ChiroSolutions Center

We Care For EVERY Body.

NEW PATIENT APPLICATION FORM
(INFANT/CHILD)

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

Child's Name _____ Date of Birth _____

Address _____

City _____ State _____ Zip _____

Phone Number _____ Gender: M F

Mother's Name _____ Date of Birth _____

Address _____

City _____ State _____ Zip _____

Phone Number _____ Email _____

Employer Name _____ Occupation _____

Father's Name _____ Date of Birth _____

Address _____

City _____ State _____ Zip _____

Phone Number _____ Email _____

Employer Name _____ Occupation _____

Mother's History

Did you experience any issues during your pregnancy?

[ ] Y [ ] N Please explain _____

_____

Did you have any spinal pain problems during your pregnancy?

[ ] Y [ ] N Please explain _____

_____

Regarding your labor, which one of the following would you say it was?

EASY HARD VERY HARD

How did you deliver your child? [ ] On back [ ] On all fours [ ] Squatting

[ ] Sitting up in a birthing chair [ ] C-Section [ ] Other _____

Were forceps used? [ ] Y [ ] N Please explain_____

Any complications?

[ ] Y [ ] N Please explain _____

Baby's History

Was your child breastfed? [ ] Y [ ] N How long? _____

Did your child have any unusual or strange habits or behaviors as a newborn? _____

_____

A. Colic? [ ] Y [ ] N

B. Fussy? [ ] Y [ ] N

C. Alert? [ ] Y [ ] N

D. Happy? [ ] Y [ ] N

E. Did the child have shots (immunizations)? [ ] Y [ ] N

F. Did the child crawl? [ ] Y [ ] N Beginning at what age? _____

G. Was the child in a walker? [ ] Y [ ] N How long? _____

H. For how long did the child crawl? _____

I. At what age did the child begin to walk? _____

J. Did you notice anything unusual about the child's efforts to learn to walk? [ ] Y [ ] N

Did the child fall a lot? [ ] Y [ ] N

Were there any particularly hard falls that you recall? [ ] Y [ ] N

If so, please explain _____

Young Child

A. Ear infections? [ ] Y [ ] N

B. Colds? [ ] Y [ ] N

C. Mucus/Sinus trouble? [ ] Y [ ] N

D. Falls? [ ] Y [ ] N

E. Collisions (Automobile)? [ ] Y [ ] N

Anything else you have noticed about your child that you think is unusual or important for Dr. Coleman to know: _____

_____

_____

List any medications, past or present: _____

_____

Any diagnosed diseases: _____

_____

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 child's 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 5 to provide a detailed notation of your child's 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___Routine

Explain: _____

Is there anything that aggravates your child's symptoms? _____

Is there anything that relieves your child's symptoms? _____

Has your child been treated for these symptoms before? ___Yes ___No When was your child last treated? ___/___/___

Who did your child see? _____ Treatment performed? _____

How did your child respond? _____

Experience with Chiropractic Care

Has your child seen a Chiropractor before? ___Yes___No If yes, who? _____

Reason for visit(s): _____

Did your child's 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 was your child treated? _____ Date of last treatment: ____/____/____

How did your child respond? _____

Are you aware of any poor posture habits that your child has? ___Yes___No If yes, please explain: _____

_____

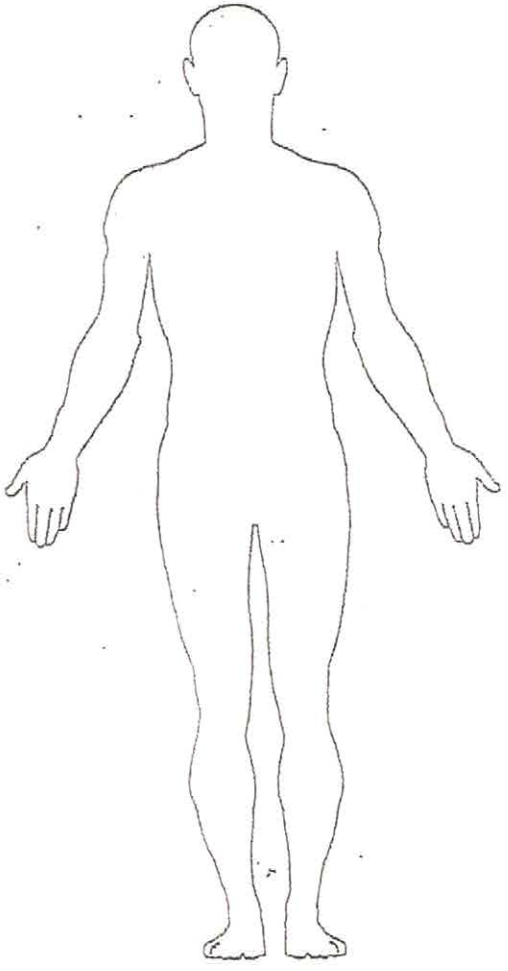
Is there any history of spinal problems in your family? ___Yes___No If yes, please explain: _____

_____

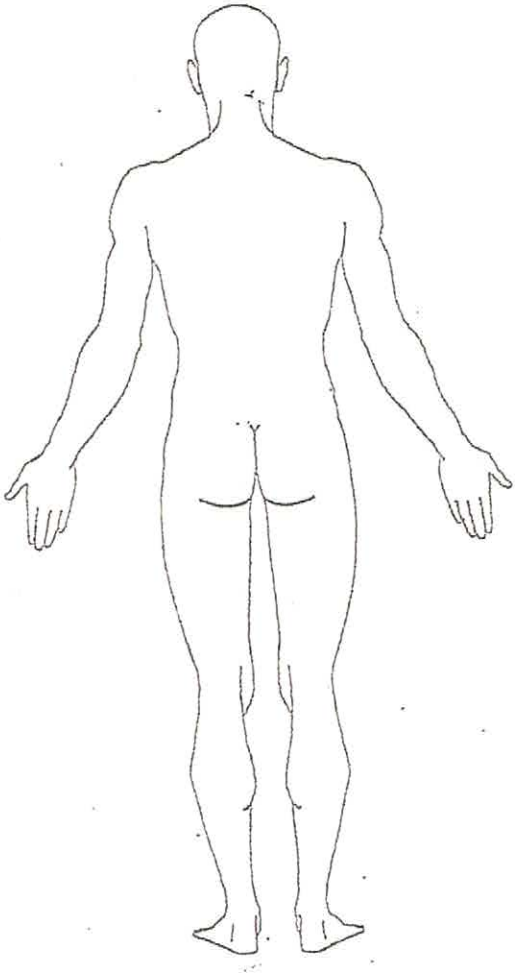
GENERAL SYMPTOMS CHART

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

_____

_____

PATIENT NAME:_____/DOB:_____

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 child's condition.

Vaccination History

What vaccinations has your child received? Please note at what age and where each was received:

1._____ Age: _____ (Months/Years) Where received: _____

2._____ Age: _____ (Months/Years) Where received: _____

3._____ Age: _____ (Months/Years) Where received: _____

4._____ Age: _____ (Months/Years) Where received: _____

5._____ Age: _____ (Months/Years) Where received: _____

Please check any of the following responses your child experienced as a result of a vaccination (please indicate which vaccination caused the condition by writing the corresponding number next to that condition).

___Body rash or hives
___Body twitching or paralysis
___Breathing problems (asthma, etc.)
___Chronic ear or respiratory infections
___Crossing of eyes
___Excessive bleeding or anemia
___Excessive diarrhea or chronic constipation
___Extreme sleepiness or unresponsiveness
___Head banging
___High fever (over 103 degrees)
___High-pitched screaming
___Joint pain
___Loss of Memory/foggy state
___Muscle weakness
___Seizures
___Swelling, redness, heat/hardness of site
___Vision or hearing disturbances
___Other (please explain)

Explanation(s): _____

_____

Cervical Spine (Neck) **3 years and up

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. Has your child experienced any of these symptoms presently or in the past?

Please indicate (N) = Now, (P) = Past next to all conditions your child has experienced or both if applicable.

___Allergies/Hay Fever
___Auto-Immune Diseases
___Coldness in hands
___Dizziness
___Flu/stomach disorders
___Headaches
___Hearing disturbances
___Hyperactivity/ADD

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

Cervical Spine (Neck) (continued) **3 years and up

___Learning disabilities ___Low Energy/Fatigue ___Neck Pain ___Numbness

___Pain in shoulders/arms/hands ___Recurrent colds/Flu ___Sinusitis ___Thyroid conditions

___Tingling in arms/hands ___TMJ/Pain/Clicking ___Visiual disturbances ___Weakness in grip

___Other (please explain)

Explanation(s): _____

_____

Thoracic Spine (Upper Back) **3 years and up

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. Has your child 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 Murmurs ___Heart Palpitations

___Pain on deep inspiration/expiration ___ Recurrent lung infections/bronchitis/pneumonia

___Shingles ___Shortness of breath ___Tachycardia (fast heart beat)

___Upper back pain ___Other (please explain)

Please explain: _____

_____

Thoracic Spine (Mid Back) **3 years and up

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. Has your child 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

___Liver problems ___Mid Back Pain ___Nausea ___Pain in Ribs/Chest

___Reflux ___Spleen problems ___Tired/irritable after eating or when not having eaten for a while

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

Thoracic Spine (Mid Back) (continued) **3 years and up

___Ulcers/Gastritis ___Other (please explain)

Please explain: _____

_____

Lumbar Spine (Low Back) **3 years and up

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. Has your child 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

___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 your child has been taking it): _____

_____

_____

_____

_____

_____

Family Health History

Have any of your family members ever been diagnosed with the following? If so, please indicate "P" for your child (patient), and "O" for Other than your child, or both if applicable (items marked with an asterisk, please offer a detailed list or explanation).

___ADD	___Allergies/Hay fever*	___Anemia	___Appendectomy
___Arthritis	___Asthma	___Bed wetting	___Blood sugar problems
___Broken bones/fracture	___Cancer	___Cerebral Palsy	___Chicken pox/Shingles
___Circulatory problems	___Crohn's/Colitis	___Depression	___Diabetes
___Ear Infections	___Eczema	___Eczema/Psoriasis	___Epilepsy/seizures
___Fetal drug exposure	___Food allergies*	___Gall bladder	___Headaches
___Heart disease	___Heart murmur	___Hepatitis	___Hernia
___High blood pressure	___HIV	___Infectious disease	___Influenza
___Kidney disease	___Liver disease	___Lumbago	___Lung disease
___Measles	___Metal implants	___Migraine headaches	___Mumps
___Neurological problems	___Osteoporosis	___Paralysis	___Pleurisy
___Pneumonia/Bronchitis	___Polio	___Rash	___Rheumatic fever
___Scoliosis	___Seizure disorder	___Sickle Cell Anemia	___Smallpox
___Spina Bifida	___Stroke	___Thyroid problems	___Tonsillectomy
___Tuberculosis	___Varicose veins	___Whooping cough	___Other*

Explanation of (*) item(s): _____

_____

_____

Pregnancy Release

This is to certify that to the best of my knowledge my child is 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 (other than parent/guardian)

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 child's 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 my child/charge does not follow Dr. Coleman's and/or staff's specific recommendations at this office that he/she will not receive the full benefit from these programs; and that if I terminate his/her 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.

I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered me will be immediately due and payable. An interest charge of 1.5% per month may be applied to balances in excess of 30 days from the time of service. If collection action is necessary, I agree to pay any collection, attorney and/or court fees incurred by Chiropractic Solution Center, P.C. in the collection of my past due balance.

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: December 30, 2020

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.

Patient Print/Sign: _____

- 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.

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 tasks such 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 outside services. 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 law enforcement 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 marketing.

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. from 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

Choose one option for each questionnaire item. Patient Name: _____

1. In general, would you say your health is:	❑ 1- Excellent ❑ 2- Very good ❑ 3 - Good ❑ 4 - Fair ❑ 5 - Poor	2. **Compared to one year ago**, how would you rate your health in general **now**?	❑ 1 - Much better now than one year ago ❑ 2 - Somewhat better now that one year ago ❑ 3 - About the same ❑ 4 - Somewhat worse now than one year ago ❑ 5 - Much worse now than one year ago

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?	**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** flights 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**?	**Yes**	**No**
13. Cut down the **amount of time** you spent on work or other activities	❑ 1	❑ 2
14. **Accomplished 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, it 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** (such as feeling depressed or anxious)?	**Yes**	**No**
17. Cut down the **amount of time** you spent on work or other activities	❑ 1	❑ 2
18. **Accomplished 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?	❑ 1- Not at all ❑ 2- Slightly ❑ 3 - Moderately ❑ 4 - Quite a bit ❑ 5 - Extremely	21. How much **bodily** pain have you had during the **past 4 weeks**?	❑ 1 - None ❑ 2 - Very mild ❑ 3 - Mild ❑ 4 - Moderate ❑ 5 - Severe ❑ 6 - Very severe

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

- ❑ 1 - Not at all
- ❑ 2 - A little bit
- ❑ 3 - Moderately
- ❑ 4 - Quite a bit
- ❑ 5 - Extremely

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**...	**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. Did 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**, how much of the time has **your physical health or emotional problems** interfered with your social activities (like visiting with friends, relatives, etc.)?

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

How TRUE or FALSE is **each** of the following statements for you?	**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 daily 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 1
Please rate your pain on average: 0 1 2 3 4 5 6 7 8 9 1

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