



## PATIENT APPLICATION FORM

WELCOME TO OUR CLINIC. We specialize in assisting our patients to achieve their highest level of health through our spinal and postural corrective programs. Our approach is very unique and advanced from other rehabilitative programs. This allows our patients to achieve far superior results compared to most other systems.

Please fill out the following information thoroughly so the doctor can let you know if you are a case we can accept. Please feel free to ask any questions if you need assistance. We look forward to serving you.

Patient Signature: \_\_\_\_\_

Date: \_\_\_\_\_

# PATIENT APPLICATION SURVEY

Name: \_\_\_\_\_ (Age) \_\_\_\_\_ Gender: M F  
Home Address: \_\_\_\_\_ Home Phone: ( ) \_\_\_\_\_  
City, State, Zip: \_\_\_\_\_ Work Phone: ( ) \_\_\_\_\_  
Email Address: \_\_\_\_\_ Cell Phone: ( ) \_\_\_\_\_  
Birth Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ Social Security #: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Marital Status: S M D W  
Names of Children: \_\_\_\_\_ Ages: \_\_\_\_\_  
Occupation: \_\_\_\_\_ Employer Name: \_\_\_\_\_  
Spouse's Name: \_\_\_\_\_ Work Phone: ( ) \_\_\_\_\_ Cell Phone: ( ) \_\_\_\_\_  
Spouse's Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_  
How were you referred to this office? \_\_\_\_\_

## PURPOSE OF THIS VISIT

Reason for this visit: \_\_\_\_\_  
Is this purpose related to an auto accident / work injury?  Yes  No If so, when: \_\_\_\_\_  
Describe: \_\_\_\_\_  
Please describe the pain & its location: \_\_\_\_\_  
When did this condition begin? \_\_\_\_/\_\_\_\_/\_\_\_\_ When did you first notice it? \_\_\_\_\_  
Is this condition getting worse?  Yes  No Is this condition:  Constant  Comes & goes  Activity related  
Does complaint(s) interfere with:  Work  Sleep  Hobbies  Daily Routine Explain: \_\_\_\_\_  
What activities aggravate your symptoms? \_\_\_\_\_  
Is there anything, which has relieved your symptoms?  Yes  No Describe: \_\_\_\_\_  
Have you experienced this condition before?  Yes  No If so, please explain: \_\_\_\_\_  
Who have you seen for this? \_\_\_\_\_ What did they do? \_\_\_\_\_  
How did you respond? \_\_\_\_\_

## EXPERIENCE WITH CHIROPRACTIC

Have you seen a Chiropractor before?  Yes  No Who? \_\_\_\_\_ When? \_\_\_\_\_  
Reason for visits: \_\_\_\_\_  
How did you respond? \_\_\_\_\_  
Did your previous chiropractor take before and after x-rays?  Yes  No  
Did you know posture determines your health?  Yes  No  
Are you aware of any of your poor posture habits?  Yes  No  
Explain: \_\_\_\_\_  
Are you aware of any poor posture habits in your spouse or children?  Yes  No  
Explain: \_\_\_\_\_

The most common postural weakness is Forward Head Syndrome (head and neck starting to bend forward and progressively moving downward weakening your whole body). Even less severe forms of this posture can cause many adverse affects on your overall health. Have you ever been told or fell like you carry your head forward, noticed a rounding of your shoulders or a developing "hump" at the base of your neck? Yes No

Date: \_\_\_\_\_

## HEALTH LIFESTYLE

Do you exercise?    Yes   No    How often? 1X 2X 3X 4X 5X per week other: \_\_\_\_\_  
What activities? Running Jogging Weight Training Cycling Yoga Pilates Swimming \_\_\_\_\_

Do you smoke?        Yes   No    How much? \_\_\_\_\_

Do you drink alcohol? Yes   No    How much / week? \_\_\_\_\_

Do you drink coffee? Yes   No    How many cups / day? \_\_\_\_\_

Do you take any supplements (i.e. vitamins, minerals, herbs)? \_\_\_\_\_

### HEALTH CONDITIONS

Abnormal postural habits or distortions are the result of trauma or stress to the body that have misaligned the vertebrae in your spine. When these vertebrae are twisted from their normal position, they will cause stress to the spinal cord and the delicate nerves that pass between the vertebrae. These misalignments are called subluxations (sub-lux-a-shuns). It has been extensively documented that subluxations, causing stress to your nerves, will weaken and distort the overall structure of your spine. This results in a weakened and distorted POSTURE. Postural distortions have many serious and adverse affects on your overall health. The most common and detrimental postural distortion is called Forward Head Syndrome (a "hunched forward" posture starting in the neck and progressively moving down your spine weakening the entire body). Please check any health condition you may be experiencing, now or in the past.

#### CERVICAL SPINE (NECK):

Postural distortions from subluxations, (causing Forward Head Syndrome), in your neck will weaken the nerves into your arms, hands and head affecting these parts of your body. Do you experience...?

- |   |   |  |
|---|---|--|
| <input type="radio"/> Neck Pain                           | <input type="radio"/> Headaches           | <input type="radio"/> Sinusitis            |
| <input type="radio"/> Pain into your shoulders/arms/hands | <input type="radio"/> Dizziness           | <input type="radio"/> Allergies/Hay fever  |
| <input type="radio"/> Numbness/tingling in arms/hands     | <input type="radio"/> Visual disturbances | <input type="radio"/> Recurrent colds/Flue |
| <input type="radio"/> Hearing disturbances                | <input type="radio"/> Coldness in hands   | <input type="radio"/> Low Energy/Fatigue   |
| <input type="radio"/> Weakness in grip                    | <input type="radio"/> Thyroid conditions  | <input type="radio"/> TMJ/Pain/Clicking    |

Explain: \_\_\_\_\_

#### THORACIC SPINE (UPPER BACK):

Postural distortions from subluxations (resulting from Forward Head Syndrome) in the upper back will weaken the nerves to the heart and lungs and affect these parts of your body. Do you experience...?

- |  |  |
|--|--|
| <input type="radio"/> Heart Palpitations   | <input type="radio"/> Recurrent Lung Infections/Bronchitis |
| <input type="radio"/> Heart Murmurs        | <input type="radio"/> Asthma/Wheezing                      |
| <input type="radio"/> Tachycardia          | <input type="radio"/> Shortness Of Breath                  |
| <input type="radio"/> Heart Attacks/Angina | <input type="radio"/> Pain On Deep Inspiration/Expiration  |

#### THORACIC SPINE (MID BACK):

Postural distortions from subluxations (resulting from Forward Head Syndrome) in the mid back will weaken the nerves into your ribs/chest and upper digestive tract, and affect these parts of your body. Do you experience...?

- |   |  |
|---|--|
| <input type="radio"/> Mid Back Pain             | <input type="radio"/> Nausea   |
| <input type="radio"/> Pain Into Your Ribs/Chest | <input type="radio"/> Ulcers/Gastritis   |
| <input type="radio"/> Indigestion/Heartburn     | <input type="radio"/> Hypoglycemia   |
| <input type="radio"/> Reflux                    | <input type="radio"/> Tired/Irritable after eating or when you haven't eaten for a while |

#### LUMBAR SPINE (LOW BACK):

Postural distortions from subluxations in the low back (resulting from Forward Head Syndrome) will weaken the nerves into your legs/feet and pelvic organs and affect these parts of your body. Do you experience...?

- |   |   |                                     |
|---|---|-------------------------------------|
| <input type="radio"/> Pain into your hips/legs/feet       | <input type="radio"/> Weakness/injuries in your hips/knees/ankles | <input type="radio"/> Low back pain |
| <input type="radio"/> Numbness/tingling in your legs/feet | <input type="radio"/> Recurrent bladder infections                |                                     |
| <input type="radio"/> Coldness in your legs/feet          | <input type="radio"/> Frequent/difficulty urinating               |                                     |
| <input type="radio"/> Muscle cramps in your legs/feet     | <input type="radio"/> Menstrual irregularities/cramping (females) |                                     |
| <input type="radio"/> Constipation / Diarrhea             | <input type="radio"/> Sexual dysfunction                          |                                     |

Please list any health conditions not mentioned: \_\_\_\_\_

Please list any medications / surgeries: \_\_\_\_\_

## FAMILY HEALTH HISTORY

Have any of your family members ever been diagnosed with the following:

- |   |   |  |                                       |
|---|---|--|---------------------------------------|
| <input type="checkbox"/> Diabetes               | <input type="checkbox"/> Varicose veins       | <input type="checkbox"/> Neurological problems | <input type="checkbox"/> Lung Disease |
| <input type="checkbox"/> Rheumatic fever        | <input type="checkbox"/> Circulatory problems | <input type="checkbox"/> Stroke                | <input type="checkbox"/> Heart murmur |
| <input type="checkbox"/> High blood pressure    | <input type="checkbox"/> Heart Disease        | <input type="checkbox"/> Cancer                | <input type="checkbox"/> Osteoporosis |
| <input type="checkbox"/> Kidney disease         | <input type="checkbox"/> Epilepsy/seizures    | <input type="checkbox"/> Migraine Headaches    | <input type="checkbox"/> Arthritis    |
| <input type="checkbox"/> Liver disease          | <input type="checkbox"/> Metal Implants       | <input type="checkbox"/> Infectious disease    | <input type="checkbox"/> Gall bladder |
| <input type="checkbox"/> Broken bones/fractures | <input type="checkbox"/> Appendectomy         | <input type="checkbox"/> Tonsillectomy         | <input type="checkbox"/> Hernia       |
| <input type="checkbox"/> Pneumonia              | <input type="checkbox"/> Polio                | <input type="checkbox"/> Tuberculosis          | <input type="checkbox"/> Anemia       |
| <input type="checkbox"/> Whooping Cough         | <input type="checkbox"/> Chicken Pox          | <input type="checkbox"/> Mumps                 | <input type="checkbox"/> Measles      |
| <input type="checkbox"/> Thyroid                | <input type="checkbox"/> Small Pox            | <input type="checkbox"/> Influenza             | <input type="checkbox"/> Pleurisy     |
| <input type="checkbox"/> Arthritis              | <input type="checkbox"/> epilepsy             | <input type="checkbox"/> Lumbago               | <input type="checkbox"/> Eczema       |
| <input type="checkbox"/> Other: _____           |   |  |                                       |

## AUTHORIZATION CARE

I authorize and agree to allow the doctor and/or chiropractic assistant to work with my spine through the use spinal adjustments and rehabilitative exercises for the sole purpose of postural and structural restoration of normal biomechanical 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.

The Doctor and/or chiropractic assistant will not be held responsible for any health conditions or diagnoses which are pre-existing, given by another health care practitioner, or are not related to the spinal structural conditions diagnosed at this clinic.

I also clearly understand that if I do not follow the doctors and/or chiropractic assistant specific recommendations at this clinic 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. I authorize the assignment of all insurance benefits be directed to the doctor and/or chiropractic assistant for all services rendered.

\_\_\_\_\_  
Patient's Name Printed

\_\_\_\_\_  
Date

\_\_\_\_\_  
Patient's signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Minors Name

\_\_\_\_\_  
Guardian/Spouse's Signature of Authorizing care for minor

\_\_\_\_\_  
Date

## IN CASE OF EMERGENCY

Name \_\_\_\_\_

Relationship \_\_\_\_\_

Work Phone \_\_\_\_\_

Home Phone \_\_\_\_\_

Cell Phone \_\_\_\_\_

## INSURANCE INFORMATION

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 are strictly as a convenience to me. The doctors office will provide any necessary reports or required information to aid in insurance reimbursement of services, but I understand that insurance carriers may deny my claims and that I am ultimately responsible for any unpaid balances. Any monies received will be credited to my account.

I understand there could be some services that my insurance company does not cover, if this is the case are you willing to pay for these services [ ] YES [ ] NO

Patients Signature \_\_\_\_\_ Date \_\_\_\_\_

Guardian or Spouse's Signature Authorizing Care \_\_\_\_\_ Date \_\_\_\_\_

I hereby authorize Active Family Chiropractic to administer care as deemed necessary to my child, a minor under the age of 18 years old.

Name of Insurance Co. \_\_\_\_\_ Policy# \_\_\_\_\_

Address \_\_\_\_\_ Phone # \_\_\_\_\_

Insured's Name \_\_\_\_\_ Insured's SS# \_\_\_\_\_

Relationship to Insured \_\_\_\_\_ Birthdate \_\_\_\_/\_\_\_\_/\_\_\_\_

Employer \_\_\_\_\_

Who should receive charges on your account?

- Patient     Spouse     Parent/Guardian     Workers Comp     Auto Insurance  
 Medicare     Personal Health Insurance

## RADIOGRAPH CONSENT

I \_\_\_\_\_ do hereby give my consent to allow Active Family Chiropractic and it's representatives, as deemed by the examining physician to take radiographs of my spine and/or extremities.

I also hereby declare that to my knowledge that I am not pregnant \_\_\_\_\_ ( Initial )

Signature of Patient/or Guardian of said Minor \_\_\_\_\_ Date \_\_\_\_\_

# HEALTHCARE AUTHORIZATION FORM

THE FOLLOWING AUTHORIZES ACTIVE FAMILY CHIROPRACTIC TO USE AND/OR DISCLOSE PROTECTED HEALTH CARE INFORMATION IN ACCORDANCE WITH THE FOLLOWING SPECIFIC AUTHORIZATIONS:

I give permission to Active Family Chiropractic to use my name, address, phone numbers and clinical records to contact me with birthday cards, holiday related cards, health related e-mails messages and information about treatment alternatives or other health related information as well as any advertisements, newsletters or patient of the week/month postings.

I give permission to Active Family Chiropractic to treat me in an open room where other patients are also being treated. I am aware that other persons in the office may overhear some of my protective health care information during the course of my treatment. Should I need to speak with a doctor or chiropractic assistant in private, the doctor or therapist will provide a private room for these conversations.

By signing the following you are giving Active Family Chiropractic permission to use and disclose your protected health information in accordance with the directives listed above

## ACKNOWLEDGEMENT OF RECEIPT & NOTICE OF PRIVACY PRACTICES

I \_\_\_\_\_ understand and have been provided with a notice of information practices that provides me a more complete description of information uses and disclosures, I understand that I have the following rights and privileges:

- \* The right to review the notice prior to signing this consent
- \* The right to object to the use of my health care information for directory purpose
- \* The right to request restrictions as to how my health care information may be used or disclosed in this office to carry out treatment, payment, or health care operations

Analysis: Pettibon

Diagnosis: (1) \_\_\_\_\_ (2) \_\_\_\_\_ (3) \_\_\_\_\_ (4) \_\_\_\_\_ (5) \_\_\_\_\_ (6) \_\_\_\_\_

Patient Accepted for Postural Corrective Care  YES  NO  Referred out \_\_\_\_\_

Doctor's Signature \_\_\_\_\_ Date \_\_\_\_\_

# Mode of Injury



Name: \_\_\_\_\_ Chart #: \_\_\_\_\_ Today's Date: \_\_\_\_\_ Date of Onset: \_\_\_\_\_

## Complete This Section if Injuries are a Result of a Work Related Accident.

<b>My injury occurred while I was...</b> <ul style="list-style-type: none"><li><input type="radio"/> Carrying an object and lost my balance.</li><li><input type="radio"/> Driving</li><li><input type="radio"/> Lifting an object.</li><li><input type="radio"/> Engaged in a repetitive motion activity. Please describe: _____</li><li><input type="radio"/> Struck by a falling object. Please describe: _____</li><li><input type="radio"/> Other: _____ Please describe: _____</li></ul>	<b>Did you report this incident in writing at work?</b> <ul style="list-style-type: none"><li><input type="radio"/> Yes</li><li><input type="radio"/> No</li></ul> <b>Did you see another health care provider for treatment related to this injury?</b> <ul style="list-style-type: none"><li><input type="radio"/> Yes</li><li><input type="radio"/> No</li></ul>
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## If you were injured by lifting, please complete all of the items which apply in the box below.

<b>I was lifting the object:</b> <ul style="list-style-type: none"><li><input type="radio"/> from the floor</li><li><input type="radio"/> from a surface over my head</li><li><input type="radio"/> from a surface about waist high</li></ul> <b>The object I was lifting was about:</b> <table><tr><td><input type="radio"/> 2 - 5 pounds</td><td><input type="radio"/> 20 - 25 pounds</td></tr><tr><td><input type="radio"/> 5 - 10 pounds</td><td><input type="radio"/> 25 - 50 pounds</td></tr><tr><td><input type="radio"/> 10 - 15 pounds</td><td><input type="radio"/> More than 50 pounds</td></tr><tr><td><input type="radio"/> 15 - 20 pounds</td><td><input type="radio"/> _____</td></tr></table>	<input type="radio"/> 2 - 5 pounds	<input type="radio"/> 20 - 25 pounds	<input type="radio"/> 5 - 10 pounds	<input type="radio"/> 25 - 50 pounds	<input type="radio"/> 10 - 15 pounds	<input type="radio"/> More than 50 pounds	<input type="radio"/> 15 - 20 pounds	<input type="radio"/> _____	<b>While I was lifting, I:</b> <ul style="list-style-type: none"><li><input type="radio"/> had my back straight</li><li><input type="radio"/> had my waist bent</li><li><input type="radio"/> was twisted to the side</li></ul> <b>The pain I felt immediately after the injury was:</b> <table><tr><td><input type="radio"/> a dull ache</td><td><input type="radio"/> a sharp pain with radiation of symptoms</td></tr><tr><td><input type="radio"/> a grabbing feeling</td><td><input type="radio"/> _____</td></tr><tr><td><input type="radio"/> a popping feeling</td><td><input type="radio"/> _____</td></tr><tr><td><input type="radio"/> a sharp pain in one spot</td><td><input type="radio"/> _____</td></tr></table>	<input type="radio"/> a dull ache	<input type="radio"/> a sharp pain with radiation of symptoms	<input type="radio"/> a grabbing feeling	<input type="radio"/> _____	<input type="radio"/> a popping feeling	<input type="radio"/> _____	<input type="radio"/> a sharp pain in one spot	<input type="radio"/> _____
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## If you were injured by falling, please complete the items in the box below.

<b>I fell:</b> <ul style="list-style-type: none"><li><input type="radio"/> from a surface 2-4 feet high</li><li><input type="radio"/> from a surface 4-6 feet high</li><li><input type="radio"/> from a surface 6-8 feet high</li><li><input type="radio"/> from a surface higher than 8 feet</li><li><input type="radio"/> onto surface I was walking on</li></ul> <b>When I fell I hit my:</b> <table><tr><td><input type="radio"/> Back</td><td><input type="radio"/> Head</td></tr><tr><td><input type="radio"/> Left elbow</td><td><input type="radio"/> Left knee</td></tr><tr><td><input type="radio"/> Right elbow</td><td><input type="radio"/> Right knee</td></tr><tr><td><input type="radio"/> Face</td><td><input type="radio"/> Tail bone</td></tr><tr><td><input type="radio"/> Left hand/wrist</td><td><input type="radio"/> _____</td></tr><tr><td><input type="radio"/> Right hand/wrist</td><td><input type="radio"/> _____</td></tr></table>	<input type="radio"/> Back	<input type="radio"/> Head	<input type="radio"/> Left elbow	<input type="radio"/> Left knee	<input type="radio"/> Right elbow	<input type="radio"/> Right knee	<input type="radio"/> Face	<input type="radio"/> Tail bone	<input type="radio"/> Left hand/wrist	<input type="radio"/> _____	<input type="radio"/> Right hand/wrist	<input type="radio"/> _____	<b>I landed on:</b> <table><tr><td><input type="radio"/> Outstretched arms</td><td><input type="radio"/> Right side</td></tr><tr><td><input type="radio"/> Back</td><td><input type="radio"/> Stomach</td></tr><tr><td><input type="radio"/> Knees</td><td><input type="radio"/> _____</td></tr><tr><td><input type="radio"/> Rear end</td><td><input type="radio"/> _____</td></tr><tr><td><input type="radio"/> Left side</td><td><input type="radio"/> _____</td></tr></table> <b>The surface I fell on can be described as:</b> <table><tr><td><input type="radio"/> Containing an object that caused the fall</td><td><input type="radio"/> Uneven carpet</td></tr><tr><td><input type="radio"/> Icy</td><td><input type="radio"/> Wet</td></tr><tr><td><input type="radio"/> Slick due to liquid</td><td><input type="radio"/> _____</td></tr><tr><td></td><td><input type="radio"/> _____</td></tr></table>	<input type="radio"/> Outstretched arms	<input type="radio"/> Right side	<input type="radio"/> Back	<input type="radio"/> Stomach	<input type="radio"/> Knees	<input type="radio"/> _____	<input type="radio"/> Rear end	<input type="radio"/> _____	<input type="radio"/> Left side	<input type="radio"/> _____	<input type="radio"/> Containing an object that caused the fall	<input type="radio"/> Uneven carpet	<input type="radio"/> Icy	<input type="radio"/> Wet	<input type="radio"/> Slick due to liquid	<input type="radio"/> _____		<input type="radio"/> _____
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	<input type="radio"/> _____																														

## Complete this section if your injuries were NOT work related or auto accident related.

<b>My injury occurred when I:</b> <ul style="list-style-type: none"><li><input type="radio"/> coughed or sneezed</li><li><input type="radio"/> looked over my shoulder</li><li><input type="radio"/> slipped and fell</li><li><input type="radio"/> straightened from bending</li><li><input type="radio"/> twisted at the waist</li></ul>	<b>Injury occurred at:</b> <table><tr><td><input type="radio"/> Home</td><td><input type="radio"/> Work</td></tr><tr><td><input type="radio"/> Mall</td><td><input type="radio"/> _____</td></tr><tr><td><input type="radio"/> Retail store</td><td><input type="radio"/> _____</td></tr><tr><td><input type="radio"/> Supermarket</td><td><input type="radio"/> _____</td></tr></table>	<input type="radio"/> Home	<input type="radio"/> Work	<input type="radio"/> Mall	<input type="radio"/> _____	<input type="radio"/> Retail store	<input type="radio"/> _____	<input type="radio"/> Supermarket	<input type="radio"/> _____
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<input type="radio"/> Mall	<input type="radio"/> _____								
<input type="radio"/> Retail store	<input type="radio"/> _____								
<input type="radio"/> Supermarket	<input type="radio"/> _____								

## Office Use Only

### The family history has been reviewed and found to:

- |   |  |   |
|---|--|---|
| <input type="radio"/> be non-contributory to current conditions | <input type="radio"/> Previous Injury - Resolved | <input type="radio"/> Long Interim Time         |
| <input type="radio"/> further evaluation needed                 | <input type="radio"/> Exacerbation               | <input type="radio"/> Previous Care Ineffective |
| <input type="radio"/> Underlying Condition                      | <input type="radio"/> Chronic                    |   |

I understand that the information I have provided above is current and complete to the best of my knowledge.

Signature: \_\_\_\_\_

# Neck Pain and Disability Index



Name: \_\_\_\_\_ Chart #: \_\_\_\_\_ Date: \_\_\_\_\_

## Please Read Instructions:

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. In each section, please fill in ONE circle only which most closely describes your problem.

### Section 1 - Pain Intensity

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

### Section 2 - Personal Care

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

### Section 3 - Lifting

- A. I can lift heavy weight without extra pain.
- B. I can lift heavy weight but it gives extra pain.
- C. Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned.
- D. Pain prevents me from lifting heavy weights, but I can manage light-medium weights if they are conveniently positioned.
- E. I can lift very light weights.
- F. I cannot lift or carry anything at all.

### Section 4 - Reading

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

### Section 5 - Headaches

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

### Section 6 - Concentration

- A. I can concentrate fully when I want with no difficulty.
- B. I can concentrate fully when I want with slight difficulty.
- C. I have a fair degree of difficulty in concentrating when I want.
- D. I have a lot of difficulty in concentrating when I want.
- E. I have a great degree of difficulty in concentrating when I want.
- F. I cannot concentrate at all.

### Section 7 - Work

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

### Section 8 - Driving

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

### Section 9 - Sleeping

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

### Section 10 - Recreation

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

## Office Use Only

Score: \_\_\_\_\_

I understand that the information I have provided above is current and complete to the best of my knowledge.

Signature: \_\_\_\_\_

# Occupational History



Name: \_\_\_\_\_ Chart #: \_\_\_\_\_ Today's Date: \_\_\_\_\_ Accident Date: \_\_\_\_\_

Current Employer: \_\_\_\_\_

Current Occupation: \_\_\_\_\_

**What limitations have you experienced as a result of your injury? (choose all that apply)**

- |   |  |  |
|---|--|--|
| <input type="radio"/> Cannot use left arm           | <input type="radio"/> Lifting exacerbates condition      | <input type="radio"/> Unable to lift more than 25 pounds |
| <input type="radio"/> Cannot use right arm          | <input type="radio"/> Pain limits amount of movement     | <input type="radio"/> Unable to lift more than 50 pounds |
| <input type="radio"/> Cannot use left leg           | <input type="radio"/> Cannot sit due to condition        | <input type="radio"/> Cannot walk due to condition       |
| <input type="radio"/> Cannot use right leg          | <input type="radio"/> Unable to lift more than 10 pounds | <input type="radio"/> _____                              |
| <input type="radio"/> Cannot drive due to condition | <input type="radio"/> Unable to lift more than 15 pounds | <input type="radio"/> _____                              |
| <input type="radio"/> Increased fatigability        | <input type="radio"/> Unable to lift more than 20 pounds | <input type="radio"/> _____                              |

**Your present job involves:**

- |   |  |                                    |                                    |   |
|---|--|------------------------------------|------------------------------------|---|
| <input type="radio"/> Standing for:     | <input type="radio"/> 30 minutes       | <input type="radio"/> 2 hours      | <input type="radio"/> 4 hours      | <input type="radio"/> 8 hours           |
|   | <input type="radio"/> 1 hour           | <input type="radio"/> 3 hours      | <input type="radio"/> 6 hours      | <input type="radio"/> More than 8 hours |
| <input type="radio"/> Driving for:      | <input type="radio"/> 30 minutes       | <input type="radio"/> 2 hours      | <input type="radio"/> 4 hours      | <input type="radio"/> 8 hours           |
|   | <input type="radio"/> 1 hour           | <input type="radio"/> 3 hours      | <input type="radio"/> 6 hours      | <input type="radio"/> More than 8 hours |
| <input type="radio"/> Walking for:      | <input type="radio"/> 30 minutes       | <input type="radio"/> 2 hours      | <input type="radio"/> 4 hours      | <input type="radio"/> 8 hours           |
|   | <input type="radio"/> 1 hour           | <input type="radio"/> 3 hours      | <input type="radio"/> 6 hours      | <input type="radio"/> More than 8 hours |
| <input type="radio"/> Sitting for:      | <input type="radio"/> 30 minutes       | <input type="radio"/> 2 hours      | <input type="radio"/> 4 hours      | <input type="radio"/> 8 hours           |
|   | <input type="radio"/> 1 hour           | <input type="radio"/> 3 hours      | <input type="radio"/> 6 hours      | <input type="radio"/> More than 8 hours |
| <input type="radio"/> Lifting           | <input type="radio"/> Less than 5 lbs. | <input type="radio"/> 10 - 15 lbs. | <input type="radio"/> 20 - 25 lbs. | <input type="radio"/> 40 - 50 lbs.      |
|   | <input type="radio"/> 05 - 10 lbs.     | <input type="radio"/> 15 - 20 lbs. | <input type="radio"/> 25 - 40 lbs. | <input type="radio"/> More than 50 lbs. |
| <input type="radio"/> Repetitive Motion |  |                                    |                                    |   |

Have you missed any work as a result of your condition?  Yes  No

If yes, how many days did you miss?

Your last full day of work was:

0	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
1	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
2	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
3	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
4	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
5	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
6	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
7	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
8	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
9	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

0	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
1	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
2	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
3	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
4	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
5	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
6	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
7	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
8	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
9	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Are you currently receiving worker's compensation?  Yes  No

I understand that the information I have provided above is current and complete to the best of my knowledge.

Signature: \_\_\_\_\_

# Revised Oswestry Low Back Pain and Disability



Name: \_\_\_\_\_ Chart #: \_\_\_\_\_ Date: \_\_\_\_\_

## Please Read Instructions:

This questionnaire has been designed to give the doctor information as to how your low back pain has affected your ability to manage in everyday life. In each section, please fill in ONE circle which most closely describes your problem.

### Section 1 - Pain Intensity

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

### Section 2 - Personal Care

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

### Section 3 - Lifting

- A. I can lift heavy weight without extra pain.
- B. I can lift heavy weight but it gives extra pain.
- C. Pain prevents me from lifting heavy weights off the floor.
- D. Pain prevents me from lifting heavy weights, but I can manage if they are conveniently positioned.
- E. Pain prevents me from lifting heavy weights, but I can manage light-medium weights if they are conveniently positioned.
- F. I can only lift very light weights at the most.

### Section 4 - Walking

- A. I have no pain walking.
- B. I cannot walk more than one mile without increasing pain.
- C. I cannot walk more than 1/2 mile without increasing pain.
- D. I cannot walk more than 1/4 mile without increasing pain.
- E. I can walk with crutches.
- F. I cannot walk at all without increasing pain.

### Section 5 - Sitting

- A. I can sit in any chair as long as I like.
- B. I can only sit in my favorite chair as long as I like.
- C. Pain prevents me from sitting more than one hour.
- D. Pain prevents me from sitting more than a half hour.
- E. Pain prevents me from sitting more than 10 minutes.
- F. I avoid sitting because it increases pain straight away.

### Section 6 - Standing

- A. I can stand as long as I want without pain.
- B. I have some pain on standing but it does not increase with time.
- C. I cannot stand for longer than one hour without increasing pain.
- D. I cannot stand for longer than 1/2 hour without increasing pain.
- E. I can't stand for longer than 10 minutes without increasing pain.
- F. I avoid standing because it increases the pain straight away.

### Section 7 - Sleeping

- A. I get no pain in bed.
- B. I get pain in bed but it doesn't prevent me from sleeping well.
- C. Because of pain my normal night's sleep is reduced by < 1/4.
- D. Because of pain my normal night's sleep is reduced by < 1/2.
- E. Because of pain my normal night's sleep is reduced by < 3/4.
- F. Pain prevents me from sleeping at all.

### Section 8 - Traveling

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

### Section 9 - Social Life

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

### Section 10 - Changing Degree of Pain

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

### Office Use Only

Score: \_\_\_\_\_

I understand that the information I have provided above is current and complete to the best of my knowledge.

Signature: \_\_\_\_\_

# Roland-Morris Low Back Pain and Disability



Name: \_\_\_\_\_ Chart #: \_\_\_\_\_ Date: \_\_\_\_\_

**Please Read Instructions:**

*This list contains some sentences that people have used to describe themselves when they have back pain. When you read them, you may find that some stand out because they describe you today. As you read the list, think of yourself today. Fill in the circle next to any sentence that describes you today. If the sentence does not describe you, then leave the space blank and go on to the next one. Remember, only check the sentences that describe you today.*

- 1) I stay at home most of the time because of my back.
- 2) I change position frequently to try and get my back comfortable.
- 3) I walk more slowly than usual because of my back.
- 4) Because of my back, I am not doing any of the jobs that I usually do around the house.
- 5) Because of my back, I use a handrail to get upstairs.
- 6) Because of my back, I lie down to rest more often.
- 7) Because of my back, I have to hold on to something to get out of an easy chair.
- 8) Because of my back, I try to get other people to do things for me.
- 9) I get dressed more slowly than usual because of my back.
- 10) I only stand up for short periods of time because of my back.
- 11) Because of my back, I try not to bend or kneel down.
- 12) I find it difficult to get out of a chair because of my back.
- 13) My back is painful almost all the time.
- 14) I find it difficult to turn over in bed because of my back.
- 15) My appetite is not very good because of my back pain.
- 16) I have trouble putting on my socks (stockings) because of the pain in my back.
- 17) I only walk short distances because of my back pain.
- 18) I sleep less well because of my back.
- 19) Because of my back pain, I get dressed with help from someone else.
- 20) I sit down for most of the day because of my back.
- 21) I avoid heavy jobs around the house because of my back.
- 22) Because of my back pain, I am more irritable and bad tempered with people than usual.
- 23) Because of my back, I go upstairs more slowly than usual.
- 24) I stay in bed most of the time because of my back.

**Office Use Only**

Score: \_\_\_\_\_

**I understand that the information I have provided above is current and complete to the best of my knowledge.**

Signature: \_\_\_\_\_