CHIROPRACTIC SOLUTION CENTER, P.C.
Specializing in Postural Rehabilitation

287 Independence Blvd. Suite 118 Virginia Beach, VA 23462
(757) 271-0001 ~ (866) 290-7581 (Fax)

Motor Vehicle Crash History – Addition to Patient Application Form
(Please Print)

Patient Information

Dr./Mr./Mrs./Ms./Miss (circle one)

_____

Last Name First Name Middle Initial Nickname

Crash/Injury History

1. Date of Crash: _____ Time of Day: _____ Road Condition: [ ] Dry [ ] Wet

2. Were you: [ ] Driver [ ] Passenger [ ] Front Seat [ ] Back Seat

3. How many people were in your vehicle? _____

4. How were your hands placed on the steering wheel?
_____

5. Were you wearing a seat belt? [ ] Y [ ] N If no, skip to question #7

6. If yes, were you wearing a lap belt? [ ] Y [ ] N Lap belt and shoulder harness? [ ] Y [ ] N

7. What direction were you headed? [ ] North [ ] South [ ] East [ ] West

On (name of street and city): _____

8. What direction was the other vehicle headed? [ ] North [ ] South [ ] East [ ] West

On (name of street and city): _____

9. Were you struck from: [ ] Behind [ ] Front [ ] Left Side [ ] Right Side

Other combination, please describe: _____

10. What was the position of your head during the crash?

[ ] Straight Ahead [ ] Turned Right [ ] Turned Left [ ] Other _____

11. Did any part of your body strike/hit anything inside your vehicle? [ ] Y [ ] N

If yes, please explain: _____

12. Did any items become displaced in the vehicle (mirror, ashtray, packages, etc.)? [ ] Y [ ] N

If yes, please describe: _____

13. If your vehicle was equipped with air bags, did they activate? [ ] Y [ ] N

14. Make/model of your car: _____ Make/model of other car: _____

15. Were the police notified? [ ] Y [ ] N **Please provide this office with a copy of the police report.**

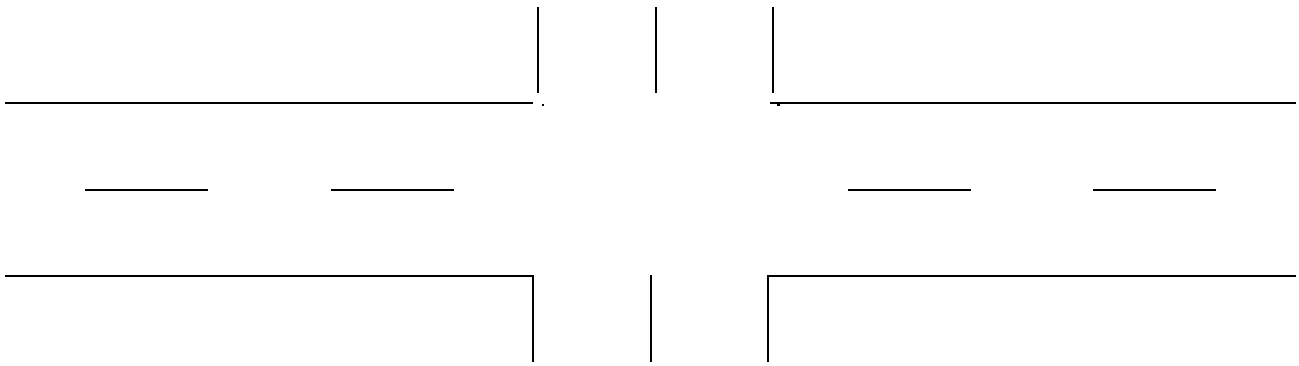
16. In your own words, please describe the crash: _____

_____

17. Did you have any physical complaints BEFORE the crash? [ ] Y [ ] N
    If yes, please describe in detail: _____
    _____
18. Please describe how you felt:
    DURING the crash: _____
    IMMEDIATELY AFTER the crash: _____
    LATER THAT DAY: _____
    THE NEXT DAY: _____
19. How confident are you that you will recover from this injury? (circle on scale)

    1 2 3 4 5 6 7 8 9 10

    Very Confident ---------- Not Confident At All
20. Did you lose consciousness during the crash? [ ] Y [ ] N If yes, for how long?
    _____
21. Where were you taken after the crash? _____
22. Have you been treated by another doctor since this accident? [ ] Y [ ] N
    If yes, please list the doctor's name and address: _____
    _____
    What type of treatment did you receive? _____
    _____
23. Did this crash occur while you were performing your regular job duties? [ ] Y [ ] N
24. Have you lost time from work as a result of this crash? [ ] Y [ ] N
    Type of employment: _____
    Last day worked: _____
25. Have you ever been involved in a crash before? [ ] Y [ ] N When? _____
    Describe the crash: _____
    Were you injured? [ ] Y [ ] N Explain:
    _____
26. Using the diagram below, draw a picture of your motor vehicle crash.



ChiroSolutions Center

We Care For EVERY Body.

NEW PATIENT APPLICATION FORM

WELCOME and THANK YOU for applying as a patient in our office. We are a very unique and different team specializing in research-based spinal and postural rehabilitation. Our methods have enabled our patients to achieve their optimal health; even when many other systems have failed. Because of our specialized approach, we do not accept every patient that applies to our office. When we are absolutely certain we know the cause of your condition, can perform the necessary tests to establish an optimal rehab program for you, and are completely confident we can help you recover your health; then you will be accepted as a patient. Please know if we do accept you as a patient, we will make specific recommendations based upon our understanding that your health will become your TOP PRIORITY. Thank you again for applying as a patient in our office.

Patient Name Patient Signature Date Completed

Patient Information

Name: _____ Preferred/Nickname: _____

Home Address: _____ Cell Phone: ( )_____

City, State, Zip: _____ Alt Phone: ( )_____

Email Address: _____ Birth Date: _____/_____/_____

SSN #: _____-_____-_____ Marital Status: S M D W Gender: M F

Occupation: _____ Employer Name: _____

Spouse's Name: _____ Spouse's Phone: ( )_____

Spouse's Employer: _____ Occupation: _____

Race: _____ Ethnicity: _____ Primary Language: _____

Who may we thank for your referral to our office? _____

Purpose For This Visit

Is there a specific health-concern or are you seeing us for a general wellness visit? _____

_____

Is this related to an accident or injury (other than auto or work related) *? ___Yes___No (Date:___/___/___)

***If your symptoms are related to an auto injury or work-related injury, please ask the front desk for additional forms.*

Describe: _____

Please use the General Symptoms Chart on page 4 to provide a detailed notation of your symptoms.

When did these symptoms begin? ___/___/___ Are they: ____Constant ____Intermittent ____ Activity-related

Are they getting worse? ___Yes___No Do they interfere with? ___Work___Sleep___Hobbies___Daily Routine

Explain: _____

Is there anything that aggravates your symptoms? _____

Is there anything that relieves your symptoms? _____

Have you been treated for these symptoms before? ____Yes____No When were you last treated? ___/___/___

Who did you see?_____ Treatment Performed? _____

How did you respond? _____

Experience with Chiropractic Care

Have you seen a Chiropractor before? ___Yes___No If yes, who? _____

Reason for visit(s): _____

Did your previous Chiropractor take "before" and "after" X-Rays? ___Yes___No

Did he or she recommend a specific course of treatment? ___Yes___No

Did they recommend a Home Health Care program? ___Yes___No If yes, what? _____

How long were you treated? _____ Date of last treatment: ____/____/____

How did you respond? _____

Are you aware of any poor posture habits? ___Yes___No

Is there any history of spinal problems in your family? ___Yes___No If yes, please explain: _____

_____

Health and Lifestyle

Do you exercise? ___Yes___No How often?_____day(s) per week; Other: _____

What activities? ___Walking___Running___Weight Training___Cycling___Yoga____Swimming___Other

If other: _____

Do you smoke? ___Yes___No How much? / How often? _____

Do you drink alcohol? ___Yes___No How much? / How often? _____

Do you drink coffee? ___Yes___No How much? / How often? _____

Do you take any supplements? (vitamins, minerals, herbs) ___Yes___No

If yes, please list: _____

_____

_____

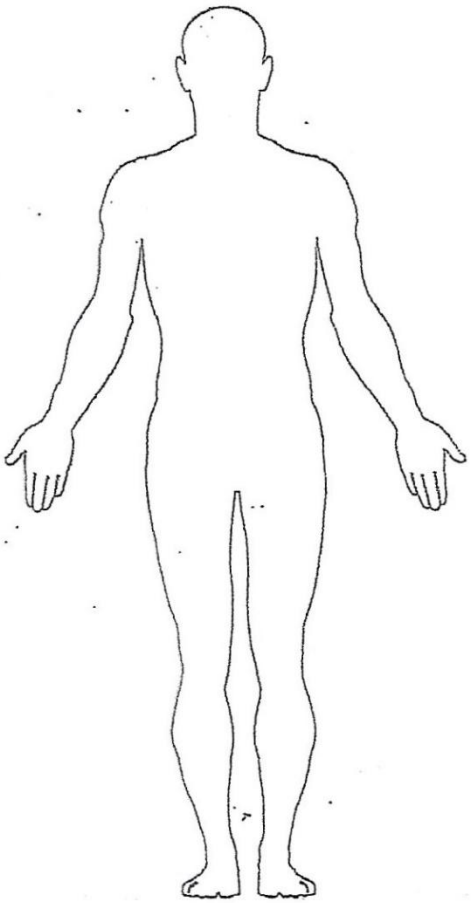
_____

_____

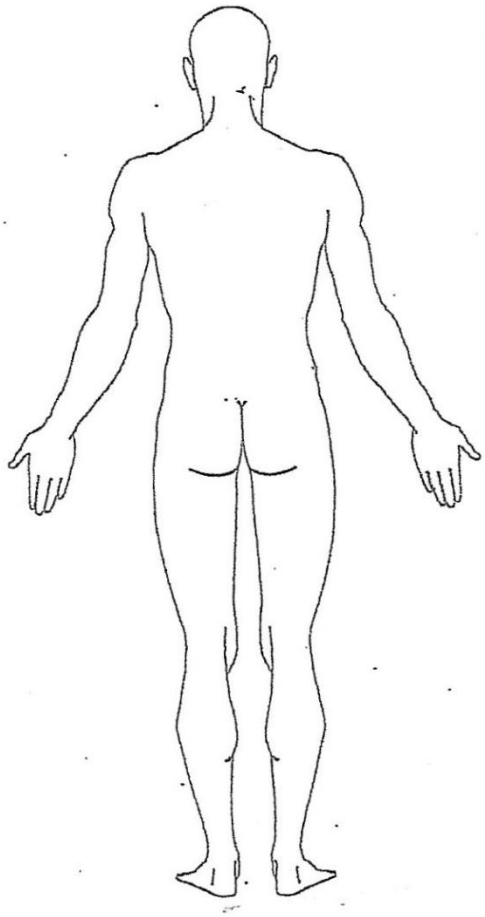
GENERAL SYMPTOMS CHART

Please use the following notations on the figures below to indicate the type and location of your symptoms, as it relates to the purpose of your visit today.

A = ACHE	G = STABBING	N = NUMBNESS
B = BURNING	M = SPASMS	T = TINGLING
P = PINS & NEEDLES	F = STIFFNESS	O = OTHER



FRONT



BACK

IF YOU MARKED "O" FOR OTHER ON ANY PART, PLEASE EXPLAIN BELOW

_____

_____

Health Conditions

Your spine is the foundation of health and core strength in your body. Shifts in the vertebrae or sections of the spine will spread ultimately causing weakness and distortion to ALL areas of the spine. These distortions are reflected in abnormal posture. Research shows abnormal posture leads to chronic pain, disease and possibly a shortened life span. [1] Please answer the following questions accurately so we may determine the full extent of your condition.

Cervical Spine (Neck)

Misalignment of the individual vertebrae or distortion of the complete cervical curve (neck) originating in the neck or a compensation from postural distortions in other areas of the spine may result in many health conditions. Have you experienced any of these symptoms presently or in the past?

Please indicate (N) = Now, (P) = Past next to all conditions you've experienced or both if applicable.

___ Allergies/Hay Fever	___Coldness in hands	___Dizziness	___Headaches
___Hearing disturbances	___Low Energy/Fatigue	___Neck Pain	___Numbness
___Pain in shoulders/arms/hands	___Recurrent colds/Flu	___Sinusitis	___Thyroid conditions
___Tingling in arms/hands	___TMJ/pain/clicking	___Visual Disturbances	___Weakness in grip

Please explain: _____

_____

Thoracic Spine (Upper Back)

Misalignment of the individual vertebrae or distortion of the upper thoracic curve (upper back) originating in the upper back or a compensation from postural distortions in other areas of the spine may results in many health conditions. Have you experienced any of these symptoms presently or in the past?

Please indicate (N) = Now, (P) = Past, next to all conditions you've experienced or both if applicable.

___ Asthma/Wheezing	___ Heart Attacks/Angina	___Heart Murmurs
___Heart Palpitations	___Pain on deep inspiration/expiration	
___Recurrent lung infections/bronchitis	___Shortness of breath	___Tachycardia

Please explain: _____

_____

1. Postural and Degenerative Kyphosis: Freeman JT. Posture in the Aging and Aged body. JAMA 1957, Oct 19: 843-846.

Health Conditions continued…

Thoracic Spine (Mid Back)

Misalignment of the individual vertebrae or distortion of the mid thoracic curve (mid back) originating in mid back or a compensation from postural distortions in other areas of the spine may results in many health conditions. Have you experienced any of these symptoms presently or in the past?

Please indicate (N) = Now, (P) = Past next to all conditions you've experienced or both if applicable.

___Diabetes ___Heartburn ___Hypoglycemia/hyperglycemia ___Indigestion

___Mid Back Pain ___Nausea ___Pain in Ribs/Chest ___Reflux

___Ulcers/Gastritis ___Tired/irritable after eating or when not having eaten for a while ____Other (please explain)

Please explain: _____

_____

Lumbar Spine (Low Back)

Misalignment of the individual vertebrae or distortion of the lumbar curve (low back) originating in low back or a compensation from postural distortions in other areas of the spine may results in many health conditions. Have you experienced any of these symptoms presently or in the past?

Please indicate (N) = Now, (P) = Past next to all conditions you've experienced or both if applicable.

___ Coldness in legs/feet ___ Constipation/Diarrhea ___ Frequent/difficulty urinating

___Low back pain ___ Menstrual irregularities/cramping (females) ___ Muscle cramps in legs/feet

___Numbness/tingling in legs/feet ___Pain in his/legs/feet ___Recurrent bladder infections

___Sexual dysfunction ___Weakness/injuries in hips/knees/ankles ___ Other (please explain)

Please explain: _____

_____

Other

Please list any health conditions not mentioned: _____

_____

Please list any surgeries (include type of surgery and date it was performed: _____

_____

Please list any medications (include name, dose, for what and how long you've been taking it): _____

_____

_____

_____

Family Health History

Have any of your family members ever been diagnosed with the following (please indicate "Y" for You, and "O" for Other than you, or both if applicable):

___Anemia	___Appendectomy	___Arthritis	___Blood sugar problems
___Broken bones/fracture	___Cancer	___Chicken Pox/Shingles	___Circulatory problems
___Diabetes	___Eczema/Psoriasis	___Epilepsy/seizures	___Gall bladder
___Heart disease	___Heart murmur	___Hernia	___High blood pressure
___Infectious disease	___Influenza	___Kidney disease	___Liver disease
___Lumbago	___Lung disease	___Measles	___Metal Implants
___Migraine headaches	___Mumps	___Neurological problems	___Osteoporosis
___Paralysis	___Pleurisy	___Pneumonia/Bronchitis	___Polio
___Rheumatic fever	___Smallpox	___Stroke	___Thyroid problems
___Tonsillectomy	___Tuberculosis	___Varicose veins	___Whooping cough

___Other*

Pregnancy Release

This is to certify that to the best of my knowledge I am not pregnant, and Dr. Coleman has my permission to perform an X-Ray evaluation. I have been advised that X-Ray can be hazardous to an unborn child.

Date of last menstrual cycle: ___/___/___ Patient's Signature: _____ Date: ___/___/___

In Case of Emergency

Name: _____ Relationship: _____

Cell Phone: _____ Home Phone: _____ Work Phone: _____

Authorization of Care

I authorize and agree to allow Dr. Coleman and her team to work with my spine or the spine of the charge I represent through the use of spinal adjustments and rehabilitative exercise for the sole purpose of postural and structural restoration of normal bio-mechanical and neurological function.

I understand that I am responsible for all fees incurred for the services provided and agree to ensure full payment of all charges.

Dr. Coleman and her staff will not be held responsible for any health conditions or diagnoses which are pre-existing, given by another healthcare practitioner, or are not related to the spinal structural conditions diagnosed at this clinic.

I also clearly understand that if I do not follow Dr. Coleman's and/or staff's specific recommendations at this office that I will not receive the full benefit from these programs; and that if I terminate my care prematurely that all fees incurred will be due and payable at that time.

Name Printed & Signature _____ Date ____/____/____

If a patient is a legal charge of limited capacity requiring guardianship for treatment, please complete the following:

Date Guardianship Awarded _____ County, State of Guardianship _____

I hereby authorize Dr. Coleman to administer care as deemed necessary to my charge as appointed to by the courts.

Guardian Signature _____ Date ____/____/____

Insurance

____ (Please Initial) We may accept assignment of insurance benefits. By signing this policy, you agree to assign your insurance benefits to ChiroSolution Center, P.C. In cases where benefits are not assignable or in any case where your benefit is processed directly to you regardless of assignment, you agree to submit any payments received along with the explanation of benefits to this clinic within 10 days of receipt unless you have paid for the services represented by said payment in full at the time of service. In no case will an assignment alleviate you of your obligation for payment of services rendered.

____ (Please Initial) Your insurance plan is a contract between you and your insurance company. This office is not a party to that contract and therefore cannot modify the terms of that contract. Payment for treatment you receive from this clinic is your responsibility whether your insurance company pays or not. We cannot bill your insurance company unless you provide us with your necessary billing information, assign your benefits to this clinic and agree to permit us to release the necessary medical information required to secure payment. We will make every effort to ensure that your insurance carrier properly processes your services for payment. In some circumstances we may require your assistance. If your insurance company does not pay your account in full, and you refuse to assist us in dealing with your carrier, the balance will be automatically transferred to you.

Declaration

I clearly understand that all insurance coverage, whether accident, work related, or general coverage is an arrangement between my insurance carrier and myself. If this office chooses to bill any services to my insurance carrier that they are performing these services as a convenience to me. Dr. Coleman's office will provide any necessary reports or information to aid in reimbursement of services but I understand that insurance carriers may deny claims that I am ultimately responsible for any unpaid balances. Any monies received will be credited to my account.

Patient's Signature: _____ Date: ____/____/____

Signature of Person Authorizing Care (if different from patient):

_____

I understand that there could be some services that my insurance company doesn't cover and if so, are you willing to pay for these services? ____Yes____No

NOTICE OF PRIVACY POLICIES

Effective Date: August 31, 2013
Updated: March 14, 2019

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

Understanding Your Health Record/Information

Each time you visit the office, a record is made of your visit. Typically, this record contains any symptoms you may report, our assessment of you on that day, any change to your diagnosis, what procedures we performed, and any change in your care plan. This information serves many purposes:

- it helps us track your care and progress toward your health goals
- it serves as a means of communication to other health professionals involved in your health care
- it is a legal document describing the care you received
- it allows a third-party payer (insurance company) to verify that the services billed were actually provided
- it can be used as a source of data for research
- it helps you track your care and gives you a way to make sure we have accurate records about you

Your Health Information Rights

Although your health record is the physical property of the health care practitioner or facility that compiled it, the information in it belongs to you. You have the right to:

- request restrictions as to how your information is used or disclosed as provided by 45 CFR 164.522
- obtain a paper copy of this notice upon request
- inspect and obtain a copy of your health record as provided by 45 CFR 164.524
- make amendments to your record as provided by 45 CFR 164.528
- obtain a record of any disclosures we've made as provided by 45 CFR 164.528
- request confidential means of communicating your health information to you from our office

Our Responsibilities

Our office is required to:

- maintain the privacy of your health information
- provide you with a copy of this notice
- abide by the terms of this notice
- notify you if we are unable to agree to a requested restriction from you
- accommodate reasonable requests from you regarding communications from our office to you

We reserve the right to change our privacy practices as necessary and to make the new provisions effective for all protected health information we maintain. Should our privacy practices change, we will supply a copy of our revised notice. We will not use or disclose your health information without your authorization, except as described in this notice.

For More Information or to Report a Problem

If you have questions or need additional information, please contact our health information director, Dr. Samantha Coleman, D.C. at (757) 271-0001. If you believe your privacy rights have been violated, you can file a complaint with our health information director or with the Secretary of the U.S. Department of Health and Human Services. There can be no retaliation for filing any complaints.

Examples of Disclosures for Treatment, Payment and Health Operations

1. How we may use your health information for treatment:

- First, we have chosen to work in an open office environment, meaning that all patient treatment is done in an open treatment area. We have found that this environment is conducive to learning and enables us to provide the highest quality of service to our patients. Of course, all consultations, exams, x-rays and financial discussions will be handled in the privacy of a separate room.

- Our patients' names may appear in a variety of places around the office. For example, all of our patients sign in on our daily sign in sheet. We have a Lifetime Wellness Wall that once patients graduate to maintenance care, their name will be displayed.
- We often display photos of office events like our Patient Luncheon or community events we're involved in.

- On occasion, Dr. Samantha Coleman, D.C. will use a patient's x-rays to help another patient see what can be achieved with corrective chiropractic care. Patient's names do not appear on the X-Rays, however.
- Lastly, patient names may appear on our office mailings, postcards, newsletters, Facebook and website.

Patient Print/Sign: _____

2. How we may use your health information for payment:

A bill for services may be sent to you or to your insurance company or other third-party payer. Information on or accompanying the bill may include information that identifies you as well as your diagnosis, procedures, and any supplies used.

3. How we may use your information for daily clinic operations:

Members of the Chiropractic Solution Center, P.C. have access to your health information for the performance of reasonable job-related taskssuch as scheduling, appointment reminders, insurance filing, report preparation, data gathering, communications with family members involved in your care, etc.

Certain business associates of Chiropractic Solution Center P.C. may have access to your health information for the performance of ouservices. These include any outside diagnostic services, lab testing services, insurance claims filing, attorneys handling legal aspects of a case and collections matters. To protect your health information, we require our business associates to appropriately safeguard your information through a signed agreement.

Other disclosures: We may disclose health information about you to Workers Compensation programs, public health officials, the FDA, or lawenforcement officials as required by state and federal law.

PRODUCT RETURN/EXCHANGE NOTICE

We are unable to accept any return/exchange for any item purchased from our office if it has been used/opened. This includes, (but not limited to) supplements, denerolls, pillows, back supports, seat cushions, Smart Weigh Food, shoe inserts, heel lifts and protein powder.

If an item is unopened/unused, it may be returned for a credit to your account (not a refund of purchase price) within 1 week of purchase date and verification of purchase here. There is a 25% restocking fee for any unopened/unused item returned.

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY NOTICE

I have been presented with a copy of Chiropractic Solution Center, P.C.'s **Notice of Privacy Policies**, detailing how my health information may be used and disclosed as permitted under state and federal law. I understand the contents of the notice and I request the following restrictions concerning the use of my personal health information:

_____

_____

Signature:_____Date:_____

If not signed by the patient, please indicate relationship to patient (ex. mother, father)

Relationship:_____Witnessed By:_____

IF PATIENT REFUSES TO SIGN, INDICATE YOUR ATTEMPT TO OBTAIN A SIGNATURE BELOW:

Patient refused to sign this acknowledgement

Employee Name/Signature: _____Date:_____

Chiropractic Solution Center, P.C.
Policies and Procedures

In order to better serve you and make your time more efficient while you are here, the following policies and procedures are mandatory. Please sign and date at the bottom.

*While it's understood that emergencies and interruptions are a part of life, appointments that are not cancelled with at least a 24 hours' notice will be charged $25. This will be due at the beginning of your next appointment with us or a bill will be mailed to you. In the event a 24-hour notice is not given, you will be responsible for the missed appointment fee unless it is a mutually agreed upon emergency.
*If you are going to be more than 5 minutes late, please call the office. (757-271-0001)
***Talking to friends/family members and talking on cell phones will not be permitted during traction. Ear phones are ok to use with your cell phone to listen to music. We appreciate your mindfulness of this during your appointment.**
***We want you to come in for an adjustment when you are sick**! Research shows that getting an adjustment when you are sick will boost your immune system and get you over your illness quicker. If you are scheduled; keep your appointment. If you are not scheduled; call and make an extra one!

All stations are first come, first serve; which means….

1. Drop off all personal items in a cubby before proceeding to a station. This will make for a smoother transition from station to station.
2. If you are waiting for an adjustment and a table is free, please go ahead and get ready (take glasses off, empty pockets, etc.) and lay down. This will better prepare your body for your adjustment and give you the appropriate amount of time with Dr. Coleman.
3. If there is a power plate free and you need to complete your posture exercises, etc. please go ahead and get started. A Chiropractic Assistant will be over to check in and answer any questions.
4. If you are waiting for traction and there is a table/chair free, please go ahead and sit down and we will be right over to put you in traction.

_____

Patient Name Patient Signature Date

ChiroSolution Center, P.C.
287 Independence Boulevard, Suite 118
Virginia Beach, Virginia 23462

General Release

I, _____(please print), and parent/legal guardian of (list names if they apply to this General Release)

_____(please print)
_____(please print)
_____(please print)
_____(please print)

grant ChiroSolution Center, P.C. permission to use my child's (children's) name, if listed, and my name, information, likeness, image, voice, remarks, and/or appearance as embodied in any written document, photographs, video recordings, audio recordings, digital images, illustrations, research, etc., taken or made on behalf of ChiroSolution Center, P.C. for educational, training, marketing and promotional purposes. This includes the practice website and 3rd party social media sites and other online marketin.

I agree that ChiroSolution Center, P.C. has full ownership of any such media, including the entire copyright. I acknowledge that online marketing sites are owned and managed by 3rd party companies. i acknowledge that I will not receive any compensation for the use of such information and media, and I hereby release ChiroSolution Center, P.C. for any and all claims that arise out of or are in any way connected with such use.

I have read and understood this consent and release.

_____

Signature Date

Sign and date here if wish to decline:

_____

CONSENT TO USE ELECTRONIC COMMUNICATIONS

ChiroSolution Center, P.C.
287 Independence Blvd., Ste 118
chirosolution1@hotmail.com
757-271-0001
www.mychirosolutions.com

The Chiropractic Physician has offered to communicate using the following means of electronic communication [check all that apply]:

____Email
____ Videoconferencing (including Skype®, FaceTime®)
____Text messaging
____Website/Portal
____Social media (specify): Facebook, Instagram, Twitter, YouTube
____Other (specify): MailChimp

PATIENT ACKNOWLEDGMENT AND AGREEMENT: I acknowledge that I have read and fully understand the risks, limitations, conditions of use, and instructions for use of the selected electronic communication Services more fully described in the Appendix to this consent form. I understand and accept the risks outlined in the Appendix to this consent form, associated with the use of the Services in communications with the Chiropractic Physician and the Chiropractic Physician's staff. I consent to the conditions and will follow the instructions outlined in the Appendix, as well as any other conditions that the Chiropractic Physician may impose on communications with patients using the Services. I acknowledge and understand that despite recommendations that encryption software be used as a security mechanism for electronic communications, it is possible that communications with the Chiropractic Physician or the Chiropractic Physician's staff using the Services may not be encrypted. Despite this, I agree to communicate with the Chiropractic Physician or the Chiropractic Physician's staff using these Services with a full understanding of the risk. I acknowledge that either I or the Chiropractic Physician may, at any time, withdraw the option of communicating electronically through the Services upon providing written notice. Any questions I had have been answered.

Patient Name: _____
Patient Address: _____
Patient Phone Number: _____
Patient Email: _____

Patient Signature: _____ Date: _____
Witness Signature: _____ Date: _____

RAND 36 ITEM HEALTH SURVEY 1.0

Patient Name: _____

1. In general, would you say your health is:
(Circle One Number)

Excellent 1
Very Good 2
Good 3
Fair 4
Poor 5

2. **Compared to one year ago**, how would you rate your: general health right **now** ?
(Circle One Number)

Much better than one year ago 1
Somewhat better than one year ago 2
About the same 3
Somewhat worse now than one year ago 4
Much worse now than one year ago 5

The following items are about activities you might do during a typical day: Does **your health now limit you** in these activities? If so, how much? **(Circle One Number on Each Line)**	**Yes, Limited A Lot**	**Yes, Limited A Little**	**No, Not Limited at All**
3. **Vigorous activities**, such as running, lifting heavy objects, participating in strenuous sports	1	2	3
4. **Moderate activities**, such as moving a table pushing a vacuum cleaner, bowling or playing golf	1	2	3
5. Lifting or carrying groceries	1	2	3
6. Climbing **several** fights of stairs	1	2	3
7. Climbing **one** flight of stairs	1	2	3
8. Bending, kneeling or stooping	1	2	3
9. Walking **more than a mile**	1	2	3
10. Walking **several blocks**	1	2	3
11. Walking **one block**	1	2	3
12. Bathing or dressing yourself	1	2	3

During the **past 4 weeks**, have you had any of the following problems with your work or other regular daily activities **as a result of your physical health** ?: **(Circle One Number on Each Line)**	**Yes**	**No**
13. Cut down the amount of time you spend on work or other activities	1	2
14. Accomplish less than you would like	1	2
15. Were limited in the kind of work or other activities	1	2
16. Had difficulty performing the work or other activities (for example, took extra effort)	1	2

During the **past 4 weeks**, have you had any of the following problems with your work or other regular daily activities **as a result of any emotional problems** ?: (depressed, anxious) **(Circle One Number on Each Line)**	**Yes**	**No**
17. Cut down the amount of time you spend on work or other activities	1	2
18. Accomplish less than you would like	1	2
19. Didn't do work or other activities as carefully as usual	1	2

20. During the **past 4 weeks**, to what extent has your physical health or emotional: problems interfered with your normal social activities with family, friends, neighbors or groups?
(Circle One Number)

Not at all 1
Slightly 2
Moderate 3
Quite a bit 4
Good 5

21. How much **bodily** pain have you had during the **past 4 weeks**:
(Circle One Number)

None 1
Very Mild 2
Mild 3
Moderate 4
Severe 5
Very Severe 6

22. During the **past 4 weeks**, how much did pain interfere with your normal work (including both work outside the home and housework ?
(Circle One Number)

Not at all 1
Slightly 2
Moderately 3
Quite a bit 4
Extremely 5

These questions are about how you feel and how things have been with you **during the past 4 weeks**. For each question, please give the one answer that comes closest to the way you have been feeling.

How much of the time during the past 4 weeks . . . **(Circle One Number on Each Line)**	**All of the Time**	**Most of the Time**	**A Good Bit of the Time**	**Some of the Time**	**A Little of the Time**	**None of the Time**
23. Did you feel full of pep?	1	2	3	4	5	6
24. Have you been a very nervous person?	1	2	3	4	5	6
25. Have you felt so down in the dumps that nothing could cheer you up ?	1	2	3	4	5	6
26. Have you felt calm and peaceful?	1	2	3	4	5	6
27. Do you have a lot of energy?	1	2	3	4	5	6
28. Have you felt downhearted and blue?	1	2	3	4	5	6
29. Did you feel worn out?	1	2	3	4	5	6
30. Have you been a happy person?	1	2	3	4	5	6
31. Did you feel tired?	1	2	3	4	5	6

32. During the **past 4 weeks**, to what extent has your **physical health or emotional problems** interfered with your normal social activities like visiting with family, friends, relatives, etc.?
(Circle One Number)

All of the time 1
Most of the time 2
Some of the time 3
A little of the time 4
None of the time 5

How TRUE or FALSE is each of the following statements for you?

(Circle One Number on Each Line)	**Definitely True**	**Mostly True**	**Don't Know**	**Mostly False**	**Definitely False**
33. I seem to get sick a little easier than other people	1	2	3	4	5
34. I am as healthy as anybody I know	1	2	3	4	5
35. I expect my health to get worse	1	2	3	4	5
36. My health is excellent	1	2	3	4	5

Comments: _____

_____

Patient Signature: _____ Date _____

Patient's Name_____ Number_____ Date_____

LOW BACK DISABILITY QUESTIONNAIRE (REVISED OSWESTRY)

This questionnaire has been designed to give the doctor information as to how your back pain has affected your ability to manage in everyday life. **Please answer every section and mark in each section only ONE box** which applies to you. We realize you may consider that two of the statements in any one section relate to you, but **please just mark the box which MOST CLOSELY describes your problem.**

Section 1 - Pain Intensity

- ☐ I can tolerate the pain without having to use painkillers.
- ☐ The pain is bad but I can manage without taking painkillers.
- ☐ Painkillers give complete relief from pain.
- ☐ Painkillers give moderate relief from pain.
- ☐ Painkillers give very little relief from pain.
- ☐ Painkillers have no effect on the pain and I do not use them.

Section 2 -- Personal Care (Washing, Dressing, etc.)

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

Section 3 -- Lifting

- ☐ I can lift heavy weights without extra pain.
- ☐ I can lift heavy weights but it gives extra pain.
- ☐ Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned, for example on a table.
- ☐ Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
- ☐ I can lift very light weights.
- ☐ I cannot lift or carry anything at all.

Section 4 -- Walking

- ☐ Pain does not prevent me from walking any distance.
- ☐ Pain prevents me from walking more than one mile.
- ☐ Pain prevents me from walking more than one-half mile.
- ☐ Pain prevents me from walking more than one-quarter mile
- ☐ I can only walk using a stick or crutches.
- ☐ I am in bed most of the time and have to crawl to the toilet.

Section 5 -- Sitting

- ☐ I can sit in any chair as long as I like
- ☐ I can only sit in my favorite chair as long as I like
- ☐ Pain prevents me from sitting more than one hour.
- ☐ Pain prevents me from sitting more than 30 minutes.
- ☐ Pain prevents me from sitting more than 10 minutes.
- ☐ Pain prevents me from sitting almost all the time.

Scoring: Questions are scored on a vertical scale of 0-5. Total scores and multiply by 2. Divide by number of sections answered multiplied by 10. A score of 22% or more is considered significant activities of dally living disability.
(Score___ x 2) / (____Sections x 10) = _____ %ADL

Section 6 -- Standing

- ☐ I can stand as long as I want without extra pain.
- ☐ I can stand as long as I want but it gives extra pain.
- ☐ Pain prevents me from standing more than 1 hour.
- ☐ Pain prevents me from standing more than 30 minutes.
- ☐ Pain prevents me from standing more than 10 minutes.
- ☐ Pain prevents me from standing at all.

Section 7 -- Sleeping

- ☐ Pain does not prevent me from sleeping well.
- ☐ I can sleep well only by using tablets.
- ☐ Even when I take tablets I have less than 6 hours sleep.
- ☐ Even when I take tablets I have less than 4 hours sleep.
- ☐ Even when I take tablets I have less than 2 hours sleep.
- ☐ Pain prevents me from sleeping at all.

Section 8 -- Social Life

- ☐ My social life is normal and gives me no extra pain.
- ☐ My social life is normal but increases the degree of pain.
- ☐ Pain has no significant effect on my social life apart from limiting my more energetic interests, e.g. dancing.
- ☐ Pain has restricted my social life and I do not go out as often.
- ☐ Pain has restricted my social life to my home.
- ☐ I have no social life because of pain.

Section 9 -- Traveling

- ☐ I can travel anywhere without extra pain.
- ☐ I can travel anywhere but it gives me extra pain.
- ☐ Pain is bad but I manage journeys over 2 hours.
- ☐ Pain is bad but I manage journeys less than 1 hour.
- ☐ Pain restricts me to short necessary journeys under 30 minutes.
- ☐ Pain prevents me from traveling except to the doctor or hospital.

Section 10 -- Changing Degree of Pain

- ☐ My pain is rapidly getting better.
- ☐ My pain fluctuates but overall is definitely getting better.
- ☐ My pain seems to be getting better but improvement is slow at the present.
- ☐ My pain is neither getting better nor worse.
- ☐ My pain is gradually worsening.
- ☐ My pain is rapidly worsening.

Comments_____

Reference: Fairbank, Physiotherapy 1981; 66(8): 271-3, Hudson-Cook. In Roland, Jenner (eds.), Back Pain New Approaches To Rehabilitation & Education. Manchester Univ Press, Manchester 1989: 187-204

PLEASE RATE YOUR PAIN ON A SCALE FROM 0-10 WITH 10 BEING THE WORST PAIN EVER.

Please rate your pain when it is at its worst: 0 1 2 3 4 5 6 7 8 9 10
Please rate your pain when it is at its best: 0 1 2 3 4 5 6 7 8 9 10

Please rate your pain today: 0 1 2 3 4 5 6 7 8 9 10
Please rate your pain on average: 0 1 2 3 4 5 6 7 8 9 10

Patient's Name_____ Number_____ Date_____

NECK DISABILITY INDEX

This questionnaire has been designed to give the doctor information as to how your neck pain has affected your ability to manage in everyday life. **Please answer every section and mark in each section only ONE box** which applies to you. We realize you may consider that two of the statements in any one section relate to you, but **please just mark the box which MOST CLOSELY describes your problem.**

Section 1 - Pain Intensity

- ☐ I have no pain at the moment.
- ☐ The pain is very mild at the moment.
- ☐ The pain is moderate at the moment.
- ☐ The pain is fairly severe at the moment.
- ☐ The pain is very severe at the moment.
- ☐ The pain is the worst imaginable at the moment.

Section 2 – Personal Care (Washing, Dressing, etc.)

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

Section 3 – Lifting

- ☐ I can lift heavy weights without extra pain.
- ☐ I can lift heavy weights but it gives extra pain.
- ☐ Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned, for example on a table.
- ☐ Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
- ☐ I can lift very light weights.
- ☐ I cannot lift or carry anything at all.

Section 4 – Reading

- ☐ I can read as much as I want to with no pain in my neck.
- ☐ I can read as much as I want to with slight pain in my neck.
- ☐ I can read as much as I want with moderate pain.
- ☐ I can't read as much as I want because of moderate pain in my neck.
- ☐ I can hardly read at all because of severe pain in my neck.
- ☐ I cannot read at all.

Section 5-Headaches

- ☐ I have no headaches at all.
- ☐ I have slight headaches which come infrequently.
- ☐ I have slight headaches which come frequently.
- ☐ I have moderate headaches which come infrequently.
- ☐ I have severe headaches which come frequently.
- ☐ I have headaches almost all the time.

Scoring: Questions are scored on a vertical scale of 0-5. Total scores and multiply by 2. Divide by number of sections answered multiplied by 10. A score of 22% or more is considered a significant activities of daily living disability.
(Score___ x 2) / (____Sections x 10) = _____ %ADL_____

Section 6 – Concentration

- ☐ I can concentrate fully when I want to with no difficulty.
- ☐ I can concentrate fully when I want to with slight difficulty.
- ☐ I have a fair degree of difficulty in concentrating when I want to
- ☐ I have a lot of difficulty in concentrating when I want to.
- ☐ I have a great deal of difficulty in concentrating when I want to.
- ☐ I cannot concentrate at all.

Section 7—Work

- ☐ I can do as much work as I want to.
- ☐ I can only do my usual work, but no more.
- ☐ I can do most of my usual work, but no more.
- ☐ I cannot do my usual work.
- ☐ I can hardly do any work at all.
- ☐ I can't do any work at all.

Section 8 – Driving

- ☐ I drive my car without any neck pain.
- ☐ I can drive my car as long as I want with slight pain in my neck.
- ☐ I can drive my car as long as I want with moderate pain in my neck.
- ☐ I can't drive my car as long as I want because of moderate pain in my neck.
- ☐ I can hardly drive my car at all because of severe pain in my neck.
- ☐ I can't drive my car at all.

Section 9 – Sleeping

- ☐ I have no trouble sleeping.
- ☐ My sleep is slightly disturbed (less than 1 hr. sleepless).
- ☐ My sleep is moderately disturbed (1-2 hrs. sleepless).
- ☐ My sleep is moderately disturbed (2-3 hrs. sleepless).
- ☐ My sleep is greatly disturbed (3-4 hrs. sleepless).
- ☐ My sleep is completely disturbed (5-7 hrs. sleepless).

Section 10 – Recreation

- ☐ I am able to engage in all my recreation activities with no neck pain at all.
- ☐ I am able to engage in all my recreation activities, with some pain in my neck.
- ☐ I am able to engage in most, but not all of my usual recreation activities because of pain in my neck.
- ☐ I am able to engage in a few of my usual recreation activities because of pain in my neck.
- ☐ I can hardly do any recreation activities because of pain in my neck.
- ☐ I can't do any recreation activities at all.

Comments_____ %ADL

Reference: Vernon, Mior. JMPT 1991; 14(7): 409

PLEASE RATE YOUR PAIN ON A SCALE FROM 0-10 WITH 10 BEING THE WORST PAIN EVER.

Please rate your pain when it is at its worst: 0 1 2 3 4 5 6 7 8 9 10
Please rate your pain when it is at its best: 0 1 2 3 4 5 6 7 8 9 10

Please rate your pain today: 0 1 2 3 4 5 6 7 8 9
Please rate your pain on average: 0 1 2 3 4 5 6 7 8 9