Welcome

Patient Information

Date _____

SS/HIC/Patient ID # _____

Patient Name _____
Last Name

_____
First Name Middle Initial

Address _____

City _____

State _____ Zip _____

E-mail _____

Sex ☐ M ☐ F Age _____

Birthdate _____

☐ Married ☐ Widowed ☐ Single ☐ Minor

☐ Separated ☐ Divorced ☐ Partnered for _____ years

Occupation _____

Patient Employer/School _____

Employer/School Address _____

_____

Employer/School Phone (_____) _____

Spouse's Name _____

Birthdate _____

SS# _____

Spouse's Employer _____

Whom may we thank for referring you? _____

Insurance

Who is responsible for this account? _____

Relationship to Patient _____

Insurance Co. _____

Group # _____

Is patient covered by additional insurance? ☐ Yes ☐ No

Subscriber's Name _____

Birthdate _____ SS# _____

Relationship to Patient _____

Insurance Co. _____

Group # _____

ASSIGNMENT AND RELEASE

I certify that I, and/or my dependent(s), have insurance coverage with

_____ and assign directly to
Name of Insurance Company(ies)

Dr. _____ all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named doctor may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

_____
Signature of Patient, Parent, Guardian or Personal Representative

_____
Please print name of Patient, Parent, Guardian or Personal Representative

_____ _____
Date Relationship to Patient

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? ☐ Yes ☐ No

Date _____

Type of accident ☐ Auto ☐ Work ☐ Home ☐ Other

To whom have you made a report of your accident?
☐ Auto Insurance ☐ Employer ☐ Worker Comp. ☐ Other

Attorney Name (if applicable)

_____

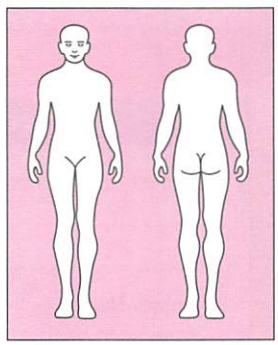
Patient Condition

Reason for Visit _____

When did your symptoms appear? _____

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 pain) to 10 (severe pain) _____

Type of pain: ☐ Sharp ☐ Dull ☐ Throbbing ☐ Numbness ☐ Aching ☐ Shooting
☐ Burning ☐ Tingling ☐ Cramps ☐ Stiffness ☐ Swelling ☐ 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

Activities or movements that are painful to perform ☐ Sitting ☐ Standing ☐ Walking ☐ Bending ☐ Lying Down

Health History

What treatment have you already received for your condition? ☐ Medications ☐ Surgery ☐ Physical Therapy

☐ Chiropractic Services ☐ None ☐ Other _____

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

Date of Last: Physical Exam _____ Spinal X-Ray _____ Blood Test _____

Spinal Exam _____ Chest X-Ray _____ Urine Test _____

Dental X-Ray _____ MRI, CT-Scan, Bone Scan _____

Place a mark on "Yes" or "No" to indicate if you have had any of the following:

AIDS/HIV	☐ Yes	☐ No	Chicken Pox	☐ Yes	☐ No	Liver Disease	☐ Yes	☐ No	Rheumatoid Arthritis	☐ Yes	☐ No
Alcoholism	☐ Yes	☐ No	Diabetes	☐ Yes	☐ No	Measles	☐ Yes	☐ No	Rheumatic Fever	☐ Yes	☐ No
Allergy Shots	☐ Yes	☐ No	Emphysema	☐ Yes	☐ No	Migraine Headaches	☐ Yes	☐ No	Scarlet Fever	☐ Yes	☐ No
Anemia	☐ Yes	☐ No	Epilepsy	☐ Yes	☐ No	Miscarriage	☐ Yes	☐ No	Stroke	☐ Yes	☐ No
Anorexia	☐ Yes	☐ No	Fractures	☐ Yes	☐ No	Mononucleosis	☐ Yes	☐ No	Suicide Attempt	☐ Yes	☐ No
Appendicitis	☐ Yes	☐ No	Glaucoma	☐ Yes	☐ No	Multiple Sclerosis	☐ Yes	☐ No	Thyroid Problems	☐ Yes	☐ No
Arthritis	☐ Yes	☐ No	Goiter	☐ Yes	☐ No	Mumps	☐ Yes	☐ No	Tonsillitis	☐ Yes	☐ No
Asthma	☐ Yes	☐ No	Gonorrhea	☐ Yes	☐ No	Osteoporosis	☐ Yes	☐ No	Tuberculosis	☐ Yes	☐ No
Bleeding Disorders	☐ Yes	☐ No	Gout	☐ Yes	☐ No	Pacemaker	☐ Yes	☐ No	Tumors, Growths	☐ Yes	☐ No
Breast Lump	☐ Yes	☐ No	Heart Disease	☐ Yes	☐ No	Parkinson's Disease	☐ Yes	☐ No	Typhoid Fever	☐ Yes	☐ No
Bronchitis	☐ Yes	☐ No	Hepatitis	☐ Yes	☐ No	Pinched Nerve	☐ Yes	☐ No	Ulcers	☐ Yes	☐ No
Bulimia	☐ Yes	☐ No	Hernia	☐ Yes	☐ No	Pneumonia	☐ Yes	☐ No	Vaginal Infections	☐ Yes	☐ No
Cancer	☐ Yes	☐ No	Herniated Disk	☐ Yes	☐ No	Polio	☐ Yes	☐ No	Venereal Disease	☐ Yes	☐ No
Cataracts	☐ Yes	☐ No	Herpes	☐ Yes	☐ No	Prostate Problem	☐ Yes	☐ No	Whooping Cough	☐ Yes	☐ No
Chemical Dependency	☐ Yes	☐ No	High Cholesterol	☐ Yes	☐ No	Prosthesis	☐ Yes	☐ No	Other _____		
			Kidney Disease	☐ Yes	☐ No	Psychiatric Care	☐ Yes	☐ No	_____		

EXERCISE
- ☐ None
- ☐ Moderate
- ☐ Daily
- ☐ Heavy

WORK ACTIVITY
- ☐ Sitting
- ☐ Standing
- ☐ Light Labor
- ☐ Heavy Labor

HABITS
- ☐ Smoking — Packs/Day _____
- ☐ Alcohol — Drinks/Week _____
- ☐ Coffee/Caffeine Drinks — Cups/Day _____
- ☐ High Stress Level — Reason _____

Are you pregnant? ☐ Yes ☐ No Due Date _____

Injuries/Surgeries you have had	Description	Date
Falls		
Head Injuries		
Broken Bones		
Dislocations		
Surgeries		

Medications	Allergies	Vitamins/Herbs/Minerals
Pharmacy Name _____		
Pharmacy Phone (____) _____		

Alliance Chiropractic of S-E
Natural Health Center
10701 W. Manslick Rd. Louisville/Fairdale Ky 40118, (502) 367-2112

INFORMED CONSENT TO CHIROPRACTIC ADJUSTMENTS AND CARE

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy and diagnostic x-rays, on me (or on the patient named below, for whom I am legally responsible) by the doctor of chiropractic named below and /or other licensed doctors of chiropractic named below, including those working at the clinic or office listed below or any other office or clinic.

I have had an opportunity to discuss with the doctor of chiropractic named below and/or with other office or clinic personnel the nature and purpose of chiropractic adjustments and other procedures.

I understand and am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment, including, but not limited to, fractures, disc injuries, strokes, dislocations and sprains. I do not expect the doctor to be able to anticipate and explain all risk and complications, and I wish to rely on the doctor to exercise judgment during the course of the procedure which the doctor feels at this time, based upon the facts then known, and is in my best interests.

I have read, or have had to read to me, the above consent. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above-named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future conditions for which I seek treatment.

TO BE COMPLETED BY PATIENT

_____

Print Patient's Name

_____

Patient's Signature Date

IF PATIENT IS UNABLE TO SIGN:

_____

Print Name of Patient's Representative

Natural Health Center

I, _____ have received a copy of this office's Privacy Notice. I also understand that I may view the Privacy Notice of this office upon request.

Also, I give my permission for **Natural Health Center** to call me with appointment reminders. I understand that reminder may include information that may identify me by my first name only and **Natural Health Center.**

I will allow them to leave a message: (please check all that apply)

_____ At my home with a family member.

_____ At my home on an answering machine or voice mail

_____ On my cell phone voice mail

_____ On my cell phone (text message)

_____ At my office with another co-worker

_____ At my office on an answering machine or voice mail.

Patient Signature: _____

Date: _____

N.H.C. Natural Health Center
CHIROPRACTIC & SPINAL REHABILITATION

Mosen R. Khani, D.C.

10701 West Manslick Road
Louisville, (Fairdale) Kentucky 40118
Telephone: (502) 367-2112
Fax: (502) 367-7799

I _____ do hereby give permission to this office, its successors and assigns to call or text (either manually or with the use of any automated dialing systems or equipment) any cell phone owned or otherwise provided by me.

I give permission to this office, its successors and assigns to leave messages which include company name on my voicemail including home and cell phone.

I give permission to this office, its successors and assigns to email me at any email address provided by me or my spouse.

I do hereby agree to notify this office, its successors and its collection agency when I change my email or voicemail including home and cell.

By providing this office, its successors and assigns with this information I warrant and assume full responsibility that I have authorization to grant these permissions.

_____ _____

Signature Date

Natural Health
CENTER

ALLIANCE CHIROPRACTIC OF SOUTH EAST, LLC

MOSEN R. KHANI, D.C. DIR.
10701 WEST MANSLICK ROAD
LOUISVILLE, (FAIRDALE), KENTUCKY 40118
TELEPHONE: (502) 367-2112
FAX: (502) 367-7799

Patient's Name: _____ Date: _____

I, _____, in signing this form, state to the best of my knowledge, there is no pregnancy, confirmed or suspected at this time.

Patient's Name: _____

Witness Signature: _____

ASSIGNMENT AND INSTRUCTION FOR DIRECT PAYMENT TO DOCTOR
PRIVATE, GROUP, ACCIDENT, AND HEALTH INSURANCE

Patient: _____

Employer: _____

Insurance Company: _____

Claim/Group No.: _____

Social Security No.: _____ Drivers License No.: _____

I hereby instruct and direct the _____ Insurance Company to pay by check made out and mailed directly to:

Alliance Chiropractic of S.E., Natural Health Center
10701 W. Manslick Rd.
Louisville/Fairdale, KY 40118

If my current policy prohibits direct payment to doctor, then I hereby also instruct and direct you to make out the check to me and mail it as follows:

My Name
Alliance Chiropractic of S.E., Natural Health Center
10701 W. Manslick Rd.
Louisville/Fairdale, KY 40118

The professional and/or medical expense benefits allowable and otherwise payable to me under my current insurance policy as payment toward the total charges for professional services rendered. THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY to this office to act on my behalf otherwise. This payment will not exceed my indebtedness to the above-mentioned assignee, and I have agreed to pay, in a current manner, any balance of said professional services charges over and above this insurance payment.

A photocopy of this Assignment shall be considered as effective and valid as the original and as so, it is hereby and thereafter non revocable.

I also authorize the release of any information pertinent to my case to any insurance company, adjuster, or attorney involved in this case.

Dated at _____ this _____ day of _____, 20____

_____ _____
Signature of policy holder Witness

_____
Signature of Claimant, if other than Policyholder

FINANCIAL AGREEMENT

Alliance Chiropractic of S.E.

Natural Health Center

10701 W. Manslick Rd., Louisville/Fairdale KY 40118, 502-367-2112

It is important for each patient to understand that their treatment programs are based on examination, x-rays, and symptomatic findings. A chiropractic treatment program should never be based on the type of insurance a patient has, or whether or not the patient has coverage at all.

Spinal misalignment, called SUBLUXATION, is what we are treating. All subluxations are very serious because they are degenerative in nature. Subluxations are proven to cause early deterioration of discs, joints, cartilage, bone, as well as causing chronic nerve and muscle irritation. In reality, the restoration of life force into your body is priceless. The longer chiropractic treatment is delayed, the less the results.

It is for this reason that we at this office are dedicated to treating spinal subluxation, regardless of a patient's insurance coverage or income. We value chiropractic and what we do. If chiropractic is something that you choose to make a part of your life, then it must be of value to you.

Payments are based on what the patient can fit into their budget. Once a weekly payment is determined, that amount will be paid each week.

Initially, the balance will run higher than the amount paid. However, as the patient gets well, the treatment will decrease and the balance will diminish. If the patient has insurance, the same program will be used toward reducing the patient's balance.

This facility operates on FEE-FOR-SERVICES basis and those fees are payable in advance, unless other arrangements have been made.

We reserve the right to charge for cancellations without a 24 hour notice, a minimum charge of $45.00, billed to the patient and not the insurance company, and a $25.00 fee for all returned checks.

FINANCIAL AND INSURANCE POLICY

We will gladly accept your insurance assignment in lieu of payment from you for your care and treatment in our office. However, it must be fully understood that the contract is between you and your insurance company and that you are fully responsible for any amount not paid by your insurance.

Initial _____

The following policy prevails:

- Please do not send in any receipts yourself when you desire us to direct bill for you.
- All deductible payments must be made prior to insurance submittal. Co-payments are due at the time the services are rendered, and there is no billing for this amount.
- By taking your insurance on assignment, we will wait for your payment. This courtesy may be withdrawn if circumstances warrant it.
- If you discontinue care or fail to keep your regular appointments for any reason without the doctor's authorization, the balance of your account is due and payable in full immediately, even if the insurance has been filed. (If your insurance company pays, it will be refunded, considering that you have a zero balance)
- Our office does not guarantee that your insurance will pay for the usual and customary charges of this office. We will assist you in making every attempt at the beginning of your health care to receive verification of our policy and what it covers. However, if for some reason your insurance claim is denied, you are responsible in full for the full amount of your bill. We ask that you read your policy handbook and know your policy.
- A finance charge of $3.00 or 1.8% per month will be added to any account 60 days or more past due. If insurance payments are 30 or more days past due, please contact your insurance company to avoid additional charges. After 60 days, you are responsible for the payment of the balance regardless of insurance coverage. Also, it is the intent of the parties signing this agreement that this health center be a third party beneficiary of any and all insurance contracts covering this treatment.
- Our office will not enter into a dispute with your insurance company over our claim. This is your responsibility and obligation.
- Once the doctor has determined the nature of your problem, he will discuss the recommendations with you and your spouse if possible. At this time we will advise you of the estimated costs and the percentage that will not be covered by your insurance. This balance may be paid all at once or in installments.
- In the event your account goes to collections, you will be responsible for all collection, attorney, and/or court fees entailing the matter.

INSURANCE DISCLAIMER

Insurance companies will only pay what is covered in each individual insurance policy. If your insurance policy does not cover services rendered from this office then you, the patient, is responsible for the non-covered services.

BENEFICIARY AGREEMENT

I have been notified by Alliance Chiropractic S.E., Natural Health Center that my insurance does not cover the services rendered. I am to be personally and fully responsible for the payment in full to this Health Center.

Initial _____

ASSIGNMENT OF CAUSE OF ACTION

In the event any insurance company obligated by contractual agreement to make payment to me or to Alliance Chiropractic of S.E., Natural Health Center for the charges made for service, refuses to make such payments upon demand, I hereby assign, transfer, and convey to Alliance Chiropractic of S.E., Natural Health Center the cause of action that exists in my favor against any such persons or company and I authorize Alliance Chiropractic of S.E., Natural Health Center to prosecute said action either in my name or their name to resolve said claim and collect legal expenses as they see fit. I understand that I am financially responsible for all charges whether or not they be paid by any third party. I agree that all charges are payable and collectable in this county. I hereby authorize Alliance Chiropractic of S.E., Natural Health Center to make inquiries, endorse drafts, and to release any information to my insurance company, employer, attorney, or benefit plan about my case. I furthermore irrevocably authorize any direct payment and any of these agents to pay what is due for professional services directly to Alliance Chiropractic of S.E., Natural Health Center.

My insurance company is _____, and I irrevocably authorize them to pay this office directly for said treatment when my signature shows below. I further request that any deductible be withheld from the final payment on the loss. The deductible amount is $_____. It is the intent of the parties signing this agreement that the office be a third party beneficiary of any and all insurance contracts covering this treatment.

Limited Power of Attorney: The office is hereby appointed in fact ONLY to endorse and deposit in its account any insurance company checks or drafts relating to said treatment in this office. This power coupled with an interest is given as security for the payment of services rendered by the office hereunder.

I certify that I have been provided a copy of the Alliance Chiropractic of S.E., Natural Health Center notice of privacy practices:

_____ I acknowledge that I was given a copy of the privacy notice.
_____ I acknowledge that I declined the copy provided.

I certify that I have read and fully understand the above consent.

Print Name: _____

SIGNED: _____ **DATE:** _____

WITNESS: _____ **DATE:** _____
Staff

Authorization for Use or Disclosure of Protected Health Information

I, _____, DOB _____,
SSN _____, hereby authorize Alliance Chiropractic S.E., LLC. to use/disclose my protected health information described below.

My protected health information will be used or disclosed upon request for the following purposes: (Please state the name and purpose, or, if the individual initiates the request and does not elect to state the purpose, please state, "At the request of the individual.")

AT THE REQUEST OF THE INDIVIDUAL:

This authorization for use and/or disclosure applies to the information described below (mark those that apply):

- ☐ Any and all records in the possession of _____, including mental health, HIV, and/or substance abuse records. (Cross out any item you do not authorize to be released.)
- ☐ Records regarding treatment for the following condition or injury: _____on or about _____
- ☐ Records covering period of time, _____ to _____
- ☐ Other (Please specify, including dates):
  _____

I understand that I have the right to revoke this authorization, in writing, at any time by sending such written notification to _____ (healthcare provider name and office address). I also understand that my revocation is not effective to the extent that the persons I have authorized to use and/or disclose my protected health information have acted in reliance upon this authorization.

I understand that pursuant to KRS 422.317, I am entitled to one free copy of any and all records in possession of this treating facility.

I understand that I do have right to refuse to sign this form. Not signing the form will not affect my regular health care, including treatment, payment, or enrollment in a health plan or eligibility for health care benefits.

I understand that information used or disclosed pursuant to this authorization may be subjected to re-disclosure by the recipient and no longer protected by federal laws and regulations regarding the privacy of my protected health information.

This authorization expires on (please list date or state "indefinitely" or "none"): _____

I certify that I have received a copy of this authorization.

X _____
Signature of Patient or Personal Representative

_____
Name of Patient or Personal Representative

_____
Description or Personal Representative's Authority

X **Date:** _____

HEADACHE DISABILITY INDEX QUESTIONNAIRE SOFTWARE

Patient Name: _____ **Ref. Dr.:** _____
Date of Test: _____

Please CHECK the correct response:

1. I have headaches: ❑ 1 per month ❑ more than 1 but less than 4 per month ❑ more than 1 per week
2. My headache is: ❑ mild ❑ moderate ❑ severe

INSTRUCTIONS: (Please read carefully): The purpose of the scale is to identify difficulties that you may be experiencing because of your headache. Please CIRCLE **"YES," "SOMETIMES," or "NO"** to each item. Answer each question as it pertains to your headache only.

E1. Because of my headaches I feel handicapped.	**Yes**	**Sometimes**	**No**
F2. Because of my headaches I feel restricted in performing my routine daily activities.	**Yes**	**Sometimes**	**No**
E3. No one understands the effect my headaches have on my life.	**Yes**	**Sometimes**	**No**
F4. I restrict my recreational activities (eg, sports, hobbies) because of my headaches.	**Yes**	**Sometimes**	**No**
E5. My headaches make me angry.	**Yes**	**Sometimes**	**No**
E6. Sometimes I feel that I am going to lose control because of my headaches.	**Yes**	**Sometimes**	**No**
F7. Because of my headaches I am less likely to socialize.	**Yes**	**Sometimes**	**No**
E8. My spouse (significant other), or family and friends have no idea what I am going through because of my headaches.	**Yes**	**Sometimes**	**No**
E9. My headaches are so bad that I feel that I am going to go insane.	**Yes**	**Sometimes**	**No**
E10. My outlook on the world is affected by my headaches.	**Yes**	**Sometimes**	**No**
E11. I am afraid to go outside when I feel that a headache is starting.	**Yes**	**Sometimes**	**No**
E12. I feel desperate because of my headaches.	**Yes**	**Sometimes**	**No**
F13. I am concerned that I am paying penalties at work or at home because of my headaches.	**Yes**	**Sometimes**	**No**
E14. My headaches place stress on my relationships with family or friends.	**Yes**	**Sometimes**	**No**
F15. I avoid being around people when I have a headache.	**Yes**	**Sometimes**	**No**
F16. I believe my headaches are making it difficult for me to achieve my goals in life.	**Yes**	**Sometimes**	**No**
F17. I am unable to think clearly because of my headaches.	**Yes**	**Sometimes**	**No**
F18. I get tense (eg, muscle tension) because of my headaches.	**Yes**	**Sometimes**	**No**
F19. I do not enjoy social gatherings because of my headaches.	**Yes**	**Sometimes**	**No**
E20. I feel irritable because of my headaches.	**Yes**	**Sometimes**	**No**
F21. I avoid traveling because of my headaches.	**Yes**	**Sometimes**	**No**
E22. My headaches make me feel confused.	**Yes**	**Sometimes**	**No**
E23. My headaches make me feel frustrated.	**Yes**	**Sometimes**	**No**
F24. I find it difficult to read because of my headaches.	**Yes**	**Sometimes**	**No**
F25. I find it difficult to focus my attention away from my headaches and on other things.	**Yes**	**Sometimes**	**No**

Functional Rating Index

For use with Neck and/or Back Problems

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

1. Pain Intensity

0	1	2	3	4
No pain	Mild pain	Moderate pain	Severe pain	Worst possible pain

2. Sleeping

0	1	2	3	4
Perfect sleep	Mildly disturbed sleep	Moderately disturbed sleep	Greatly disturbed sleep	Totally disturbed sleep

100%

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

0	1	2	3	4
No pain; no restrictions	Mild pain; no restrictions	Moderate pain; need to go slowly	Moderate pain; need some assistance	Severe pain; need 100% assistance

4. Travel (driving, etc.)

0	1	2	3	4
No pain on long trips	Mild pain on long trips	Moderate pain on long trips	Moderate pain on short trips	Severe pain on short trips

Increased with walking

5. Work

0	1	2	3	4
Can do usual work plus unlimited extra work	Can do usual work no extra work	Can do 50% of usual work	Can do 25% of usual work	Cannot work

6. Recreation

0	1	2	3	4
Can do all activities	Can do most activities	Can do some activities	Can do a few activities	Cannot do any activities

7. Frequency of pain

0	1	2	3	4
No pain	Occasional pain; 25% of the day	Intermittent pain; 50% of the day	Frequent pain; 75% of the day	Constant pain; of the day

8. Lifting

0	1	2	3	4
No pain with heavy weight	Increased pain with heavy weight	Increased pain with moderate weight	Increased pain with light weight	Increased pain with any weight

9. Walking

0	1	2	3	4
No pain; any distance	Increased pain after 1 mile	Increased pain after ½ mile	Increased pain after ¼ mile	Increased pain all

10. Standing

0	1	2	3	4
No pain after several hours	Increased pain after several hours	Increased pain after 1 hour	Increased pain after ½ hour	Increased pain with any standing

Name: _____(Printed) ID#: _____ Group #: _____

Signature: _____ Date: _____ Total Score: _____

Neck Pain Disability Questionnaire

After Vernon &Mior, 1991, rev. 1/1/95

Name_____

Date_____

Please mark the ONE choice from EACH group that best describes you.

PAIN INTENSITY

❑A. I have no pain at the moment.
❑B. The pain is very mild at the moment.
❑C. The pain is moderate at the moment.
❑D. The pain is fairly severe at the moment.
❑E. The pain is very severe at the moment.
❑F. The pain is worst imaginable at the moment.

PERSONAL CARE

❑A. I can look after myself normally without causing extra pain.
❑B. I can look after myself normally, but it causes extra pain.
❑C. It is painful to look after myself and I am slow and careful.
❑D. I need some help, but manage most of my personal care.
❑E. I need help every day in most aspects of self care.
❑F. I do not get dressed, I wash with difficulty and stay in bed.

LIFTING

❑A. I can lift heavy weights without extra pain.
❑B. I can lift heavy weights, but it causes extra pain.
❑C. Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned, for example, on a table..
❑D. Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
❑E. I can only lift very light weights.
❑F. I cannot lift or carry anything at all.

READING

❑A. I can read as much as I want to with no pain in my neck.
❑B. I can read as much as I want to with slight pain in my neck.
❑C. I can read as much as I want with moderate pain in my neck.
❑D. I cannot read as much as I want because of moderate pain in my neck.
❑E. I cannot read as much as I want because of severe pain in my neck.
❑F. I cannot read at all.

HEADACHES

❑A. I have no headaches at all.
❑B. I have slight headaches which come infrequently.
❑C. I have moderate headaches which come infrequently.
❑D. I have moderate headaches which come frequently.
❑E. I have severe headaches which come frequently.
❑F. I have headaches almost all the time.

CONCENTRATION

❑A. I can concentrate fully when I want to with no difficulty.

❑B. I can concentrate fully when I want to with slight difficulty.
❑C. I have a fair degree of difficulty in concentrating when I want to.
❑D. I have a lot of difficulty in concentrating when I want to.
❑E. I have a great deal of difficulty concentrating when I want to.
❑F. I cannot concentrate at all.

WORK
❑A. I can do as much work as I want to
❑B. I can only do my usual work, but no more.
❑C. I can do most of my usual work, but no more.
❑D. I cannot do my usual work.
❑E. I can hardly do any work at all.
❑F. I cannot do any work at all.

DRIVING
❑A. I can drive my car without any neck pain.
❑B. I can drive my car as long as I want with slight pain in my neck.
❑C. I can drive my car as long as I want with moderate pain in my neck.
❑D. I cannot drive my car as long as I want because of moderate pain in my neck.
❑E. I can hardly drive at all because of severe pain in my neck.
❑F. I cannot drive my car at all.

SLEEPING
❑A. I have no trouble sleeping.
❑B. My sleep is slightly disturbed (less than 1 hour sleepless).
❑C. My sleep is midly disturbed (1-2 hours sleepless).
❑D. My sleep is moderately disturbed (2-3 hours sleepless).
❑E. My sleep is greatly disturbed (3-5 hours sleepless).
❑F. My sleep is completely disturbed (5-7 hours sleepless).

RECREATION
❑A. I am able to engage in all of my recreational activities, with no neck pain at all.
❑B. I am able to engage in all of my recreational activities, with some neck pain at all.
❑C. I am able to engage in most, but not all of my usual recreational activities because of pain in my neck.
❑D. I am able to engage in a few of my usual recreational activities because of pain in my neck.
❑E. I can hardly do any recreational activities because of pain in my neck.
❑F. I cannot do any recreational activities at all.

Patient Signature

_____ **Date**_____

Revised Oswestry Low Back Pain Disability Questionnaire

From N. Hudson, K. Tome-Nicholson, A. Breen; 1989 rev. 09/11/92

Name_____

Date_____

Please mark the ONE choice from EACH group that best describes you.

PAIN INTENSITY

- ❑A. The pain comes and goes and is very mild.
- ❑B. The pain is mild and does not vary much.
- ❑C. The pain comes and goes and is moderate.
- ❑D. The pain is moderate and does not vary much.
- ❑E. The pain comes and goes and is severe.
- ❑F. The pain is severe and does not vary much.

PERSONAL CARE

- ❑A. I would not have to change my way of washing or dressing in order to avoid pain.
- ❑B. I do not normally change my way of washing or dressing even though it causes some pain.
- ❑C. Washing and dressing increases the pain, but I manage not to change my way of doing it.
- ❑D. Washing and dressing increases the pain and I find it necessary to change my way of doing it.
- ❑E. Because of the pain, I am unable to do some washing and dressing without help.
- ❑F. Because of the pain, I am unable to do any washing or dressing without help.

LIFTING

- ❑A. I can lift heavy weights without extra pain.
- ❑B. I can lift heavy weights, but it causes extra pain.
- ❑C. Pain prevents me from lifting heavy weights off the floor.
- ❑D. Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned, e.g., on a table.
- ❑E. Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
- ❑F. I can only lift very light weights, at the most.

WALKING

- ❑A. Pain does not prevent me from walking any distance.
- ❑B. Pain prevents me from walking more than one mile.
- ❑C. Pain prevents me from walking more than ½ mile.
- ❑D. Pain prevents me from walking more than 1/4 mile.
- ❑E. I can only walk while using a cane or on crutches.
- ❑F. I am in bed most of the time and have to crawl to the toilet.

SITTING

- ❑A. I can sit in any chair as long as I like without pain.
- ❑B. I can only sit in my favorite chair as long as I like.
- ❑C. Pain prevents me from sitting more than one hour.
- ❑D. Pain prevents me from sitting more than ½ hour.
- ❑E. Pain prevents me from sitting more than ten minutes.
- ❑F. Pain prevents me from sitting at all.

STANDING

❑A. I can stand as long as I want without pain.
❑B. I have some pain while standing, but it does not increase with time.
❑C. I cannot stand for longer than one hour without increasing pain.
❑D. I cannot stand for longer than ½ hour without increasing pain.
❑E. I cannot stand for longer than ten minutes without increasing pain.
❑F. I avoid standing, because it increases the pain straight away.

SLEEPING

❑A. I get no pain in bed.
❑B. I get pain in bed, but it does not prevent me from sleeping well.
❑C. Because of pain, my normal night's sleep is reduced by less than one-quarter.
❑D. Because of pain, my normal night's sleep is reduced by less than one-half.
❑E. Because of pain, my normal night's sleep is reduced by less than three-quarters.
❑F. Pain prevents me from sleeping at all.

SOCIAL LIFE

❑A. My social life is normal and gives me no pain.
❑B. My social life is normal, but increases the degree of my pain.
❑C. Pain has no significant effect on my social life apart from limiting my more energetic interests, e.g., dancing, etc.
❑D. Pain has restricted my social life and I do not go out very often.
❑E. Pain has restricted my social life to my home.
❑F. I have hardly any social life because of the pain.

TRAVELING

❑A. I get no pain while traveling.
❑B. I get some pain while traveling, but none of my usual forms of travel make it any worse.
❑C. I get extra pain while traveling, but it does not compel me to seek alternative forms of travel.
❑D. I get extra pain while traveling which compels me to seek alternative forms of travel.
❑E. Pain restricts all forms of travel.
❑F. Pain prevents all forms of travel except that done lying down.

CHANGING DEGREE OF PAIN

❑A. My pain is rapidly getting better.
❑B. My pain fluctuates, but overall is definitely getting better.
❑C. My pain seems to be getting better, but improvement is slow at present.
❑D. My pain is neither getting better nor worse.
❑E. My pain is gradually worsening.
❑F. My pain is rapidly worsening.

Patient Signature

_____ **Date** _____

Activities that are affected by my current health problems

Name: _____ Date: _____

0 = No affect
1 = I am aware of my problem when I do this activity (Mild)
2 = I don't want to do this activity because of my problem (Moderate)
3 = I can't do this activity at all. (Severe)

Basic

_____ Bending
_____ Climbing Stairs
_____ Falling Asleep
_____ Kneeling
_____ Lifting
_____ Looking Over Shoulder
_____ Lying Down
_____ Rising Out of Chair
_____ Sitting
_____ Standing
_____ Staying Asleep
_____ Walking

Daily Living

_____ Caring for Infirm Family Member
_____ Child Care
_____ Computer Use (extended time)
_____ Computer Use (short time)
_____ Concentrating
_____ Driving
_____ Housework
_____ Lifting Children
_____ Lifting/Carrying Groceries
_____ Pet Care
_____ Reading
_____ Sexual Activity
_____ Yard Work

Occupational Duties

_____ Computer Work
_____ Desk Work
_____ Driving (at work)
_____ Lifting (at work)
_____ Using the Telephone

Personal Care

_____ Bathing
_____ Dressing
_____ Hair Care
_____ Shaving

Recreational Activities

_____ Cycling
_____ Drawing
_____ Exercise
_____ Golf
_____ Needle Work
_____ Piano
_____ Running
_____ Softball
_____ Swimming
_____ Tennis