

Optimum Health Through Alternative Care

30789 SW Boones Ferry Rd., Suite P – Wilsonville, OR 97070 – 503-682-6778 – fax 503-682-6744

Welcome

Patient Information (*Please print. If you have no answer to a question please write "none"*)

Thank you for choosing our practice for your chiropractic needs. Please complete this form in ink. If you have any questions or concerns; do not hesitate to ask for assistance. We will be happy to help you.

Name _____

First MI Last

Address _____ Apt # _____

City _____ State _____ Zip _____

Sex: Female Male Are you: Minor Married Divorced Widowed Single Separated

DOB _____ Age _____ Hm phone# _____ Cell _____

E-mail: _____

Would you like appointment reminders by: text _____ or voice mail _____ (home or cell)

Your employer _____ Occupation _____

Contact person in case of emergency _____ Phone# _____

Whom may we thank for referring you to us? _____

Date of injury _____ **Date symptoms began** _____

Is this visit today the result of an auto injury? _____ or work related injury? _____

Insurance information:

Do you have health insurance? Yes No *(if yes, please provide card to front desk)*

Subscriber Name _____ **DOB:** _____

Do you have secondary insurance? Yes No *(if yes, please also give card to front desk for copy)*

Subscriber Name _____ **DOB:** _____

Primary Care Physician _____

Specialist

Past Health History (*please use the back of page for additional information)

Date of last physical exam _____

Do you have a history of high blood pressure? Yes No

*Have you ever had any serious illness, trauma, accidents, injuries, surgeries or been hospitalized?

If yes, please describe date and illness/ injury: _____

Patient Name: _____ DOB: _____ Date: _____

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*List any history of connective tissue disorders, vascular conditions including, but not limited to: fibro-muscular dysplasia, Vascular Ehlers-Danlos Syndrome, Marphans Syndrome, etc.:

*What, if any, supplements, prescription, and over the counter medications are you taking?

Do you have any allergies? _____

Please list any X-rays and/or MRI's with dates when they were taken _____

Have you seen a Chiropractor previously? Yes No
Name: _____ When? _____

(Females only)

Are you pregnant? Yes No If yes, due date: _____
Do you have any problems with your menstrual cycle? _____
Have you reached menopause? Yes No Surgical or physiological? _____ Oophorectomy? _____
Have you had a Mammogram? _____
Hormone replacement therapy? Yes No
Oral contraceptives? Yes No (if not currently, in past? Yes No)

Family Health History (please use the back of page for additional information)

Are there any serious illnesses, disorders, conditions, or ailments that run in your family?

Personal/Social History

Height _____ Weight _____
What is your occupation? _____ Describe your duties _____
What regular exercise do you participate in? _____
What other interests/ hobbies do you enjoy? _____
Do you eat a balanced diet? _____ Describe _____
How much water do you drink per day? _____
Do you get enough sleep? Yes No If no, is it due to pain? Yes No How many hours? _____
Have there been any changes in your bowel or bladder habits? _____
How many alcohol drinks do you consume on average per week? _____
Do you currently smoke? Yes No Did you smoke in past? Yes No If yes, when did you quit? _____
Have there been any significant stressors in your life lately? _____
How do you handle stress? _____ Has this changed recently? _____

Patient Name: _____ DOB: _____ Date: _____

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Symptoms

Reason for this visit _____

Health History (*circle any condition you currently have or have had in past*):

AIDS/HIV	Cataracts	Hepatitis	Numbness	Thyroid Problems
Alcoholism	Chemical Dependency	Hernia	Osteoporosis	Tingling
Allergy Shots	Chicken Pox	Herniated Disc	Pacemaker	Tonsillitis
Anemia	Depression	Herpes	Parkinson's Disease	Tuberculosis
Anorexia	Diabetes	High Cholesterol	Pinched Nerve	Tumors, Growths
Anxiety	Emphysema	Kidney Disease	Pneumonia	Typhoid Fever
Appendicitis	Epilepsy	Liver Disease	Polio	Ulcers
Arm / Leg Pain	Fractures	Measles	Prostate Problems	Vaginal Infections
Arthritis	Glaucoma	Migraine Headaches	Prosthesis	Venereal Disease
Asthma	Goiter	Miscarriage	Psychiatric Care	Vision Problems
Back Pain	Gonorrhea	Mononucleosis	Rheumatoid Arthritis	Whooping Cough
Bleeding Disorders	Gout	Muscle Weakness	Rheumatic Fever	
Breast Lump	Headaches	Multiple Sclerosis	Scarlet Fever	
Bronchitis	Hearing Problems	Mumps	Stroke	
Bulimia	Heart Disease	Neck Pain	Suicide Attempt	

Cancer (current or remission)

Blood pressure (high or low)

Please list anything that is not listed: _____

Authorization

The Health Insurance Portability & Accountability Act of 1996 ("HIPAA") is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally, are kept properly confidential.

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the chiropractor to release any information including the diagnosis and the records of any treatment or examination rendered to my child or myself during the period of such chiropractic care to third party payers and/or health practitioners. I authorize and request my insurance company to pay directly to the chiropractor insurance benefits otherwise payable to me. I understand that my chiropractic insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

Signature of Patient (or parent of a minor)

Date

Patient Name: _____ DOB: _____ Date: _____

FINANCIAL POLICIES STATEMENT

Boones Ferry Chiropractic and Massage would like to take this opportunity to familiarize you with our office financial policies.

Please be sure to update front desk personnel with any changes in address, phone numbers, or insurance information so that billing is done correctly and in a timely manner.

Insurance

For those of you with chiropractic benefits on your insurance, we will file your claims for you. You will be charged as we are instructed by your insurance company. Our staff will call and verify your benefits and coverage; however, this is not a guarantee of payment. Your coverage is determined by the individual policy secured and limitations, you will ultimately be responsible for payment of services you receive.

- It is our office policy to collect all money when services are provided. If we over estimate the amount you owe, you will receive a refund or we can keep the credit on file. If you owe more than what we estimate, you will be balance billed.

Initial

- Interest will accrue at 1.5% on any outstanding balance. Interest won't be charged until 30 days after the first statement has been issued. If you need to set up a payment plan, we require a credit or debit card on file, and outstanding balances to be paid within 90 days.

Initial

Workers Comp / Auto Accident

We will file your claims for you; however, this is not a guarantee of payment or acceptance of your claim. You will ultimately be responsible for payment of services you receive. Time of service discount is not applicable for these services.

Time of Service Discount

For patients without chiropractic insurance, we offer a time of service discount, which requires payment at the time services are rendered. We honor our senior citizen patients (age 65 and over without insurance coverage) with a discount on their chiropractic adjustment.

Canceled Appointments

We require 24 hours advance notification if you are unable to keep your appointment. We reserve the right to charge a cancellation fee for missed chiropractic and massage appointments at the current rate of the reserved time. We do our best to fill the appointment time if we have ample notice to contact one of the patients on our wait list. This fee is non-billable to insurance.

NSF Checks

Checks returned from the bank will incur a \$25.00 processing fee.

Initial

The above policies are designed to keep our office running as efficiently as possible. Knowing the importance of the relationship between chiropractic health and your overall health, our efforts are intended to make your chiropractic experience not only beneficial but also affordable.

Signature

Date

Patient Name: _____ DOB: _____ Date: _____

INFORMED CONSENT FOR CHIROPRACTIC EXAMINATION AND TREATMENT

Chiropractic Examination

In order to provide appropriate evaluation and treatment recommendations, a doctor will need to obtain a medical history from you and perform an examination. This examination will include palpation, where the doctor uses his hands on your spine, and/or other joints, and the surrounding soft tissue. Palpation allows the doctor to assess joint function and areas of subluxation. Your examination may also include other evaluation techniques such as: assessing your range of motion, orthopedic and neurological testing, imaging studies (like x-rays), and obtaining your blood pressure and other relevant vital signs. Some portions of the examination may elicit or aggravate your pain or symptoms. It is important that you communicate all symptoms to the doctor and advise him/her if any portion of the examination causes you pain. All our patients are encouraged to ask questions before, during and after all aspects of the examination and subsequent care.

I _____ (print name), give my consent for examination.

Signature of Patient or Legal Guardian

Date

Chiropractic Treatment

Procedure: Chiropractic adjustment or manipulation is a manual procedure where the doctor uses his/her hands, or an instrument, to manipulate the joints of the body to restore or enhance joint function and mobility. You may hear an audible “pop” or “click” or feel or sense movement. Chiropractic care may include any of the following depending on your condition: chiropractic adjustments of the spine or other joints, manual muscle work such as massage, traction, ultrasound therapy, electric muscle stimulation (EMS), heat or cold therapy, the use of therapeutic exercise, cold laser light therapy and the use of nutritional counseling and supplementation. Your doctor will discuss with you a proposed treatment plan, which may at times be carried out by other doctors in the clinic or trained staff.

Risks: Chiropractic care, as in the practice of medicine and all health care, carries some risk during examination and treatment. Patients may experience temporary muscle soreness, inflammation, dizziness, worsening of symptoms with treatment, therapies or physical examination. Soreness following treatment, like that following exercise, should resolve within 24-48 hours. While the chances of experiencing serious complications are rare, it is the practice of this clinic to inform our patients about them. These complications include, but are not limited to, burns or skin irritation from heat or other therapies, sprains/strains, disc injuries, dislocations or rib fractures following any manual technique. More serious complications are extremely rare. Cervical artery dissection is associated with many neck movements, including chiropractic adjustments of the cervical spine. Current research indicates cervical artery dissection is not caused by, but is associated with, cervical adjustment. According to some authorities, the association between cervical adjustments and cervical artery dissection is one in a million (1 in 1 million). Cervical artery dissections can lead to serious medical complications, including stroke. Additional information on side effects, risks and complications is available upon request. If you have any unusual symptoms before, during or following treatment, you should immediately advise your doctor(s) and seek appropriate care.

Patient Name: _____ DOB: _____ Date: _____

INFORMED CONSENT FOR CHIROPRACTIC EXAMINATION AND TREATMENT

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PATIENT RIGHTS AND RESPONSIBILITIES

Patient Rights

A patient, and/or the patient's legal representative, has the right to:

- Receive complete and current information and answers to questions about diagnosis, treatment and prognosis.
- Participate in decisions about care and provide informed consent for procedures.
- Refuse treatment and accept potential consequences of that decision.
- Receive considerate and respectful care in an environment that permits reasonable privacy.
- Know the identity and professional status of individuals providing service and know who has primary responsibility for coordinating care.
- Have another person present during examination and/or treatment.
- Expect reasonable safety with regard to the health care environment.
- Be fully advised of and accept or refuse to participate in any research project and/or experimental procedures.
- Expect that all communications and records pertaining to care will be subject to appropriate confidentiality.
- Examine and receive an explanation of charges for services rendered.
- Expect not to be denied care solely on the basis of race, gender, national origin, religion or sexual preference.
- Express grievances regarding any perceived violation of rights to the institution and to appropriate regulatory agencies.

Patient Responsibilities

A patient, and/or the patient's legal representative, has the responsibility to:

- Provide accurate and complete information regarding present complaints, past illnesses, hospitalizations, medications, and any other matters related to his/her health.
- Report in a timely manner any new incident, trauma, or changes in health condition.
- Acknowledge and consider instructions and recommendations provided by health care providers and/or office staff.
- Request clarification about any aspect of care not fully comprehended.
- Keep scheduled appointments or give adequate notice of delay or cancellation.
- Assure that the financial obligations related to his/her health care are fulfilled as promptly as possible.
- Treat members of the health care community with respect and courtesy.

Signature

Date

Patient Name: _____ DOB: _____ Date: _____

ACKNOWLEDGEMENT OF RECEIPT—NOTICE OF PRIVACY PRACTICES

This form represents documentation that Boones Ferry Chiropractic and Massage Notice of Privacy Practices was given to the patient or their personal representative.

By signing this form, you acknowledge receipt of Boones Ferry Chiropractic and Massage Notice of Privacy Practices. The notice provides information about how we may use and disclose your protected health information. You are encouraged to review the notice carefully.

I acknowledge receipt of Boones Ferry Chiropractic and Massage Notice of Privacy Practices.

Signature _____ Date _____
(Patient or personal representative)

If you are signing as a personal representative, please complete the following:

Parent/Guardian/Personal representative's name: _____

Relationship to patient: _____

Boones Ferry Chiropractic and Massage Use Only:

☐ Inability to obtain acknowledgement

To be completed only if a signature is not obtained. Describe the efforts made to obtain the individual's acknowledgement and the reasons why the acknowledgement was not obtained.

☐ Notice already given

Location: _____ Date: _____

Signature of Boones Ferry Chiropractic and Massage representative:

_____ Date: _____

Patient Name: _____ DOB: _____ Date: _____

PERSONAL INJURY PROTECTION

Oregon Law requires that every auto insurance policy contain “personal injury protection”. These benefits will pay for medical expenses for the driver, any passengers at the time of the accident, and any pedestrians or bicyclists hit by the auto. The following are our office procedures as they relate to you and your personal injury claim.

- Regardless of who was at fault, it is our office policy to bill **your** insurance carrier. This allows us to protect your rights. If you were **not at fault**, your insurance carrier will collect from the opposing carrier when your claim is settled, and this should not affect your premium or insurance standing.
- The following information is required for billing purposes:
 - a) Insured's name, if not patient
 - b) Insurance company name
 - c) Policy Number
 - d) Claim Number
 - e) Name and phone number of insurance agent
 - f) Date of accident - critical for this to be accurate
 - g) Name and phone number of insurance adjuster
 - h) Name and address of attorney - we must have written authorization prior to releasing information to anyone requesting.
- You are required by the insurance carrier to fill out a PIP Application (Personal Injury Protection). It is important that this application is filled out as soon as possible to enable our office to inquire into billing properly. To protect the confidentiality and rights of the injured patient our office does not discuss personal injury claim information without the proper authorization that is filled out in this application.
- If your insurance carrier does not pay all of your charges, any residual amounts are due from you and are to be factored in to any settlement you might make when you have reached a medically stationary status.
- Please inform our office of notification by your insurance company to attend an IME (Independent Medical Examination). All bills will be pending insurance coverage at the time of notification of the IME. If you do not attend the IME, the insurance company can deny coverage due to non-compliance. You will also need to notify our office of the results of the IME.
- It is important to note that Oregon Law allows personal injury benefits for two years only. Therefore, if the accident occurred today, benefits would expire on two years from accident date.

Financial Agreement For Personal Injury /Motor Vehicle Accident

Date _____ **Patient Name:** _____ **DOB:** _____

Insurance Company: _____

Insured Business or Individual: _____ Date of injury: _____

Claim # _____ Open Claim: Y / N State accident occurred: _____

Adjuster: _____ Phone # _____

Fax #: _____ Adjusters E-Mail: _____

Billing Address: _____

Health Insurance (please provide a copy of card):

Insurance Company: _____

ID # _____ Group # _____

Subscriber(if different than patient) _____ DOB _____

Notes: _____

It is our billing policy, as with Oregon Law, to bill the injured party's Personal Injury/Auto Insurance Carrier. You are expected to provide our office at the time of your first visit with the above information.

Please inform our office of notification from your insurance company to attend an IME (Independent Medical Examination). All bills will be pending payment at the time of notification of the IME. If you do not attend the IME, the insurance company can deny coverage due to non-compliance. You will also need to notify our office of the results of the IME.

If you retain an attorney, please provide our office with the attorney's name and phone number.

It is important to note that Oregon Law allows PIP (personal injury protection) for two years only from the **date of the accident**, or up to \$15,000 depending on the insurance policy. It is your responsibility to contact the insurance carrier and complete the proper forms for opening a PIP claim prior to your appointment with our office.

As a courtesy we will bill your PIP insurance carrier listed above; however, ultimately it is your financial responsibility for all charges incurred at this office.

Patient Signature: _____ Date: _____

Ins is Patients ☐ Claims Address ☐ Claim # ☐ Open PIP ☐ Adjuster and # ☐ Fax ☐ E-mail ☐

PERSONAL INJURY REPORT

Patient Name: _____ Date/Time of Accident: _____ am/pm

Auto Collision ☐ On The Job Injury ☐ Other _____

Please describe the accident in detail: _____

Were you the: DRIVER ☐ PASSENGER ☐ PEDESTRIAN ☐

Was your car struck: HEAD ON ☐ BEHIND ☐ RIGHT SIDE ☐ LEFT SIDE ☐ PARKED ☐

Did your car strike the other car involved? Yes ☐ No ☐ Did other car strike you? Yes ☐ No ☐

What were your symptoms immediately following the accident? _____

To your knowledge, list extent of your injuries _____

Were you taken to a hospital? Yes ☐ No ☐ Name of Hospital: _____

Date of admission: _____ Date of discharge: _____

Have you had X-rays taken for this injury? Yes ☐ No ☐

Have you seen another Doctor for this accident? _____ Doctor's name _____

What was their diagnosis? _____

What treatment did you receive? _____

Did you report the accident to your foreman or employer? Yes ☐ No ☐

Has this injury resulted in any disability? Yes ☐ No ☐ Number of days lost from work _____

Date disability (time loss) began _____ Date returned to work _____

Have you had any previous injuries, serious trauma, or car accidents? _____

REVIEW OF SYSTEMS:

CHECK SYMPTOMS YOU HAVE NOTICED SINCE ACCIDENT:

- | | | |
|--|---|--|
| ☐ Headache | ☐ Irritability | ☐ Face Flushed |
| ☐ Neck Pain | ☐ Chest Pain | ☐ Shortness of Breath |
| ☐ Neck Stiff | ☐ Dizziness | ☐ Lights Bother Eyes |
| ☐ Problems Sleeping | ☐ Head Feel Heavy | ☐ Fatigue |
| ☐ Back Pain | ☐ Pins/Needles in Arms | ☐ Depression |
| ☐ Nervousness | ☐ Pins/Needles in Legs | ☐ Loss of Memory |
| ☐ Tension | ☐ Numbness in Fingers | ☐ Ears Ringing |
| ☐ Feet Cold | ☐ Hands Cold | ☐ Upset Stomach |
| ☐ Numbness in Toes | ☐ Fainting | ☐ Constipation |
| ☐ Loss of Smell | ☐ Loss of Taste | ☐ Diarrhea |

List any symptoms other than above _____

Patient Signature _____ Date _____

NECK DISABILITY INDEX (NDI) QUESTIONNAIRE

Patient's Name _____ **Date** _____

PLEASE READ: Answer each of the 10 sections by marking the ONE BOX that most applies to your NECK PAIN.

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 neck pain.
- ☐ I can lift heavy weights but it gives extra neck pain.
- ☐ Neck pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned, for example on a table.
- ☐ Neck 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 in my neck.
- ☐ I cannot 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 because of the pain in my neck.

SECTION 5: Headaches

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

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 cannot do any work at all.

SECTION 8: Driving

- ☐ I can drive my car without any neck pain at all.
- ☐ 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 cannot drive my car as long as I want because of moderate pain in my neck.
- ☐ I can hardly drive at all because of severe pain in my neck.
- ☐ I cannot drive my car at all because of the pain in my neck.

SECTION 9: Sleeping

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

SECTION 10: Recreation

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

How Strong is Your Pain?

Please place an "X" on the line below at the point which you feel represents your pain right now.

No Pain ←————→ **Excruciating (the worst possible)**

BACK -- REVISED OSWESTRY PAIN QUESTIONNAIRE

Patient's Name _____ **Date** _____

PLEASE READ: Answer each of the 10 sections by marking the ONE BOX that most applies to your LOW BACK PAIN.

SECTION 1: Pain Intensity

- ☐ The pain comes and goes and is very mild.
- ☐ The pain is mild and does not vary much.
- ☐ The pain comes and goes and is moderate.
- ☐ The pain is moderate and does not vary much.
- ☐ The pain comes and goes and is severe.
- ☐ The pain is severe and does not vary much.

SECTION 2: Personal Care

- ☐ I would not have to change my way of washing or dressing in order to avoid pain.
- ☐ I do not normally change my way of washing or dressing even though it causes me some pain.
- ☐ Washing and dressing increase the pain but I manage not to change my way of doing it.
- ☐ Washing and dressing increase the pain and I find it necessary to change my way of doing it.
- ☐ Because of the pain I am unable to do some washing and dressing without help.
- ☐ Because of the pain I am unable to do any washing or dressing without help.

SECTION 3: Lifting

- ☐ I can lift heavy weights without extra pain.
- ☐ I can lift heavy weights but it causes extra pain.
- ☐ Pain prevents me lifting heavy weights off the floor.
- ☐ Pain prevents me lifting heavy weights off the floor but I can manage if they are conveniently positioned (e.g., on a table).
- ☐ Pain prevents me lifting heavy weights but I can manage light to medium weights if they are conveniently positioned.
- ☐ I can only lift very light weights at the most.

SECTION 4: Walking

- ☐ I have no pain on walking.
- ☐ I have some pain on walking but it does not increase with distance.
- ☐ I cannot walk more than 1 mile without increasing pain.
- ☐ I cannot walk more than ½ mile without increasing pain.
- ☐ I cannot walk more than ¼ mile without increasing pain.
- ☐ I cannot walk at all without increasing pain.

SECTION 5: Sitting

- ☐ I can sit in any chair as long as I like.
- ☐ I can sit only in my favorite chair as long as I like.
- ☐ Pain prevents me sitting more than 1 hour.
- ☐ Pain prevents sitting more than ½ hour.
- ☐ Pain prevents me sitting more than 10 minutes.
- ☐ I avoid sitting because it increases pain immediately.

SECTION 6: Standing

- ☐ I can stand as long as I want without pain.
- ☐ I have some pain on standing but it does not increase with time.
- ☐ I cannot stand for longer than 1 hour without increasing pain.
- ☐ I cannot stand for longer than ½ hour without increasing pain.
- ☐ I cannot stand for longer than 10 minutes without increasing pain.
- ☐ I avoid standing because it increases the pain right away.

SECTION 7: Sleeping

- ☐ I get no pain in bed.
- ☐ I get pain in bed but it does not prevent me from sleeping well.
- ☐ Because of my pain my normal night's sleep is reduced by less than ¼.
- ☐ Because of my pain my normal night's sleep is reduced by less than ½.
- ☐ Because of my pain my normal night's sleep is reduced by less than ¾.
- ☐ Pain prevents me from sleeping at all.

SECTION 8: Social Life

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

SECTION 9: Travel

- ☐ I get no pain while traveling.
- ☐ I get some pain while traveling but none of my usual forms of travel make it any worse.
- ☐ I get extra pain while traveling but it does not compel me to seek alternative forms of travel.
- ☐ I get extra pain while traveling which compels me to seek alternative forms of travel.
- ☐ Pain restricts all forms of travel.
- ☐ Pain prevents all forms of travel except that done lying down.

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 present.
- ☐ My pain is neither getting better nor worse.
- ☐ My pain is gradually worsening.
- ☐ My pain is rapidly worsening.

How Strong is Your Pain?

Please place an "X" on the line below at the point which you feel represents your pain right now.

No Pain ←————→ Excruciating (the worst possible)