Southtowns Chiropractic, PLLC
3445 Orchard Park Rd.
Orchard Park, NY 14127
(716) 674-0821

Please Bring the Following To Your Appointment

- ❑ Driver's License
- ❑ Auto Policy Insurance Card

Insurance Information
Please Complete Prior to Appointment

Patient Name: _____ DOB:_____

Patient's Auto Insurance Company:_____

Patient's Auto Policy #:_____

Patient's Insurance Agent:: _____Phone:_____

Patient's Medical Adjuster: _____ Phone:_____

Patient's Claim #:_____

Office Use Only Below

Claims Billing Address: Claims Phone:_____

_____ Claim Fax #:_____

_____ Accident Date:_____

_____

Employee Providing Info:_____ **Date:**_____

PIP is open : Yes or No

Remaining amount: _____

ENTERED in the computer:_____ **by** _____

New Patient Registration

Patient Information

_____ _____
(First, Middle, Last Name) *(Date of Birth)*

_____ _____
(Address) *(City, State, Zip Code)*

_____ _____ _____
(Home Telephone Number) *(Work Telephone Number)* *(Cell Phone Number)*

_____ **XXX - XX -** _____
(Email Address- will not be released to anyone outside the clinic) *(Last 4 digits of S S N)*

Marital Status: ☐ **Single** ☐ **Married** ☐ **Divorced** ☐ **Widowed**
Sex: ☐ **Male** ☐ **Female**
Employment Status: ☐ **Employed** ☐ **Part-time Student** ☐ **Full-time Student** ☐ **Other**

Employment Information

_____ _____
(Occupation) *(Employer)*

_____ _____
(Address) *(City, State, Zip)*

Spouse Information

_____ _____
(Name) *(Date of Birth)*

_____ _____
(Phone Number) *(Occupation)*

_____ _____
(Employer) *(Employer Phone Number)*

Responsible Person (If Applicable)

_____ _____ _____
(Name) *(Date of Birth)* *(Relationship to Patient)*

_____ _____
(Address) *(City, State, Zip Code)*

_____ _____ _____
(Phone Number) *(Social Security Number)* *(Occupation)*

_____ _____
(Employer) *(Employer Phone Number)*

Relative to Contact in Case of Emergency (Not Living in Home of Patient**)**

_____ _____ _____

(Name) ***(Phone Number)*** ***(Relationship to Patient)***

_____ _____

(Address) ***(City, State, Zip Code)***

Please print the name and phone number of your Primary Care Physician below:

_____ _____

(Name) ***(Phone Number)***

How were you referred to our office?

- ❑ **By an Attorney**
- ❑ **By a Doctor**
- ❑ **By a Patient**
- ❑ **Other**

Please print the name of your source below.

_____

Is your illness or injury related to any of the following?

- ❑ **Employment**
- ❑ **Emergency**
- ❑ **Accident**
- ❑ **Auto Accident**

Please print the date the problem began below. If Auto Accident, please include the name of your insurance company.

_____

****Cancellation Fees****

Patients with scheduled CHIROPRACTIC APPOINTMENTS must call a minimum of TWENTY FOUR (24) HOURS prior to cancel or reschedule, otherwise the patient will be billed a $25 cancellation fee for each occurrence.

_____ _____

Patient (or Guardian) Signature Date

Assignment of Benefits Notice

This office will provide insurance billing services for you if you so desire as a courtesy. Remember that you are ultimately responsible for any charges incurred in this office. It is your responsibility to pay any deductible amount, co-insurance, and or any other balances not paid by your insurance carrier, including services deemed not medically necessary. Your signature on this document indicates that you agree to pay for any outstanding bills incurred in this office.

Attention Blue Cross Insured (and everyone else): We do everything reasonable to document medical necessity. If your insurance determines your care was not medically necessary, you are still responsible for all charges.

In order to keep our office overhead down and keep our patient fees reasonable, we ask for payment at the conclusion of each treatment for cash patients and the deductible and/or co-payment for regular insurance patients. If insurance benefits are not verified at the time of service, it is office policy that you pay the first visit in full. Should insurance benefits subsequently pay, a refund check or account credit will be issued.

Unless other prior written agreements have been made, any outstanding account balance more than 45 days old is considered delinquent.

Please be advised that we will bill the insurance company whose information you provide to us for the services you receive. However, if after 60 days of billing for services, that insurance carrier denies coverage or has not paid for your care for any reason, we will not provide any further insurance billing. Your care and payment of services will be fully your responsibility. As a courtesy, you will have the option to pay off your entire balance at our time of service discount (our lowest fee schedule) for any outstanding charges, if you do so within 15 days of notice. After that time, our full fees apply.

I authorize payment of insurance benefits directly to Dr. Dossett or Southtowns Chiropractic. I authorize the doctor to release all information necessary to communicate with personal physicians, other healthcare providers, collection agencies, and payers to secure the payment of benefits. I further authorize Dr. Dossett to contact my primary physician as needed to advise of my concurrent treatment.

My signature below indicates that I have read and understand and agree with the terms on this page titled Assignment of Benefits Notice.

_____ _____

Patient (or Guardian) Signature Date

Financial Policy

As noted earlier, you the patient are ultimately responsible for all charges resulting from care at our clinic. This is true regardless of any agreement you have with your insurance company.

Insurance Patients

Patients with a Co-pay/Co-insurance:

There will be a fixed amount ($10, $15, $25 etc.) or a percentage of fees for the services provided on each visit, depending on your policy.

Patients with a deductible:

You can pay our regular fee schedule and we will bill insurance for you. This notifies the insurance company that your deductible should be reduced by what you pay on each visit. If and when the deductible is met, your plan will most likely switch to a co-pay status.

Uninsured Patients

Initial visits are $65.00.

Each subsequent visit is $40.00 which is due at the time of the visit.

_____ _____

Patient (or Guardian) Signature Date

Patient Health Information Consent Form

We want you to know how your Patient Health Information (PHI) is going to be used in this office and your rights concerning those records. Before we will begin any health care operations we must require you to read and sign this consent form stating that you understand and agree with how your records will be used. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your Patient Health Information we encourage you to read the HIPAA NOTICE that is available to you at the front desk before signing this consent. HIPAA stands for Health Information Privacy Accountability Act.

1. The patient understands and agrees to allow this chiropractic office to use their Patient Health Information (PHI) for the purpose of treatment, payment, healthcare operations, and coordination of care. As an example, the patient agrees to allow this chiropractic office to submit requested PHI to the Health Insurance Company (or companies) provided to us by the patient for the purpose of payment. Be assured that this office will limit the release of all PHI to the minimum needed for what the insurance companies require for payment.
2. The patient has the right to examine and obtain a copy of his or her own health records at any time and request corrections. The patient may request to know what disclosures have been made and submit in writing any further restrictions on the use of their PHI. Our office is not obligated to agree to those restrictions.
3. A patient's written consent need only be obtained one time for all subsequent care given the patient in this office.
4. The patient may provide a written request to revoke consent at any time during care. This would not effect the use of those records for the care given prior to the written request to revoke consent but would apply to any care given after the request has been presented.
5. For your security and right to privacy, all staff has been trained in the area of patient record privacy and a privacy official has been designated to enforce those procedures in our office. We have taken all precautions that are known by this office to assure that your records are not readily available to those who do not need them.
6. Patients have the right to file a formal complaint with our privacy official about any possible violations of these policies and procedures.
7. If the patient refuses to sign this consent for the purpose of treatment, payment and health care operations, the chiropractic physician has the right to refuse to give care.

I have read and understand how my Patient Health Information will be used and I agree to these policies and procedures.

_____ _____

Patient (or Guardian) Signature Date

Implied Consent

Dear Patient:
It is prudent for us to obtain your informed consent prior to examination and treatment. The purpose of this information is to inform you, not to alarm you. What you are being asked to sign is simply a confirmation that we have discussed the following:

Associates and Assistants
In this office we use trained staff personnel to assist the doctor with portions of your consultation, examination, and treatment. Occasionally when your doctor is unavailable, another clinic doctor will treat you.

Treatment
The Chiropractic Adjustment: I will use my hands upon your body in such a way as to move your joints. This procedure may cause an audible "pop" or "click" much as you have experienced when you "crack" your knuckles. There are some material risks involved in doing this and they are as follows:

Inherent Risks
Pain: It is common for an adjustment as well as traction, massage therapy, exercise, in fact almost any treatment, to result in temporary increase in soreness in the region being treated.

Soft Tissue Injury: Soft tissue, such as ligaments and muscle may be stretched or torn during an adjustment. The result is a temporary increase in pain. However, there are no long term affects. These problems occur so rarely I have not been able to find available statistics to quantify their probability.

Rib Fractures: The force of an adjustment might "crack" a rib. This can happen with anyone, however, it occurs most often in patients that have weakened bones from such things as osteoporosis. Osteoporosis can be noted on your x-rays and when detected, we proceed with extra caution. These problems occur so rarely that I have not been able to find available statistics to quantify their probability.

Disc Herniations: Occasionally treatment will aggravate or cause a problem if the disc is in a weakened state. It is possible that surgery may become necessary for correction, but again these problems occur so rarely that I have not been able to find available statistics to quantify their probability.

Stroke: Even though strokes happen with some frequency in our world, strokes resulting from chiropractic adjustments are rare, so rare that you have the same chance of getting hit by lightening; one in a million.

Physical Therapy Burns: The electric heating pad that we use generates heat. We will also use ice in the office. Since everyone's skin has different sensitivity to these modalities, we test our patients for sensitivity deficiencies prior to therapy use. If a burn is obtained, there will be a temporary pain and possible blistering. This should be reported to a doctor. This is so rare that I have not been able to find available statistics to quantify their probability. The chances of this happening with our heating pads are reduced even further since you, the patient, will be able to turn the pad off if it ever becomes too warm.

Other Problems: There may be other problems or complications that might arise from treatment, such as massage, traction, etc., than noted above. These other problems or complications occur so rarely that it is not plausible to anticipate and/or explain them all in advance of treatment.

Other Treatment Options (non-chiropractic):

Medication: Medication may be used to relieve pain and swelling. However, medication can mask progress and the efficiency of chiropractic treatment. Caution should be used since the danger of side effects and damage to the health of the person taking the medication is well documented.

Hospitalization: Hospitalization has proven expensive and dangerous. The documentation of such is overwhelming.

Surgery: Surgery is always a possibility. The expense, danger and ineffectiveness of such treatment is more a probability than a possibility.

Non Treatment:

Remaining untreated, results in adhesions, pain, and reduction in associated joint mobility. The probability that these adhesions will interfere with the motion, function and enjoyment of life is very high.

THE DOCTOR HAS EXPLAINED TO ME THE MOST LIKELY COMPLICATIONS OF THE POSSIBLE UNDESIRED RESULTS OF HIS EXAMINATION AND TREATMENT, AND I UNDERSTAND THEM.

I hereby authorize and direct the above named physician with associates or assistants to provide such additional services as they may deem reasonable and necessary.

Consent to Treatment

I HEREBY STATE THAT I HAVE READ OR HAVE HAD READ TO ME THIS CONSENT FORM PRIOR TO MY SIGNATURE.

Date: _____

Patient's Signature: _____

Patients Printed Name: _____

Signature of Parent or Guardian:_____

Auto Accident Information.

Date and time of accident: _____ ☐ a.m. ☐ p.m

Were you the: ☐ Driver ☐ Front Passenger ☐ Rear passenger

Make and model of the vehicle you were occupying?

_____

If a traffic violation was issued, to whom was it issued?

_____

Number of people in accident vehicle? _____

Did the police come to the accident site? ☐ Yes ☐ No

Was a police report filed? ☐ Yes ☐ No

Were there any witnesses? ☐ Yes ☐ No

Were you wearing a seat belt? ☐ Yes ☐ No

Was this vehicle equipped with airbags? ☐ Yes ☐ No

If yes, did it/ they inflate? ☐ Yes ☐ No

In relation to the base of your skull, where was the headrest?

☐ Above ☐ Below ☐ At base of skull

What did your vehicle impact? ☐ Another vehicle ☐ Other

If other, explain: _____

Did any part of your body strike anything in the vehicle? ☐ Yes ☐ No

If yes, please describe:

_____

Make and model of the other vehicle(s) involved?

_____

Name of the location/ street on which you were traveling?

_____

In which direction were you headed? ☐ N ☐ S ☐ E ☐ W

What was the approx. speed of your vehicle? _____

Did the impact to your vehicle come from the:

☐ Front ☐ Rear ☐ Right Side ☐ Left Side ☐ Other

During impact, were you facing: ☐ Right ☐ Left ☐ Forward

Were you: ☐ aware ☐ surprised by the impact?

If accident vehicle made impact with another vehicle:

Direction other vehicle was headed? ☐ N ☐ S ☐ E ☐ W

Approximate Speed of the other vehicle? _____

In your words, please describe the accident:

_____

_____

After Injury:

Did accident render you unconscious? ☐ Yes ☐ No

If yes, for how long? _____

Please describe how you felt immediately after the accident:

_____

Have you gone to a hospital or seen any other Doctor? ☐ Yes ☐ No

When did you go? ☐ Just after accident ☐ The next day ☐ 2 days plus

How did you get there? ☐ Ambulance ☐ Private transportation

Name of hospital and/ or attending doctor:

_____

Was he/she a: ☐ D.C. ☐ M.D. ☐ D.O. ☐ D.D.S.

Describe any treatment you received:

_____

Were X-Rays taken? ☐ Yes ☐ No

Was medication prescribed? ☐ Yes ☐ No

Have you been able to work since this injury? ☐ Yes ☐ No

Are your work activities restricted as a result of this injury? ☐ Yes ☐ No

Indicate the symptoms that are a result of this accident:

☐ Dizziness ☐ Difficulty Sleeping ☐ Jaw problems ☐ Nausea

☐ Memory loss ☐ Irritability ☐ Arms/ shoulder pain ☐ Back pain

☐ Headache(s) ☐ Fatigue ☐ Numb hands/fingers ☐ Lower back pain

☐ Blurred vision ☐ Tension ☐ Back stiffness ☐ Buzzing in ear

☐ Neck pain ☐ Chest pain ☐ Leg pain ☐ Ears ringing

☐ Neck stiff ☐ Shortness of breath ☐ Numb feet/ toes ☐ Stomach upset

☐ Other (please describe):

_____

Is your condition getting worse? ☐ Yes ☐ No ☐ Constant ☐ Comes and goes

Indicate your degree of comfort while performing the following activities:

	Comfortable	Uncomfortable	Painful
Lying on back……	☐	☐	☐
Lying on side……	☐	☐	☐
Lying on stomach…….	☐	☐	☐
Sitting…….	☐	☐	☐
Standing……..……	☐	☐	☐
Stretching……	☐	☐	☐
Lovemaking……..	☐	☐	☐
Walking……	☐	☐	☐
Running……	☐	☐	☐
Sports……..	☐	☐	☐
Working……	☐	☐	☐
Lifting……	☐	☐	☐
Bending……...	☐	☐	☐
Kneeling……...	☐	☐	☐
Pulling……..	☐	☐	☐
Reaching…….	☐	☐	☐

Have you retained an attorney: ☐ Yes ☐ No

If yes, whom? _____

His/ Her phone #:_____

Recovery

How many hours are in your normal workday? _____

Please indicate on your daily job duties and any activities, which you are occasionally asked to perform.

☐ Standing ☐ Driving ☐ Operating equipment

☐ Sitting ☐ Twisting ☐ Work with arms above head

☐ Walking ☐ Crawling ☐ Lifting

☐ Bending ☐ Typing ☐ Stooping

☐ Other:

_____

_____

What positions can you work in with minimum physical effort and for how long?

_____

_____

_____

Prior to the injury were you capable of working on an equal basis with others your age?

☐ Yes ☐ No ☐ N/A

Do you work with others who can help you with any heavy lifting? ☐ Yes ☐ No ☐ N/A

While in recovery, is there any light duty work you could request? ☐ Yes ☐ No ☐ N/A

Signature _____ Date____/_____/_____

☐ Adult patient ☐ Parent or Guardian ☐ Spouse

Patient Name: _____ **Date:** _____

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General Pain Disability Index Questionnaire

The rating scales below are designed to measure the degree to which several aspects of your life are presently disrupted by chronic pain. In other words, we would like to know how much your pain is preventing you from doing what you would normally do, or from doing it as well as you normally would. Respond to each category by indicating the overall impact of pain in your life, not just when the pain is at its worst.

PLEASE CIRCLE THE NUMBER WHICH BEST DESCRIBES YOUR TYPICAL LEVEL OF ACTIVITIES for each of the six categories of daily living listed. A score of 0 means no disability at all, and a score of 10 signifies that all of the activities in which you would normally be involved have been totally disrupted or prevented by your pain.

Family/Home Responsibilities

This category refers to activities related to the home or family. It includes chores and duties performed around the house (e.g., yard work) and errands or favors for other family members (e.g., driving the children to school).

0 1 2 3 4 5 6 7 8 9 10
Completely able to function **Totally unable to function**

Recreation

This category includes hobbies, sports, and other similar leisure time activities.

0 1 2 3 4 5 6 7 8 9 10
Completely able to function **Totally unable to function**

Social Activity

This category refers to activities that involve participation with friends and acquaintances other than family members. It includes parties, theater, concerts, dining out, and other social functions.

0 1 2 3 4 5 6 7 8 9 10
Completely able to function **Totally unable to function**

Occupation

This category refers to activities that are a part of or directly related to one's job. This includes non-paying jobs as well, such as that of a homemaker or volunteer worker.

0 1 2 3 4 5 6 7 8 9 10
Completely able to function **Totally unable to function**

Self Care

This category includes activities that involve personal maintenance and independent daily living such as taking a shower, driving, getting dressed, etc.

0 1 2 3 4 5 6 7 8 9 10
Completely able to function **Totally unable to function**

Life-Support Activity

This category refers to basic life-supporting behaviors such as eating, sleeping, and breathing.

0 1 2 3 4 5 6 7 8 9 10
Completely able to function **Totally unable to function**

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Neck Pain Disability Index Questionnaire

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 CIRCLE THE ONE CHOICE THAT MOST CLOSELY DESCRIBES YOUR PROBLEM RIGHT NOW.

Section 1 – 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 the worst imaginable at the moment.

Section 2 – 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.

Section 3 - 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, e.g., 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 lift very light weights.
F. I cannot lift or carry anything at all.

Section 4 - Reading

A. I can read as much as I want with no pain in my neck.
B. I can read as much as I want 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.

Section 5 - 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

Section 6 - 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 in concentrating when I want to.
F. I cannot concentrate at all.

Section 7 - 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.

Section 8 – 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.

Section 9 - Sleeping

A. I have no trouble sleeping.
B. My sleep is slightly disturbed (less than 1 hour sleepless).
C. My sleep is mildly 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).

Section 10 – 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 pain in my neck.
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.

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Oswestry Chronic Low Back Pain Disability Questionnaire

Please Read: This questionnaire is designed to enable us to understand how much your low back 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 CIRCLE THE ONE CHOICE THAT MOST CLOSELY DESCRIBES YOUR PROBLEM RIGHT NOW.

Section 1 – 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.

Section 2 – 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.

Section 3 - 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.

Section 4 - 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 ¼ 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.

Section 5 - 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.

Section 6 - 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.

Section 7 - 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 then three-quarters.
F. Pain prevents me from sleeping at all.

Section 8 – 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.

Section 9 - 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.

Section 10 – 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.