Walking Lying: Up Down Side _____

Position you sleep in? Face Up Face Down Side _____

Is the Condition: Better Worse N/C in the AM PM

Has it affected any other systems? Yes Pt. Denies

Urinary Bowel Cardiac Respiratory Vision

Do you get Headaches? Yes No **Frequency:** ____ da/wk/mo

Is it worse if you cough or sneeze? Yes No **Loc:** _____

Is the patient house confined? Yes No **Duration:** _____

Have you missed work? Yes No **Amount:** _____

Date patient returned to normal work? ____/____/____ N/A

Have you ever had this condition before? Yes No

When: _____ # of prev. episodes? _____

Duration: _____

Treatment: Chiro. MD DO PT Other: _____

Results: Good Condition worse No Change

Have administered any home remedies? Yes No

OTC Ice Heat Massage Analgesic Creams

What: _____

Result: Did it help? Yes No _____

Diagnosis 1. _____ 2. _____ 3. _____

4. _____ 5. _____ 6. _____

Have you Previously worn custom orthotics? Yes No

Have you Previously undergone rehabilitation? Yes No

Have you ever undergone spinal decompression? Yes No

Have you ever had your spine scanned for neurological disturbances? Yes No

Do you normally take vitamins or supplements? Yes No

Are you currently dieting or watching your weight? Yes No

Do you drink adequate water on a daily basis? Yes No

Do you currently have a gym membership? Yes No

Do you eat out more frequently than at home? Yes No

Do you have meals on a regular basis? Yes No

Would you generally say that you are happy? Yes No

Do you drive long distances in traffic frequently? Yes No

Are you conscious about your posture? Yes No

Our patients choose our office because they want a natural approach to better health. On your first visit you'll meet the doctor to discuss your current health situation and to see if you're a good candidate for chiropractic care. If we think we can help, we'll conduct a thorough examination. This helps us identify the likely cause(s) of your problem. We'll tell you what we found, what we can do to help, how long it may take and how much it will cost. Our office enjoys high levels of patient satisfaction because we explain everything in advance. Find out for yourself!

Informed Consent to Chiropractic Treatment

The nature of chiropractic treatment: The doctor will use his/her hands or a mechanical device in order to move your joints. You may feel a “click” or “pop”, such as the noise when a knuckle is “cracked”, and you may feel movement of the joint. Various ancillary procedures, such as hot or cold packs, electric muscle stimulation, therapeutic ultrasound or dry hydrotherapy may also be used.

Possible Risks: As with any health care procedure, complications are possible following a chiropractic manipulation. Complications could include fractures of bone, muscular strain, ligamentous sprain, dislocations of joints, or injury to intervertebral discs, nerves or spinal cord. Cerebrovascular injury or stroke could occur upon severe injury to arteries of the neck. A minority of patients may notice stiffness or soreness after the first few days of treatment. The ancillary procedures could produce skin irritation, burns or minor complications.

Probability of risks occurring: The risks of complications due to chiropractic treatment have been described as “rare”, about as often as complications are seen from the taking of a single aspirin tablet. The risk of cerebrovascular injury or stroke, has been estimated at one in one million to one in twenty million, and can be even further reduced by screening procedures. The probability of adverse reaction due to ancillary procedures is also considered “rare”.

Other treatment options which could be considered may include the following:

- *Over-the-counter analgesics.* The risks of these medications include irritation to stomach, liver and kidneys, and other side effects in a significant number of cases.
- *Medical care,* typically anti-inflammatory drugs, tranquilizers, and analgesics. Risks of these drugs include a multitude of undesirable side effects and patient dependence in a significant number of cases.
- *Hospitalization* in conjunction with medical care adds risk of exposure to virulent communicable disease in a significant number of cases.
- *Surgery* in conjunction with medical care adds the risks of adverse reaction to anesthesia, as well as an extended convalescent period in a significant number of cases.

Risks of remaining untreated: Delay of treatment allows formation of adhesions, scar tissue and other degenerative changes. These changes can further reduce skeletal mobility, and induce chronic pain cycles. It is quite probable that delay of treatment will complicate the condition and make future rehabilitation more difficult.

Unusual risks: I have had the following unusual risks of my case explained to me.

I have read the explanation above of chiropractic treatment. I have had the opportunity to have any questions answered to my satisfaction. I have fully evaluated the risks and benefits of undergoing treatment. I have freely decided to undergo the recommended treatment, and hereby give my full consent to treatment.

Printed Name

Signature

Date

WITNESS:

Printed Name

Signature

Date

Acknowledgement for Consent to Use and Disclosure of Protected Health Information

Use and Disclosure of your Protected Health Information

Your Protected Health Information will be used by Lake Cities Chiropractic Center, P.C. or disclosed to others for the purposes of treatment, obtaining payment, or supporting the day-to-day health care operations of this office.

Notice of Privacy Practices

You should review the Notice of Privacy Practices for a more complete description of how your Protected Health Information may be used or disclosed. It describes your rights as they concern the limited use of health information, including your demographic information, collected from you and created or received by this office.

You may review the Notice prior to signing this consent. You may request a copy of the Notice at the Front Desk.

Requesting a Restriction on the Use or Disclosure of Your Information

You may request a restriction on the use or disclosure of your Protected Health Information.

This office may or may not agree to restrict the use or disclosure of your Protected Health Information.

If we agree to your request, the restriction will be binding with this office. Use or disclosure of protected information in violation of an agreed upon restriction will be a violation of the federal privacy standards.

Revocation of Consent

You may revoke this consent to the use and disclosure of your Protected Health Information. You must revoke this consent in writing. Any use or disclosure that has already occurred prior to the date on which your revocation of consent is received will not be affected.

Reservation of Right to Change privacy practice

This office reserves the right to modify the privacy practices outlined in the Notice.

Signature

I have reviewed this consent form and give my permission to this office to use and disclose my health information in accordance with it.

Name of Patient (print)

Signature of Patient

Date

Signature of Patient Representative

Date

Relationship of Patient Representative to Patient

Office Representative

Date

Others we may release your PHI to

NON-RESCINDABLE AGREEMENT LETTER

This agreement is between _____ and _____,
and any third-party involved in the accident on _____.

I, _____ do hereby authorize and agree to pay any outstanding
balance due on my account at the time of my release from care.

I instruct any monies due from my personal injury protection to be paid directly to my physician.
Furthermore, claims shall be paid in accordance with Article 5.06-3, in a timely manner, not to exceed 30
days upon receipt of each claim.

I instruct my attorney to pay in full any outstanding monies due my physician at the time of settlement with
any liability claim that may result from this case. My agreement to offset attorney's fees which my attorney
now or hereafter may claim to be owed by me. I instruct my attorney to pay my doctor immediately upon
settlement, by way of issuance of s separate draft made payable to the physician/clinic.

I instruct any third-party individual or insurance carrier that may be liable, to pay my physician direct for any
outstanding medical bills which are the result of this accident. If payment is not made until time of
settlement, I instruct the third party to issue a separate draft to be payable to the physician/clinic for the
medical bills.

I understand and acknowledge that all charges incurred by me are my responsibility regardless of any
settlement made by a third-party. I am instructing and agreeing to the above conditions as a safeguard to the
physician's right to collect payment. I understand that the physician/clinic has the right to expect good faith
payments on my account and that full payment is being deferred only until such time as a third party
settlement occurs. If a settlement does not occur within a reasonable amount of time, I agree to make other
arrangements to pay my account in full.

Patient's Signature

Date

ACKNOWLEDGEMENT OF RECEIPT OF AGREEMENT

As the insurance adjuster, or attorney, on this claim, I acknowledge that I have received notice of the
patient's agreement and will abide as instructed.

Adjuster/Attorney Signature

Date

VEHICLE ACCIDENT INFORMATION

PATIENT INFORMATION

Date _____

Patient Name _____

Date of Accident _____ Time of Accident _____ AM PM

Please describe the accident in your own words: _____

Were you the: Driver Front Passenger Rear Passenger Pedestrian How many people were involved? _____

ACCIDENT SITE	IMPACT
---------------	--------

Road/Street Name _____

City/State _____

Nearest Intersection with road/street _____

Driving Conditions Dry Wet Icy Other _____

Which direction were you headed? _____

Speed you were traveling? _____

Did your car impact another vehicle? Yes No

Did your car impact a structure? Yes No

If Yes, please explain: _____

Did any part of your body strike anything in the vehicle?

Yes No If yes, please explain: _____

Your Vehicle Information	Police
--------------------------	--------

Make and Model of your vehicle _____

Were You wearing your seat belt? Yes No

Type of belt: Lap Shoulder

Was your vehicle equipped with airbags? Yes No

If yes did they inflate properly? Yes No

Did your seat have a headrest? Yes No

If yes, what was the position of the headrest?

Low Mid-position High

Was impact from: Rear Front Right Left

At the time of impact were you?

Looking straight ahead Looking to the right

Looking to the left Looking down

Looking up

Were both hands on the steering wheel? Yes No

If no, which hand was on the wheel? Right Left

Was your foot on the brake? Yes No

If no, which foot was on the break? Right Left

Were you: Surprised by impact Braced for impact

Other Vehicle	Police
---------------	--------

Make and model of other vehicle _____

Which direction was the other vehicle headed? _____

Speed other vehicle was traveling? _____

Police

Did the police come to the accident site? Yes No

Were there any witnesses? Yes No

Was a police report filed? Yes No

Was a traffic violation issued? Yes No

If yes, to whom? _____

(Over)

VEHICLE ACCIDENT INFORMATION

Patient Condition

Were you unconscious immediately after the accident? Yes No If yes, how long? _____

Please describe how you felt immediately after the accident:

Treatment

Did you go to the hospital? Yes No

When did you go? Immediately after accident Next day 2 days or more after the accident

How did you get to the hospital? Ambulance Private transportation

Name of hospital _____ Name of doctor _____

Diagnosis _____

Treatment Received _____

X-rays Taken _____

Symptoms/Injuries

- | | | |
|---|---|--|
| <input type="checkbox"/> Arm/ Shoulder pain | <input type="checkbox"/> Feet/Toe numbness | <input type="checkbox"/> Neck pain |
| <input type="checkbox"/> Back pain | <input type="checkbox"/> Hand/Finger numbness | <input type="checkbox"/> Neck stiffness |
| <input type="checkbox"/> Back stiffness | <input type="checkbox"/> Headaches | <input type="checkbox"/> Shortness of breath |
| <input type="checkbox"/> Chest pain | <input type="checkbox"/> Irritability | <input type="checkbox"/> Sleep difficulty |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Jaw problems | <input type="checkbox"/> Stomach upset |
| <input type="checkbox"/> Ear buzzing | <input type="checkbox"/> Leg pain | <input type="checkbox"/> Tension |
| <input type="checkbox"/> Ear Ringing | <input type="checkbox"/> Memory loss | <input type="checkbox"/> Vision blurred |
| <input type="checkbox"/> Fatigue | <input type="checkbox"/> Nausea | <input type="checkbox"/> Shoulder pain |

Is this condition getting progressively worse? Yes No Unknown

Mark an X on the picture where you continue to have pain, numbness or tingling.

Rate the severity of your pain on a scale from 1 (least) to 10 (severe pain) _____

Type of pain you are experiencing:

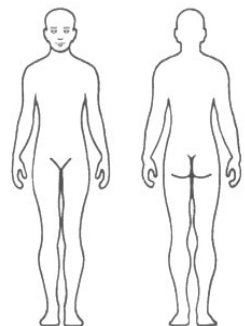
- | | | | | |
|-----------------------------------|---------------------------------------|------------------------------------|-----------------------------------|------------------------------------|
| <input type="checkbox"/> Sharp | <input type="checkbox"/> Dull | <input type="checkbox"/> Throbbing | <input type="checkbox"/> Numbness | <input type="checkbox"/> Aching |
| <input type="checkbox"/> Shooting | <input type="checkbox"/> Burning | <input type="checkbox"/> Tingling | <input type="checkbox"/> Cramps | <input type="checkbox"/> Stiffness |
| <input type="checkbox"/> Swelling | <input type="checkbox"/> Other: _____ | | | |

How often do you have this pain? _____

Is it constant or does it come and go? _____

Does it interfere with your: Work Sleep Daily routine Recreation Family interactions

Activities or movements that are painful to perform: Sitting Standing Walking Bending Lying down



I certify that the above information is correct to the best of my knowledge.

Patient signature _____ Date _____

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 relate to you. But **PLEASE JUST CHECK THE ONE CHOICE THAT MOST CLOSELY DESCRIBES YOUR PROBLEM RIGHT NOW.**

<p>Section 1 – Pain Intensity</p> <ul style="list-style-type: none"> <input type="checkbox"/> 0. I have no pain at the moment. <input type="checkbox"/> 1. The pain is very mild at the moment <input type="checkbox"/> 2. The pain is very moderate at the moment. <input type="checkbox"/> 3. The pain is fairly severe at the moment. <input type="checkbox"/> 4. The pain is very severe at the moment <input type="checkbox"/> 5. The pain is the worst imaginable at the moment. 	<p>Section 6 – Concentration</p> <ul style="list-style-type: none"> <input type="checkbox"/> 0. I can concentrate when I want to with no difficulty <input type="checkbox"/> 1. I can concentrate fully when I want to with slight difficulty. <input type="checkbox"/> 2. I have a fair degree of difficulty in concentrating when I want. <input type="checkbox"/> 3. I have a lot of difficulty in concentrating when I want to. <input type="checkbox"/> 4. I have a great deal of difficulty in concentrating when I want to. <input type="checkbox"/> 5. I cannot concentrate at all.
<p>Section 2 – Personal Care (Washing, Dressing, etc.)</p> <ul style="list-style-type: none"> <input type="checkbox"/> 0. I can look after myself normally without causing extra pain. <input type="checkbox"/> 1. I can look after myself normally, but it causes extra pain. <input type="checkbox"/> 2. It is painful to look after myself and I am slow and careful. <input type="checkbox"/> 3. I need some help, but manage most of my personal care. <input type="checkbox"/> 4. I need help every day in most aspects of self care. <input type="checkbox"/> 5. I do not get dressed; I wash with difficulty and stay in bed. 	<p>Section 7 – Work</p> <ul style="list-style-type: none"> <input type="checkbox"/> 0. I can do as much work as I want to. <input type="checkbox"/> 1. I can only do my usual work, but no more. <input type="checkbox"/> 2. I can do most of my usual work, but no more. <input type="checkbox"/> 3. I cannot do my usual work. <input type="checkbox"/> 4. I can hardly do any work at all. <input type="checkbox"/> 5. I cannot do any work at all.
<p>Section 3 – Lifting</p> <ul style="list-style-type: none"> <input type="checkbox"/> 0. I can lift heavy weights without extra pain. <input type="checkbox"/> 1. I can lift heavy weights, but it gives extra pain. <input type="checkbox"/> 2. Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned, for example, on a table. <input type="checkbox"/> 3. Pain prevents me from lifting heavy weights, but I can manage light to medium weight if they are conveniently positioned. <input type="checkbox"/> 4. I can lift very light weights. <input type="checkbox"/> 5. I cannot lift or carry anything at all. 	<p>Section 8 – Driving</p> <ul style="list-style-type: none"> <input type="checkbox"/> 0. I can drive my car without any neck pain. <input type="checkbox"/> 1. I can drive my car as long as I want with slight pain in my neck. <input type="checkbox"/> 2. I can drive my car as long as I want with moderate pain in my neck. <input type="checkbox"/> 3. I cannot drive my car as long as I want because of moderate pain in my neck. <input type="checkbox"/> 4. I can hardly drive at all because of severe pain in my neck. <input type="checkbox"/> 5. I cannot drive my car at all.
<p>Section 4 – Reading</p> <ul style="list-style-type: none"> <input type="checkbox"/> 0. I can read as much as I want to with no pain in my neck. <input type="checkbox"/> 1. I can read as much as I want to with slight pain in my neck. <input type="checkbox"/> 2. I can read as much as I want to with moderate pain in my neck. <input type="checkbox"/> 3. I cannot read as much as I want because of moderate pain in my neck. <input type="checkbox"/> 4. I cannot read as much as I want to because of severe pain in my neck. <input type="checkbox"/> 5. I cannot read at all. 	<p>Section 9 – Sleeping</p> <ul style="list-style-type: none"> <input type="checkbox"/> 0. I have no trouble sleeping <input type="checkbox"/> 1. My sleep is slightly disturbed (less than 1 hour sleepless) <input type="checkbox"/> 2. My sleep is mildly disturbed (1-2 hours sleepless) <input type="checkbox"/> 3. My sleep is moderately disturbed (2-3 hours sleepless) <input type="checkbox"/> 4. My sleep is greatly disturbed (3-5 hours sleepless) <input type="checkbox"/> 5. My sleep is completely disturbed (5-7 hours)
<p>Section 5 – Headaches</p> <ul style="list-style-type: none"> <input type="checkbox"/> 0. I have no headaches at all <input type="checkbox"/> 1. I have slight headaches with come infrequently. <input type="checkbox"/> 2. I have moderate headaches which come infrequently. <input type="checkbox"/> 3. I have moderate headaches which come frequently. <input type="checkbox"/> 4. I have severe headaches which come frequently. <input type="checkbox"/> 5. I have headaches almost all the time. 	<p>Section 10 – Recreation</p> <ul style="list-style-type: none"> <input type="checkbox"/> 0. I am able to engage in all of my recreational activities with no neck pain at all. <input type="checkbox"/> 1. I am able to engage in all of my recreational activities with some pain in my neck. <input type="checkbox"/> 2. I am able to engage in most, but not all of my recreational activities because of pain in my neck. <input type="checkbox"/> 3. I am able to engage in a few of my recreational activities because of pain in my neck. <input type="checkbox"/> 4. I can hardly do any recreational activities because of pain in my neck. <input type="checkbox"/> 5. I cannot do any recreational activities at all.

Comments: _____

Oswestry Back Disability Index

Please Read: Could you please complete this questionnaire. It is designed to give us information as to how your back (or leg) trouble has affected you ability to manage in everyday life. Please answer every section. Mark **one box only** in each section that most closely describes you **today**.

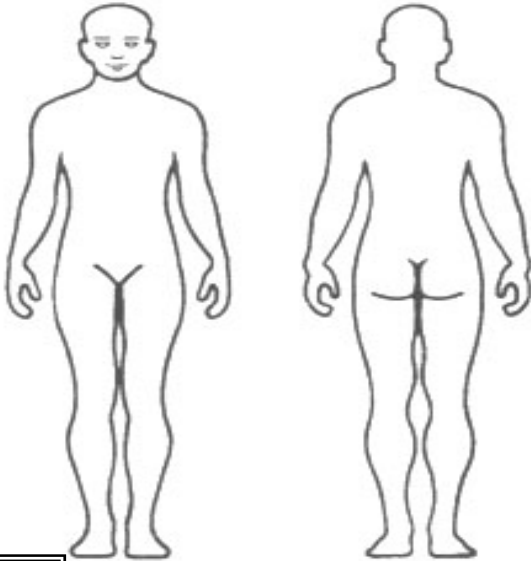
<p>Section 1 – Pain Intensity</p> <ul style="list-style-type: none"> <input type="checkbox"/> 0. I have no pain at the moment. <input type="checkbox"/> 1. The pain is very mild at the moment <input type="checkbox"/> 2. The pain is moderate at the moment. <input type="checkbox"/> 3. The pain is fairly severe at the moment. <input type="checkbox"/> 4. The pain is very severe at the moment <input type="checkbox"/> 5. The pain is the worst imaginable at the moment. 	<p>Section 6 – Standing</p> <ul style="list-style-type: none"> <input type="checkbox"/> 0. I can stand as long as I want without extra pain. <input type="checkbox"/> 1. I can stand as long as I want but it gives me extra pain. <input type="checkbox"/> 2. Pain prevents me from standing for more than 1 hour. <input type="checkbox"/> 3. Pain prevents me from standing for more than 1/2 hour. <input type="checkbox"/> 4. Pain prevents me from standing for more than 10 minutes. <input type="checkbox"/> 5. Pain prevents me from standing at all.
<p>Section 2 – Personal Care (Washing, Dressing, etc.)</p> <ul style="list-style-type: none"> <input type="checkbox"/> 0. I can look after myself normally without causing extra pain. <input type="checkbox"/> 1. I can look after myself normally, but it is very painful. <input type="checkbox"/> 2. It is painful to look after myself and I am slow and careful. <input type="checkbox"/> 3. I need some help, but manage most of my personal care. <input type="checkbox"/> 4. I need help every day in most aspects of self care. <input type="checkbox"/> 5. I do not get dressed; I wash with difficulty and stay in bed. 	<p>Section 7 – Sleeping</p> <ul style="list-style-type: none"> <input type="checkbox"/> 0. My sleep is never disturbed by pain. <input type="checkbox"/> 1. My sleep is occasionally disturbed by pain. <input type="checkbox"/> 2. Because of pain I have less than 6 hours' sleep. <input type="checkbox"/> 3. Because of pain I have less than 4 hours' sleep. <input type="checkbox"/> 4. Because of pain I have less than 2 hours' sleep. <input type="checkbox"/> 5. Pain prevents me from sleeping at all.
<p>Section 3 – Lifting</p> <ul style="list-style-type: none"> <input type="checkbox"/> 0. I can lift heavy weights without extra pain. <input type="checkbox"/> 1. I can lift heavy weights, but it causes extra pain. <input type="checkbox"/> 2. Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned, for example, on a table. <input type="checkbox"/> 3. Pain prevents me from lifting heavy weights, but I can manage light to medium weight if they are conveniently positioned. <input type="checkbox"/> 4. I can only lift very light weights, at the most <input type="checkbox"/> 5. I cannot lift or carry anything at all. 	<p>Section 8 – Sex Life (if applicable)</p> <ul style="list-style-type: none"> <input type="checkbox"/> 0. My sex life is normal and causes me no extra pain. <input type="checkbox"/> 1. My sex life is normal and causes me some extra pain. <input type="checkbox"/> 2. My sex life is nearly normal, but is very painful. <input type="checkbox"/> 3. My sex life is severely restricted by pain. <input type="checkbox"/> 4. My sex life is nearly absent because of pain. <input type="checkbox"/> 5. Pain prevents any sex life at all.
<p>Section 4 – Walking</p> <ul style="list-style-type: none"> <input type="checkbox"/> 0. Pain does not prevent me from walking any distance. <input type="checkbox"/> 1. Pain prevents me from walking more than one mile. <input type="checkbox"/> 2. Pain prevents me from walking more than 1/4th mile. <input type="checkbox"/> 3. Pain prevents me from walking more than 100 yds. <input type="checkbox"/> 4. I can only walk while using a stick or crutches <input type="checkbox"/> 5. I am in bed most of the time and have to crawl to the toilet. 	<p>Section 9 – Social Life</p> <ul style="list-style-type: none"> <input type="checkbox"/> 0. My social life is normal and causes me no extra pain. <input type="checkbox"/> 1. My social life is normal, but increases the degree of pain. <input type="checkbox"/> 2. Pain has no significant effect on my social life apart from limiting my more energetic interest, eg., sports. <input type="checkbox"/> 3. Pain has restricted my social life and I do not go out as often. <input type="checkbox"/> 4. Pain has restricted my social life to my home. <input type="checkbox"/> 5. I have no social life because of the pain.
<p>Section 5 – Sitting</p> <ul style="list-style-type: none"> <input type="checkbox"/> 0. I can sit in any chair as long as I like. <input type="checkbox"/> 1. I can only sit in my favorite chair as long as I like. <input type="checkbox"/> 2. Pain prevents me from sitting more than 1 hour. <input type="checkbox"/> 3. Pain prevents me from sitting more than 1/2 hour. <input type="checkbox"/> 4. Pain prevents me from sitting more than ten minutes. <input type="checkbox"/> 5. Pain prevents me from sitting at all. 	<p>Section 10 – Traveling</p> <ul style="list-style-type: none"> <input type="checkbox"/> 0. I can travel anywhere without pain. <input type="checkbox"/> 1. I can travel anywhere but it gives me extra pain. <input type="checkbox"/> 2. Pain is bad but I manage journeys over 2 hours. <input type="checkbox"/> 3. Pain restricts me to journeys of less than 1 hour. <input type="checkbox"/> 4. Pain restricts me to short necessary journeys under 30 minutes. <input type="checkbox"/> 5. Pain prevents me from traveling except to receive treatment.

Comments: _____

Patient Name: _____ Date: ___/___/___ Case: _____

1

Please indicate on the chart where you are experiencing pain, concern, or seeking treatment for this office visit.



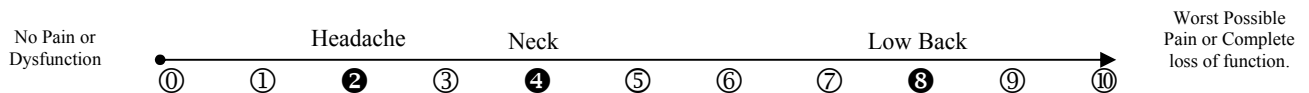
Describe the LOCATION and SYMPTOMS you are experiencing below:

^^^ Ache === Numbness 000 Pins & Needles/Numbness
 xxx Burning Sensation /// Sharp or Stabbing Pain

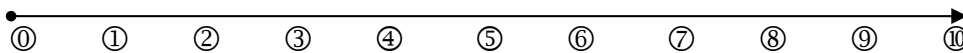
2

INSTRUCTIONS: Please fill in the circle of the number that best describes the question being asked. (0= NO PAIN or DYSFUNCTION, 5=MODERATE PAIN or DYSFUNCTION, and 10=WORST PAIN IMMAGINABLE or COMPLETE LOSS OF FUNCTION) *Dysfunction = impaired or abnormal function of a muscle or joint of the body.*

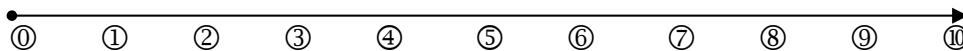
Example:



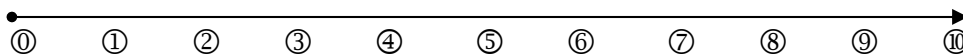
1. What is your pain/dysfunction level right now?



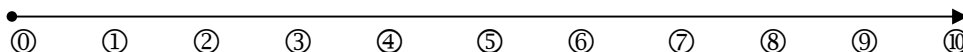
2. What is your typical or average pain/dysfunction?



3. What is your pain/dysfunction level at it's best? (How close to "0" does you pain get at it's best)



4. What is you pain/dysfunction level at it's worst (how close to "10" does your pain get at it's worst)



((1+2+4)/3) x10 **Score:** _____