PATIENT INTRODUCTION FORM

Patient Name:	Today's Date:
Address:	Home Telephone:
City/Zip:	Work Telephone:
Date Birth:	Age:
Height:	Occupation:
Weight:	Employer:
Drivers Lic No:	Social Security No:

IS THIS VISIT RELATED TO A:

☐ Work Related Injury
☐ Home Injury
☐ Non-Injury Symptoms
☐ Other (Describe):
☐ Car Collision Injury
☐ Sports Injury
☐ Check-up Only
☐ School/Employment Physical

WOMEN ONLY

☐ Yes, ☐ No Is there any chance that you are currently pregnant or suspect pregnancy?

INSURANCE INFORMATION

Does your insurance cover Chiropractic treatment?	☐ Yes, ☐ No
If yes, Indicate Insurance Company Name (Need copy of card)	Name:
Are you the insured person or dependent (wife/husband/child)?	☐ Insured, ☐ Dependent
If dependent, we need insured persons name/social security number	Name/SSN:
What percentage does your insurance pay?	Percentage (%):
What is your insurance deductible amount each year?	Amount: $
Have you met your deductible this year?	☐ Yes, ☐ No
Does your insurance policy limit each office payment amount?	☐ Yes, ☐ No Limit is: $
Does your insurance limit the number of office visits per year?	☐ Yes, ☐ No Number:
Does your insurance limit the amount paid per year?	☐ Yes, ☐ No Limit is: $

Our office will provide insurance billing services for you if you so desire as a courtesy. *Remember that you are ultimately responsible for any charges incurred in this office. It is your responsibility to pay any deductible amount, co-insurance, and or any other balances not paid by your insurance carrier.*

IN ORDER TO KEEP OUR OFFICE OVERHEAD DOWN AND KEEP OUR PATIENT FEES REASONABLE, WE EXPECT PAYMENT AT THE CONCLUSION OF EACH TREATMENT FOR CASH PATIENTS AND THE CO-PAYMENT FOR REGULAR INSURANCE PATIENTS.

Signature of responsible party (Patient or Parent)_____ Date _____

GENERAL HEALTH HISTORY

Check only those conditions that apply to you and indicate if you have had in the past or currently have:

YES	GENERAL QUESTIONS	YEAR
☐	I bruise easily	
☐	I heal slowly	
☐	Diabetic	
☐	My body temperature is normally low (feel cold)	
☐	Smoke cigarettes	
☐	Heart Attack history (recent and old)	
☐	Epilepsy-Seizure history	
☐	History of gout, lupus, psoriasis, or spinal meningitis	
☐	Cancer history or treatment of any type	
☐	Stroke history	
☐	Scoliosis	
☐	Genetic conditions in your body	
☐	Rheumatoid arthritis	
☐	Thyroid disorders	
☐	Coma from head injury or other problem	
☐	Told you have osteoporosis of your spine	
☐	Told you have osteoarthritis of your spine	

PRIOR INJURY HISTORY

(☐ I have no history of previous painful injury) If you have had prior injuries, please check below:

☐ Work Injury	☐ Fall	☐ Pedestrian Injury
☐ Lifting Injury	☐ Car accident	☐ Military Injury
☐ Motorcycle Injury	☐ Bicycle Injury	☐ Sports Injury

FRACTURES/BROKEN BONES

(☐ I have no history of broken bones) Please indicate if you have ever broken any of the following and when:

Region	Year	Region	Year
☐ Spinal Vertebra		☐ Skull	
☐ Collar bone		☐ Rib bone	
☐ Arm bone		☐ Leg bone	
☐ Pelvis bone		☐ Other	

PREVIOUS SURGERIES

(☐ I have no history of any surgical procedure) If you have had surgery, indicate type and when:

Surgery	Year	Surgery	Year
☐ Spine Surgery (neck or back)		☐ Appendix	
☐ Disc surgery in neck or back		☐ Gallbladder/Stomach/Kidney	
☐ Heart		☐ Cancer	
☐ Tonsillectomy		☐ Rib/Collar bone	
☐ Head/Brain		☐ Hernia	
☐ Shoulder/Arm/Leg		☐ Other	

GENERAL HEALTH HISTORY (Page 2)

CHECK RECENT OR CURRENT SYMPTOMS

SYMPTOM	HOW LONG	SYMPTOM	HOW LONG
☐ Headaches/Migraines		☐ Dizziness	
☐ Neck Pain/Soreness or Stiffness		☐ Upper Back Pain or Stiffness	
☐ Low Back Pain/Soreness		☐ Hip Pain	
☐ Arm/Hand Pain, Numbness, or Tingling		☐ Leg or Foot Pain, Numbness, or Tingling	
☐ Chest wall pain		☐ Other	

⚑ WHAT SYMPTOM PRIMARILY BROUGHT YOU TO MY OFFICE? _____

SYMPTOM/PAIN DESCRIPTION

Please circle any word or words below that best describes how your symptoms currently feel to you.

Pain	Pinching	Spreading	Vicious
Ache	Pricking	Shooting	Sickening
Cutting	Tingling	Stabbing	Miserable
Tearing	Gnawing	Dull	Troublesome
Crushing	Nagging	Bony	Pressing
Pulling	Boring	Terrifying	Deep pain
Irritating	Burning-Hot	Dreadful	Superficial pain
Annoying	Drill like	Fearful	Stinging
Taunt	Heavy	Unhappy	Throbbing
Exhausting	Tight/Stiff	Torturing	Sharp
Unbearable	Radiating	Suffocating	Tender
Soreness	Weakness	Punishing	Small area
Pins and Needles	Falls asleep	Crawling	Large area

ARE YOU TAKING MEDICATIONS

☐ I am not taking any medications currently. Check any of the following that you are taking currently.

☐ Muscle Relaxants	☐ Aspirin	☐ Anacin
☐ Anti-inflammatory	☐ Tylenol	☐ Bufferin
☐ Narcotics for Pain	☐ Advil/Motrin	☐ Stroke prevention meds
☐ Heart medications	☐ Birth control medications	☐ Other

WHEN IS YOUR PAIN USUALLY BETTER?

☐ Morning	☐ Afternoon	☐ Evening
☐ During sleep hours	☐ Lying down flat	☐ Standing
☐ Walking	☐ Sitting	☐ Rest
☐ Stress (mental) is less	☐ Good posture	☐ Exercise/Stretching

HAS YOUR PAIN BEEN ASSOCIATED WITH:

☐ Excessive fatigue-malaise	☐ Bowel or bladder disorders
☐ Weight loss	☐ Ovarian pain
☐ Low grade fever	☐ Kidney pain or painful urination
☐ Night pain	☐ Night sweats
☐ Abdominal pain	☐ Balance problems

SYMPTOM QUESTIONNAIRE

PATIENT INSTRUCTIONS: It is important for this section to be filled out in detail. Look at each symptom listed below and make a single check mark or several check marks in the appropriate columns for the specific symptom which applies to you. Leave the row blank if the symptom listed does not apply to you.

SYMPTOM LIST	FELT RIGHT AFTER INJURY	FELT 24-48 HOURS LATER	HAVE SYMPTOMS NOW	HAD SIMILAR SYMPTOMS 1-3 MONTHS BEFORE THIS INJURY
Headache/migraine				
Dizziness				
Tinnitus (ear ringing)				
Blurry vision				
Memory problems				
Poor concentration				
Irritability				
Balance problems				
Loss of coordination				
Sensitivity to sound				
Sensitivity to light				
Fatigue				
Anxiety				
Pain/difficulty swallowing				
Jaw pain				
Neck pain/soreness				
Neck stiffness				
Shoulder pain/stiffness				
Arm pain/tingling/numbness				
Wrist/hand/finger pain/numbness				
Weakness in arms/legs				
Upper/middle back pain				
Rib cage pain				
Low back pain/soreness				
Hip pain				
Leg pain				
Leg numbness/tingling				
Pain shoots down legs				
Knee pain				
Ankle/foot pain				
Other				

SYMPTOM QUESTIONNAIRE

Please fill out only the sections that apply to you. Skip sections that do not relate to your condition.

NECK REGION

YES	NO	
☐	☐	Does neck movement cause your neck pain to get worse?
☐	☐	Do you get dizzy when you look up or twist your head?
☐	☐	Do you black out or lose your balance when you look up or twist your head?
☐	☐	Do you have to support your head with your hand or grasp your mouth or hair to be able to lift your head up when you are lying down and attempting to sit up? If your difficulty/inability to lift your head without support is injury related, indicate how soon this occurred after injury? (min/hrs)
☐	☐	Do you feel your neck pain sends pain downwards between your shoulders?
☐	☐	Do you feel your neck pain sending pain downwards to the front of your chest?
☐	☐	Have you noticed your head leaning to one side recently?
☐	☐	Have you ever had a head injury before?
☐	☐	Have you been diagnosed as having a disc problem in your neck in the past?

ARM, HAND, OR FINGER REGION

YES	NO	
☐	☐	Do you have pain, numbness, or tingling in your shoulder or upper arm?
☐	☐	Do you have pain, numbness, or tingling in your elbow, lower arm or hand?
☐	☐	Do you have pain, numbness, or tingling in your fingers? If Yes, circle finger(s): Thumb, Index finger, Middle finger, Ring finger, Little finger
☐	☐	Do your arm/hand symptoms ever effect both arm/hand.
☐	☐	Does changing your sitting posture increase your arm/hand symptom intensity?
☐	☐	If you sit and slouch forward for several minutes, do your arm symptoms intensify?
☐	☐	Do your hands burn?
☐	☐	If your have night time hand or arm pain, does it help to shake and massage them?
☐	☐	Do your hands feel tender when you grasp objects?
☐	☐	Do you feel weakness in your grip strength?
☐	☐	Do you drop objects in your hand?
☐	☐	Do you get increased arm numbness when lying flat on your back?
☐	☐	Have you been diagnosed as having Raynaud's syndrome in your past?
☐	☐	If you have arm symptoms, do they improve or worsen when you lift your arms over your head?

MID BACK AND CHEST WALL REGION

YES	NO	
☐	☐	Do you have pain that shoots outwards along your rib cage?
☐	☐	Does your mid back pain intensify when you take a deep breath in?
☐	☐	Does your mid back pain intensify when you twist your torso?
☐	☐	When you bend your mid back to the left side, does the pain increase on the left or right side?
☐	☐	When you bend your mid back to the right side, does the pain increase on the left or right side?
☐	☐	Have you been diagnosed as having angina before?
☐	☐	Do you have a tight band-like chest feeling?
☐	☐	Do you have any associated indigestion pain or pain down your left arm?
☐	☐	Does your mid back pain mostly bother you during sleep?
☐	☐	Does your upper-middle back pain radiate inwards or upwards into your neck?

SYMPTOM QUESTIONNAIRE (Page 2)

Please fill out only the sections that apply to you. Skip sections that do not relate to your condition.

LOW BACK, HIP AND LEG/FOOT REGION

YES	NO	
☐	☐	When you cough, sneeze, or bear down to go to the bathroom, does your low back pain or leg pain get worse?
☐	☐	Does your leg or foot drag on the floor?
☐	☐	Do you get a lot of leg cramps at night time?
☐	☐	Have you noticed pain and/or difficulty when urinating, incontinence, or difficulty having bowel movements during the same time as your having low back pain or leg pain?
☐	☐	Have you had abdominal pain, indigestion, colicky symptoms with your low back pain?
☐	☐	Have you had low back pain that is not relieved by any type of postural change?
		Does your low back or leg pain intensify when you .....?
☐	☐	Sit?
☐	☐	Stand?
☐	☐	Walk?
☐	☐	Bend Forwards?
☐	☐	Bend Backwards?
		Describe any other locations of any pain, numbness, or tingling?
☐	☐	Hip?
☐	☐	Buttock muscles and/or back of your thigh?
☐	☐	Front of your thigh?
☐	☐	Groin area?
☐	☐	Knee?
☐	☐	Calf?
☐	☐	Foot?
☐	☐	Toes?
☐	☐	Do you have prostate problems (past or current)? Men only.
☐	☐	Do your feet feel cold?
☐	☐	Have you ever been diagnosed as having a herniated or bulging disc?
☐	☐	Have you ever had an injection of chymopapain into your discs?
☐	☐	Does either leg feel weak?
☐	☐	If you have leg pain, is the pain primarily focused in front of your thigh(s)?
☐	☐	Other

SLEEPING PATTERNS

YES	NO	
☐	☐	Do you sleep poorly at night?
☐	☐	Do you sleep on your stomach?
☐	☐	Do you feel poorly rested and very tired when you wake up?

Have you ever been to a Chiropractor before?

☐ No, ☐ Yes If yes, Chiropractors Name : _____ Year:_____

Problem seen for: _____

HEADACHE FORM

(CHECK ALL THAT APPLY TO YOU)

WHEN DO YOU USUALLY GET YOUR HEADACHES?

☐ Morning	☐ After napping or oversleeping
☐ Afternoon	☐ After drinking alcohol
☐ Evening	☐ During emotional stress
☐ During sleep	☐ After emotional stress
☐ During weekends	☐ During physical exertion
☐ Beginning of week	☐ Before menstrual cycle
☐ Middle of week	☐ During menstrual cycle
☐ End of week	☐ After menstrual cycle
☐ Bright light causes them	☐ After having head bent downwards
☐	☐ No pattern

WHAT USUALLY HELPS YOUR HEADACHES?

☐ Sleeping	☐ Improving posture
☐ Rest	☐ Dark quiet room
☐ Eating	☐ Drinking coffee
☐ Spinal adjustments	☐ Muscle massage
☐ Medications	☐ Cold packs
☐ Nothing helps	☐ Hot showers

DESCRIBE HOW YOUR HEADACHE USUALLY FEELS:

☐ Pounding	☐ Burning	☐ Pressure
☐ Constant pain	☐ Aching	☐ Exploding
☐ Throbbing	☐ Sharp-Piercing	☐ Dullness

Where does most of your headache pain focus? (Check all that apply)

☐ Neck area	☐ Front of head	☐ Left side of head
☐ Back of head	☐ Eye region	☐ Right side of head
☐ Top of head	☐ No pattern	☐ Both sides of head

If your head pain radiates, where do your headaches start?

☐ Neck area	☐ Front of head	☐ Near eyes
☐ Back of head	☐ Side of head	☐ Other

If your head pain radiates, where do your headaches end?

☐ Neck area	☐ Front of head	☐ Near eyes
☐ Back of head	☐ Side of head	☐ Other

Recently have your headaches been?

☐ The same ☐ Better ☐ Worse ☐ Unusually intense

HEADACHE FORM (Page 2)

How many headaches do you have typically in a week? _____ Times.
How many hours long is a typical headache for you? _____ Hours
How many pills do you take a month for your headaches on the average? _____ Pills/month

☐ YES ☐ NO Have you seen other Doctors for your headaches? Please list and describe treatment and if it treatment helped. Also indicate if you have had any brain scans, laboratory tests, or other diagnostic tests done to evaluate your headaches.

_____

MEDICATIONS:

Please check any medications that you have taken recently for your headaches or other conditions

☐	Narcotics (Codeine, Demerol, Tylenol with Codeine, Percodan, Fiorinal, Esgic, Midrin)	☐	Anti-inflammatory medications (Naprosyn, Meclomen, and Feldene).
☐	Muscle relaxants	☐	Aspirin or Tylenol
☐	Asthma drugs (Aminophylline, Theophylline)	☐	Anacin or Bufferin
☐	Inderal (beta blocker)	☐	Motrin/Advil/Nuprin
☐	Heart or blood pressure medications	☐	Oral contraceptives
☐	Ergotamine-Cafergot (vasoconstrictors)	☐	Other:

Check any of the following that apply to you:

☐	Family history of headaches
☐	History of motion sickness as a child
☐	Headaches associated with shortness of breath or excessive exhaustion
☐	Headaches associated with numbness of face and/or tongue
☐	Headaches associated with arm or leg weakness
☐	You usually know your headache is starting soon by various symptoms such as visual or sensory feelings
☐	You see lights/spots in your vision 5-50 minutes before headache pain begins
☐	You are very sensitive to light or sound during or after headache
☐	You had a fever recently, just before headaches, or during headache
☐	You had a rash, chills, fever, headache, and joint pain/swelling 2 weeks prior to your headaches starting.
☐	Physical exertion makes your headache worse (climbing stairs, lifting, etc)
☐	Headaches start 3-4 hours after eating and/or your headaches improve after you eat
☐	Jaw pain before or during headache
☐	Muscles in neck and shoulders are tight/stiff or sore prior to headache
☐	Headaches get worse when you have sustained poor posture
☐	Headaches begin or get worse when you rotate or twist your head and/or neck
☐	You get dizzy or black out when headaches occur
☐	Get tearing, face flushing, or nasal discharge during headache
☐	History of sinus infection, allergies, deviated septum, or other nasal disorders
☐	Bruise easily
☐	History of neck or head injury
☐	You eat or drink substances having caffeine (coffee, chocolate, or tea). Number cups per day:
☐	Your body usually feels cold
☐	Thyroid problems currently or in past
☐	You usually do not feel rested after a nights sleep

SYMPTOM INTENSITY AND FREQUENCY FORM

Patient Name _____ Date _____

For **Section 1** describe on a scale of 1-10 how intense your pain (includes mild to severe amount of aching, soreness, hurting, or pain), numbness, and/or tingling levels are currently. A zero (0) indicates that no symptoms exists. A 1-3 level is a mild level and indicates that your pain is an annoyance primarily. A 4-7 level is moderate pain that restricts or limits your ability to perform some activities to some degree. An 8-10 level is severe and means that the pain intensity is to point where you are unable to perform most activities. A 10 level pain is equal to the most severe pain you have ever had and means that you are unable to do anything. For **Section 2**, describe how frequent you have symptoms such as pain, numbness, and tingling in the respected areas. Please pay attention to the headache portion.

SECTION 1 CURRENT PAIN INTENSITY LEVELS

Circle the box following the area of pain that best indicates your overall average-usual pain severity today.

Pain Intensity	None	Mild Discomfort/Ache/Stiff			Moderate Hurts/Sore/Bearable Sensation				Severe Sharp/Intense Pain		
Headache	0	1	2	3	4	5	6	7	8	9	10
Neck Pain/Soreness	0	1	2	3	4	5	6	7	8	9	10
Arm/Hand Symptoms	0	1	2	3	4	5	6	7	8	9	10
Mid Back Pain	0	1	2	3	4	5	6	7	8	9	10
Low back Pain	0	1	2	3	4	5	6	7	8	9	10
Leg/Foot Symptoms	0	1	2	3	4	5	6	7	8	9	10

SECTION 2 CURRENT PAIN FREQUENCY LEVELS

Circle the box following the area of pain that best indicates the average percentage of time you have pain today.

Pain Frequency	None	Occasional		Intermittent		Frequent				Constant	
Neck pain/soreness	0%	10%	20%	30%	40%	50%	60%	70%	80%	90%	100%
Arm/Hand Symptoms	0%	10%	20%	30%	40%	50%	60%	70%	80%	90%	100%
Mid-back Pain	0%	10%	20%	30%	40%	50%	60%	70%	80%	90%	100%
Low Back Pain	0%	10%	20%	30%	40%	50%	60%	70%	80%	90%	100%
Leg/Foot Symptoms	0%	10%	20%	30%	40%	50%	60%	70%	80%	90%	100%

CURRENT HEADACHE FREQUENCY & DURATION

During the past week or since the accident/injury if applicable (if less than one week) indicate how frequently you have had headaches and/or migraines. Be sure to indicate how long each headache typically lasts.

A. How frequently do you have headaches currently?

☐ No headaches ☐ 4 times a week
☐ 1 times a week ☐ 5 times a week
☐ 2 times a week ☐ 6 times a week
☐ 3 times a week ☐ Daily

B. How many hours does your typical headache last? _____ Hours? _____ Hours?

PRE-INJURY AND POST-INJURY PAIN COMPARISON FORM

Patient _____ Date _____

For **section 1** please describe on a scale of 1-10 in how intense your pain level was 2-3 months prior to this injury and indicate your current intensity recently. A zero indicates that no symptoms exists. A 1-3 level is a mild level and indicates that your pain is an annoyance primarily. A 4-7 level is moderate in severity and should restrict or limit activity to some degree. A 8-10 level is severe and mean that the pain intensity is to point where some or complete disability exists. For **section 2**, please relate the percentage of time you had pain 2-3 months prior to this injury and indicate your current status in a percentage. Please fill in (circle) all shaded areas that best apply to your case.

SECTION 1 PRIOR AND CURRENT PAIN INTENSITY LEVELS

Circle the box once following the area of pain that best indicates your overall average-usual pain severity before this injury. Secondly, ***circle the box twice*** that indicates your current usual pain intensity.

Pain Intensity	None	Mild Discomfort/Ache/Stiff			Moderate Hurts/Sore/Bearable Sensation				Severe Sharp/Intense Pain		
Headache	0	1	2	3	4	5	6	7	8	9	10
Neck Pain/Soreness	0	1	2	3	4	5	6	7	8	9	10
Arm/Hand Symptoms	0	1	2	3	4	5	6	7	8	9	10
Mid Back Pain	0	1	2	3	4	5	6	7	8	9	10
Low back Pain	0	1	2	3	4	5	6	7	8	9	10
Leg/Foot Symptoms	0	1	2	3	4	5	6	7	8	9	10

SECTION 2 PRIOR AND CURRENT PAIN FREQUENCY LEVELS

Circle the box once following the area of pain that best indicates what average percentage of time you had pain before this injury. Secondly, ***circle the box twice*** that indicates your current typical pain frequency.

Pain Frequency	None	Occasional		Intermittent		Frequent				Constant	
Neck pain/soreness	0%	10%	20%	30%	40%	50%	60%	70%	80%	90%	100%
Arm/Hand Symptoms	0%	10%	20%	30%	40%	50%	60%	70%	80%	90%	100%
Mid-back Pain	0%	10%	20%	30%	40%	50%	60%	70%	80%	90%	100%
Low Back Pain	0%	10%	20%	30%	40%	50%	60%	70%	80%	90%	100%
Leg/Foot Symptoms	0%	10%	20%	30%	40%	50%	60%	70%	80%	90%	100%

HEADACHE AND/OR MIGRAINE FREQUENCY & DURATION

During the past week or since the accident/injury if applicable (if less than one week) indicate how frequently you have had headaches and/or migraines. Be sure to indicate how long each headache typically lasts.

How frequent did you have headaches 2-3 months before this injury?	_____ times a week
How frequent do you have headaches currently?	_____ times a week
How many hours did a typical headache last 2-3 months before this injury?	_____ Hours
How many hours do your typical headaches last currently?	_____ Hours

PAIN INTENSITY INSTRUCTION SHEET

Pain Intensity	None	MILD			MODERATE				SEVERE		
PAIN LEVEL	0	1	2	3	4	5	6	7	8	9	10

	No Pain	Annoying Pain Level Only.	Pain Levels Now Cause You to Slow Down.	Pain Levels Now Limit Your Ability to Perform Activities.
PAIN LEVEL		Able to Perform All Activities.	You Are Able to Do Activities, But They Take You Longer to Do or You Need to Take Breaks.	You Must have Some Inability to Do Certain Activities.
HOW DOES IT FEEL?		Ache, Dull Soreness, Stiffness	Hurting Pain	Sharp Pain, Stabbing or Jabbing Pain
		MILD	MODERATE	SEVERE

A LEVEL 10 PAIN IS EQUAL TO THE MOST SEVERE PAIN YOU HAVE EVER HAD!

HEAD INJURY QUESTIONNAIRE

Patient Name: _____ Date: _____

HOW DID YOU INJURE YOUR HEAD?

AUTO COLLISION (Check what your head hit or what hit your head)

- ☐ Windshield
- ☐ Steering Wheel
- ☐ Dash board
- ☐ Side car window
- ☐ Other passenger
- ☐ Mirror
- ☐ Other _____

FALL

- ☐ Down stairs
- ☐ Slipped and fell, hitting head on
  - ☐ Floor ☐ Stairs (Indicate if wood, concrete or carpet)
  - ☐ Wood ☐ Concrete ☐ Carpeted
- ☐ Off ladder or other structure. How much distance _____feet?
- ☐ Horse-Bicycle-Motorcycle

BLOW TO HEAD

- ☐ Sports injury
- ☐ Assault by another person
- ☐ You hit your head on object
- ☐ Some object hit your head

OTHER (Please describe):

WHAT PART OF YOUR HEAD WAS HIT?

- ☐ Front
- ☐ Back
- ☐ Left side
- ☐ Right side
- ☐ Top
- ☐ Other

HISTORY

YES	NO	
☐	☐	Did you lose consciousness or black out for any time (seconds or minutes) after the head injury? How long _____?
☐	☐	Have you lost any memory before the head injury?
☐	☐	Have you lost any memory or has your memory been different since the head injury?
☐	☐	Did you have a lump or bruise after the head injury? Where? _____
☐	☐	Have you had any head injuries in your past (include childhood)?
☐	☐	Have you seen other doctors for this head injury?
☐	☐	Have you had any x-rays taken?
☐	☐	Have you had a CT or MRI scan taken of your head?

CONCUSSION QUESTIONNAIRE

Patient Name: _____ Date: _____

Please check the following boxes that correspond to any symptoms that you have had recently since your neck or head injury.

YES	SYMPTOM
☐	Headaches
☐	Loss of coordination
☐	Reduced drive/motivation
☐	Poor memory
☐	Difficulty finishing tasks
☐	Sleep disorders
☐	Abnormal levels of anxiety
☐	Reduced tolerance to alcohol
☐	More assertive
☐	Forgetful
☐	Anger outbursts
☐	Depression
☐	Fatigue
☐	Absence of ability to anticipate
☐	Inflexibility
☐	Impaired sexual function
☐	Language difficulty
☐	Impaired judgment
☐	Need daytimer to remember home and/or work activities
☐	Blurry vision
☐	Loss of balance
☐	Difficulty handling multiple tasks
☐	Dizziness/lightheadedness
☐	Irritability
☐	Personality change
☐	Hand tremors
☐	Ringing in ears
☐	Less diplomatic than normal
☐	Mood swings
☐	Reduced attention span
☐	Blackouts
☐	Indifference to other people
☐	More shallow relationships
☐	Difficulty with problem solving
☐	Less mental stamina
☐	Performance inconsistencies
☐	Verbal learning problems
☐	Slower reaction times

HEAD INJURY HOME INSTRUCTION FORM

Patient Name: _____ Date: _____

GENERAL ADVICE

While checking the person with head injury, it is important for you the observer to pay very close attention to any mental or physical changes that might develop. When awakening the person with the head injury, be sure to fully awaken. If any of the following symptoms become worse or if there are any new symptoms that develop from the list below, call the doctor immediately.

Under no circumstances is this person to do any heavy lifting or other exertional activities (including sex) for the next _____ days. No alcohol, Aspirin products, or smoking is allowed for the next week.

CHECK THIS PERSON EVERY _____ HOURS DAY AND NIGHT FOR ____DAYS.

OBSERVE ANY MENTAL CHANGES

☑	Ease of arousability
☑	Abnormal behavior
☑	Worsening headache or persistent headache beyond 24 hours
☑	Decrease in awareness of where they live (location), name (family), and time (date)
☑	Agitation or restlessness
☑	Memory loss
☑	Progressive drowsiness

OBSERVE ANY PHYSICAL CHANGES

☑	Weakness or numbness in the arms or legs
☑	Fever
☑	Unequal pupil size
☑	Convulsions or seizures
☑	Vomiting spells more than three times or continuous nausea
☑	Any vomiting without nausea before
☑	Inability to make a circle with thumb and index finger
☑	Balance problems
☑	Walking abnormality
☑	Speech difficulty
☑	Blurry or double vision
☑	Hearing loss

CHILDREN (Under Age 3)

Observe for excessive crying, consistent difficulty or inability to console child, abnormal or inappropriate interaction, persistent headaches, temper tantrums, lack of initiative, acting immaturely, awkwardness in social activities, awkward athletic abilities, and disturbances in writing or artwork.

I, _____, have read the above instructions and understand them.
(Print Name)

Date _____ Signature _____

AUTOMOTIVE CRASH FORM

BILLING INFORMATION

Patient name:_____
Date of injury:_____ Time of injury _____ ☐ AM ☐ PM
City and street where crash occurred: _____
What is the estimated damage to your vehicle? $_____
☐ Yes ☐ No Do you have automobile medical insurance coverage?
Name/address/phone _____
☐ Yes ☐ No What is your car insurance medical coverage limit? $_____
☐ Yes ☐ No What is the claim number? _____
☐ Yes ☐ No Do you know the claims adjuster's name? _____
☐ Yes ☐ No Have you reported this injury to your car insurance company?
☐ Yes ☐ No Did the police come to the accident scene and make a report?
☐ Yes ☐ No Is an attorney representing you? Name/address/phone: _____

AUTO ACCIDENT DESCRIPTION

DESCRIBE HOW THE CRASH HAPPENED

_____
_____
_____
_____
_____

COLLISION DESCRIPTION

Check all that apply to you:

☐ Single-car crash	☐ Two-vehicle crash	☐ More than 3 vehicles
☐ Rear-end crash	☐ Side crash	☐ Rollover
☐ Head-on crash	☐ Hit guardrail/tree	☐ Ran off road

YOU WERE THE:

☐ Driver	☐ Front passenger	☐ Rear passenger

DESCRIBE THE VEHICLE YOU WERE IN

Model year and Make:

☐ Subcompact car	☐ Compact car	☐ Mid-sized car
☐ Full-sized car	☐ Pick-up truck	☐ Larger than one ton

AUTOMOTIVE CRASH FORM (Page 2)

DESCRIBE THE OTHER VEHICLE :

Model year and Make:		
☐ Subcompact car	☐ Compact car	☐ Mid-sized car
☐ Full-sized	☐ One-ton vehicle	☐ Larger than one ton

AT THE TIME OF IMPACT YOUR VEHICLE WAS:

☐ Slowing down	☐ Gaining speed
☐ Stopped	☐ Moving at steady speed

AT THE TIME OF IMPACT THE OTHER VEHICLE WAS:

☐ Slowing down	☐ Gaining Speed
☐ Stopped	☐ Moving at steady speed

DURING AND AFTER THE CRASH, YOUR VEHICLE:

☐	Kept going straight, not hitting anything	☐	Spun around, not hitting anything
☐	Kept going straight, hitting car in front	☐	Spun around, hitting another car
☐	Was hit by another vehicle	☐	Spun around, hitting object other than car

DESCRIBE YOURSELF DURING THE CRASH

Check only the areas that apply to you.

☐	You were unaware of the impending collision
☐	You were aware of the impending crash and relaxed before the collision
☐	You were aware of the impending crash and braced yourself
☐	Your body, torso, and head were facing straight ahead
☐	You had your head and/or torso turned at the time of collision ☐ Turned to left ☐ Turned to right
☐	You were intoxicated (alcohol) at the time of crash
☐	You were wearing a seatbelt If yes, does your seatbelt have a shoulder harness? ☐ Yes ☐ No
☐	You were holding onto the steering wheel at the time of impact

AUTOMOTIVE CRASH FORM (Page 3)

INDICATE IF YOUR BODY HIT SOMETHING OR WAS HIT BY ANY OF THE FOLLOWING: Please draw lines and match the left side to the right side.

Head	Windshield
Face	Side window
Shoulder	Side door
Arm/hand	Dashboard
Front chest wall	Knee bolster/glove compartment
Side chest wall	Seatbelt
Hip/abdomen	Frame of car near windows
Knee	Roof of vehicle
Leg	Another occupant/animal
Foot	Other

CHECK IF ANY OF THE FOLLOWING VEHICLE PARTS BROKE, BENT, OR WERE DAMAGED IN YOUR CAR

☐ Windshield	☐ Seat frame	☐ Knee bolster
☐ Steering wheel	☐ Side-rear window	☐ Other
☐ Dash	☐ Mirror	☐ Other

REAR-END COLLISIONS ONLY Answer this section only if you were hit from the rear.

Does your vehicle have

- ☐ Movable/adjustable headrest
- ☐ Fixed, non-moveable headrest
- ☐ No headrests in my vehicle

Please indicate how your headrest was positioned at the time of crash.*

- ☐ At the top of the back of your head
- ☐ Midway height of the back of your head
- ☐ Lower height of the back of your head
- ☐ Located at the level of your neck
- ☐ Located at the level of your shoulder blades (upper back) below neck

*Estimate the distance between the back of your head and the front of the headrest. _____ inches

ALL TYPES OF COLLISIONS

Answer this section regardless of the type of crash; indicating those relevant to your case.

YES	NO	
☐	☐	Did any of the front or side structures, such as the side door, dashboard, or floorboard of your car dent inward during the crash?
☐	☐	Did the side door touch your body during the crash?
☐	☐	Did your body slide under the seatbelt?
☐	☐	Was the door(s) of your vehicle damaged to point where you could not open the door?
☐	☐	Have you noticed any bruising on your body since the accident?

AUTOMOTIVE CRASH FORM (Page 4)

EMERGENCY ROOM

YES	NO	
☐	☐	Did you go to the emergency room afterward? What is name of the emergency room?_____ When did you go (date and time)?
☐	☐	Did you go to emergency room in an ambulance?
☐	☐	Did you or another person drive you to emergency room?
☐	☐	Were you hospitalized overnight?
☐	☐	Did emergency room doctor take X-rays? Check what was taken ☐ Skull ☐ Neck ☐ Low back ☐ Arm or leg
☐	☐	Did the emergency room doctor give you pain medications?
☐	☐	Did the emergency room doctor give you muscle relaxants?
☐	☐	Did you have any cuts or lacerations?
☐	☐	Did you require any stitching for cuts?
☐	☐	Were you given a neck collar or back brace to wear?

WHEN DID YOU FIRST NOTICE ANY PAIN AFTER INJURY?

☐	Immediately	☐	_____ Hours after injury	☐	_____ Days after injury

IF YOU DID NOT SEE A DOCTOR FOR THE FIRST TIME WITHIN THE FIRST WEEK, INDICATE WHY (Check all that apply)

☐	No pain was noticed	☐	No appointment schedule available
☐	No transportation	☐	Work/home schedule conflicts

IF YOU DID NOT SEE A DOCTOR FOR THE FIRST TIME WITHIN THE FIRST MONTH AFTER INJURY, INDICATE WHY? (Check all that apply)

☐	No pain was noticed	☐	No appointment schedule available
☐	No transportation	☐	Work/home schedule conflicts
☐	I thought pain would go away	☐	I had no insurance or money
☐	I self-treated with over-the-counter drugs	☐	Other

HAVE YOU BEEN UNABLE TO WORK SINCE INJURY?

☐ YES ☐ NO If yes, you were off work ☐ partially or ☐ completely

Please list dates off work _____ to _____.

LIST ALL DOCTORS, TESTS, & TREATMENT SINCE INJURY?

(Start with the first doctor/office/hospital you saw after your injury and check all that apply)

① Name hospital/doctor/therapist/center: _____

Address:_____ Date _____

Indicate what was done:

- ☐ Exam-consultation
- ☐ X-ray of neck
- ☐ X-ray of low back
- ☐ Other X-rays
- ☐ MRI/CT scan
- ☐ Other diagnostic test
- ☐ Rehabilitation
- ☐ Physical therapy
- ☐ Exercises recommended
- ☐ Medications prescribed
  - ☐ Neck collar
- ☐ Spinal manipulation/adjustments
  - ☐ Muscle massage/myotherapy
  - ☐ Low back brace
  - ☐ Heat packs
  - ☐ Ice packs
- ☐ Ultrasound
- ☐ Other

Indicate if treatment: ☐ Made condition worse ☐ Did not help ☐ Helped

② Name hospital/doctor/therapist/center seen: _____

Address:_____ Date _____

Indicate what was done:

- ☐ Exam-consultation
- ☐ X-ray of neck
- ☐ X-ray of low back
- ☐ Other X-rays
- ☐ MRI/CT scan
- ☐ Other diagnostic test
- ☐ Rehabilitation
- ☐ Physical therapy
- ☐ Exercises recommended
- ☐ Medications prescribed
  - ☐ Neck collar
- ☐ Spinal manipulation/adjustments
  - ☐ Muscle massage/myotherapy
  - ☐ Low back brace
  - ☐ Heat packs
  - ☐ Ice packs
- ☐ Ultrasound
- ☐ Other

Indicate if treatment: ☐ Made condition worse ☐ Did not help ☐ Helped

③ Name hospital/doctor/therapist/center seen: _____

Address:_____ Date _____

Indicate what was done:

- ☐ Exam-consultation
- ☐ X-ray of neck
- ☐ X-ray of low back
- ☐ Other X-rays
- ☐ MRI/CT scan
- ☐ Other diagnostic test
- ☐ Rehabilitation
- ☐ Physical therapy
- ☐ Exercises-stretching
- ☐ Medications prescribed
  - ☐ Neck collar
- ☐ Spinal manipulation/adjustments
  - ☐ Muscle massage/myotherapy
  - ☐ Low back brace
  - ☐ Heat packs
  - ☐ Ice packs
- ☐ Ultrasound
  - ☐ Other

Indicate if treatment: ☐ Made condition worse ☐ Did not help ☐ Helped

WORK RELATED INJURY

Patient Name: _____ Date:_____

☐ YES ☐ NO Have you notified your employer about your injury?
☐ YES ☐ NO Has your employer notified their workers comp insurance carrier?
☐ YES ☐ NO Have you filled out an injured worker's claim form?

EMPLOYEE JOB DESCRIPTION

How many years have you been employed: _____?
How many hours do you work in a typical day: _____?
How many hours do you work in a typical week: _____?

JOB DESCRIPTION	HOW MANY HOURS DO YOU DO THESE ACTIVITIES IN A TYPICAL DAY AT WORK?
Bending head downward	
Looking up	
Driving car	
Working at computer	
Working at desk	
Lifting hands above level of shoulder	
Lifting hands above level of head	
Reaching activities	
Carrying objects in hand	
Gripping objects	
Stooping	
Bending	
Twisting	
Crouching	
Walking	
Kneeling	
Standing	
Sitting	
Pushing	
Pulling	
Lifting at work	

HAVE YOU BEEN UNABLE TO WORK SINCE INJURY?

☐ YES ☐ NO If yes, you were off work: from _____ to _____.

Check the following if you are currently on:

☐ Full Disability ☐ Partial Disability

POST INJURY INSTRUCTIONS

PATIENT: _____ DATE: _____

You have had a recent injury and these are general instructions for you to follow for six weeks after injury. Most of the repair/healing in your injured muscles, tendons, and/or ligaments will happen within six weeks after injury. These recommendations, if followed, will speed up the time it takes for you to heal and repair.

USE ICE FOR 1-2 WEEKS AFTER INJURY:

☑ Place ice on the areas of your body that hurt every two hours for the next 4-5 days. During the first few nights if pain wakes you up use ice but be sure to not fall asleep with ice on. After one week, use ice when you hurt, on a as needed basis. Be sure to use a thin cloth between your skin and the ice. Be sure to notify your Doctor if you have intolerance to ice.
☑ Use ice _____ minutes on your neck or extremity each time. Use ice _____ minutes on your middle and/or low back area each time. Never exceed these time limits.
☑ Use crushed ice, flat ice packs, or ice pack given to you by your Doctor.
☑ Never fall asleep with ice on.
☑ Stop using ice if any unusual pain or discomfort develops and notify your Doctor.
☑ Avoid using any heat on sore areas of your body for two weeks after injury.

AVOID THESE ACTIVITIES FOR 6 WEEKS:

☑	Prolonged sitting, take a break every 30 minutes.
☑	Bending your neck forward or sideways for more than 10 minutes at any time.
☑	Twisting your neck rapidly (driving).
☑	Prolonged bending, stooping, twisting, or squatting.
☑	Lying down in bed or couch with head on two pillows or arm of couch.
☑	Jarring activities (particularly if they cause pain).
☑	Heavy exercise, lifting, competitive sports, or contact sport activities.
☑	Alcohol and Aspirin products for 2 days only as they both increase bleeding.
☑	Smoking (reduces oxygen to tissues which need it for repair).
☑	Consumption of excessive amounts of junk food.

DO THE FOLLOWING FOR 6 WEEKS AFTER INJURY:

☑ Rest physically and mentally after injury. Gradually increase activity level as pain lessens.
☑ Drink 6-8 glasses of water daily.
☑ Take a 15-30 minute nap each day and sleep an extra hour every night.
☑ Take 3,000 mg of vitamin C daily starting 2 days after injury (helps repair and reduces pain).
☑ Take a general stress vitamin supplement daily (begin 1 day after injury).
☑ Sleep on a good firm mattress.

Please read and sign this form at the bottom indicating that you have read and fully understand these recommendations. You will get a copy to take home.

Date: _____ Signature:_____

ACTIVITY QUESTIONNAIRE

Patient Name: _____ Date: _____

Check only the activities below that affect you currently. Be specific and indicate whether your pain, weakness, stiffness, or other symptoms, while doing the activity, annoy you, slow you down, or prevent (unable to do) your ability to perform the activity.

ACTIVITY DESCRIPTION	ANNOY ONLY	SLOWS DOWN	HARD TO DO	UNABLE TO DO
Bending head downward or upwards				
Working at computer station				
Driving car				
Sitting				
Working at desk				
Lifting/reaching hands over level of shoulder				
Lifting/reaching hands over level of head				
Lifting at work				
Doing reaching activities				
Combing/brushing hair				
Typing on a keyboard				
Carrying objects in hand				
Gripping objects or using wrists or hands				
Sleeping				
Recreational/sports/hobby activities				
Doing housework or gardening				
Stooping/bending				
Twisting				
Crouching/kneeling				
Walking				
Standing				
Pushing/pulling				
Lifting at home				
Having sex				

PATIENT UPDATE HISTORY FORM

PATIENT NAME:_____Date: _____
STREET/APT:_____
CITY/ZIP:_____
PHONE: (Home)_____ (Work)_____

It has been several months since your last office visit in this office. It is important that you inform our office of any new injuries, symptoms, illnesses, or diseases since your last visit. Check any that apply to you:

		DATE
☐	Car accident/fall/motorcycle accident	
☐	Work injury	
☐	Sports/home/recreational injury	
☐	Surgery of any type	
☐	Heart attack	
☐	Stroke	
☐	Major illness	
☐	Hospitalization for any condition	
☐	Told you have cancer of any type	
☐	Told you have arthritis of any type	
☐	Told you have a thyroid disorder	
☐	Told you have diabetes	
☐	Told you have osteoporosis	
☐	Recent weight loss	
☐	Recent excessive fatigue	
☐	Recent shortness of breath	
☐	Recent low-grade or high-grade fever	
☐	Night sweats	
☐	Night time pain	
☐	Head injury	
☐	Fracture of any type	

WHAT BRINGS YOU BACK TO MY OFFICE?

☐	Check up	☐	Headache
☐	Old pain returning	☐	Neck Pain
☐	New type of pain	☐	Middle Back Pain
☐	New injury	☐	Low Back Pain
☐	Physical examination	☐	Arm/Hand symptoms
☐	Other	☐	Hip/Leg symptoms

HAS THERE BEEN ANY CHANGES IN YOUR INSURANCE OR LACK OF INSURANCE BENEFITS STATUS?

☐ YES ☐ NO Describe:_____

(Chiropractor's Name and Address)

LIEN AUTHORIZATION
TO PAY CHIROPRACTIC FEES
-and Constructive Trust for the Chiropractor-

ATTORNEY NAME/ADDRESS:
Date of Injury

PATIENT NAME/ADDRESS:
Social Security No:

PATIENT AGREEMENT

I hereby authorize the above Chiropractor to furnish you, my attorney, a full report of his/her examination, diagnosis, treatment, and prognosis of my injuries, arising from the accident in which I was involved.

I further authorize and irrevocably direct you, my attorney, **to pay directly to above Chiropractor** such billings and fees as may be due and owing to him for these chiropractic services/treatment, X-rays, reports, all deposition time, court appearances, transcription time, and costs rendered to me by reason of this accident. You, my attorney, are further irrevocable directed to pay such billings and fees from funds held for me in your client trust account, or to withhold such sums from any settlements, judgments, dispositions, proceeds, payments or verdicts received by you on my behalf as may be necessary to adequately protect above Chiropractor. I hereby further, irrevocably, give a lien on my case to above Chiropractor against any and all proceeds of any settlements, judgments, dispositions, proceeds, payments, payments or verdicts which may be paid to you, my attorney, or myself, as a result of the injuries which necessitated diagnostic testing, examination, and treatment.

I fully realize and understand that I am directly and fully, personally responsible to the above Chiropractor for all chiropractic billing and that ***this obligation is not contingent upon my receiving any settlement for my claim***. With this in mind, I agree to give the above Chiropractor all information concerning any and all insurance policies which may cover my chiropractic treatment and diagnosis. I further agree to notify the said Chiropractor's office and to pay his/her billings at such time as I may personally receive payments made directly to myself from any of the involved insurance carriers.

Should I receive payment for the above Chiropractic fees and have not turned said monies over to the above Chiropractor within thirty (30) days, or should I fail to perform my obligation to pay these fees, then the entire amount of the Chiropractors billing shall bear interest at the highest rate permitted by law from the date chiropractic services were first rendered.

In the event I discharge my present attorney, or change or substitute another attorney, at any time, prior to payment in full for all chiropractic billing and other charges, the new attorney shall honor this lien as inherent to the settlement and enforceable upon the case as if it were executed by him/her. I agree to notify said Chiropractor if any change in attorney status within two weeks. If my new attorney does not honor this lien for any reason, or if I have no legal representation for any reason, then I will pay all of said Chiropractor bills in full within thirty (30) days.

(Continued on Other Side-Page 2)

Lien Authorization-(Continued from Side One)

Chiropractor's Name:

PATIENT AGREEMENT CONTINUED (PAGE 2)

I agree to be responsible for any legal fees, court, or collection agency costs incurred, which are necessary to enforce this agreement. Those additional expenses for legal or collection agency fees or court costs, will be added on top of the billings and/or fees of said Chiropractor along with the highest interest rate permitted by law, calculated from the date chiropractic services were first rendered. I understand that, in view of the protracted time for cases to be tried, I waive any right to statute of limitations for collections.

I hereby appoint the said Chiropractor at the address on this lien as my Attorney-in-Fact, to act in my name and place, and on my behalf with authority to endorse any checks issued to me in payment for Chiropractic fees.

This contract is binding upon me, whether or not signed by my attorney.

A photocopy reproduction of this authorization and signature may be used in place of the original.

Dated:_____ Patient's Signature:_____

Print Name: _____

ATTORNEY AGREEMENT

The undersigned, being the attorney of record for the above-mentioned patient, does hereby agree to observe all the terms of the above **Chiropractic Lien and agrees to withhold such sums In Trust** from any payments, proceeds, dispositions, settlements, judgments, or verdicts as may be necessary to adequately protect said Chiropractor. This lien is given with the understanding that it applies only to the net proceeds received, after deduction of attorney's fees and costs of suit. Furthermore, this lien is to be treated on a pro rata basis, with all other liens of equal stature. Counsel further agrees to notify said Chiropractor in writing, at such time as this patient's case is surrendered to the patient/client or is transferred to a new attorney. The undersigned also represents and warrants to said Chiropractor that he/she has explained fully to his/her client, all of the legal ramifications of the foregoing chiropractic lien for services rendered including, but not limited to, its irrevocability, its waiver of the defense of the statute of limitations and its provision for direct payments of chiropractic billings. Furthermore, counsel agrees that after receiving monies to send payment to said Chiropractor within thirty (30) days or be charged an additional finance charge at the highest interest rate permitted by the law for every month that the suit has been settled and/or chiropractic payments have been received and said Chiropractor remains unpaid. Counsel agrees to pay all legal fees and court costs should this lien necessitate enforcement through the legal process.

Dated:_____ Attorney Signature:_____

Print Name:_____

☺ Attorney, please date, print and sign your name, and then promptly return this form to said Chiropractor's office after making a copy for your own records.

PATIENT INSTRUCTION AND AUTHORIZATION TO PERSONAL INJURY INSURANCE CARRIER TO MAKE DIRECT PAYMENT TO CHIROPRACTOR

I, hereby authorize and instruct the following insurance carrier_____ to send (mail) all paid monies for diagnostic testing, treatment, and/or medical supplies to the following Doctor/Clinic/Office for all services/supplies billed:

SEND AND MAKE ALL PAYMENT CHECKS PAYABLE TO:

(Doctor's name, address, state license number, and tax ID)

√	I authorize said Doctor to release any information pertinent to my case to the insurance carrier.
√	A photocopy of this authorization shall be considered as valid as the original.
√	I authorize said Doctor to use my name in the "Signature on File" in future billings.
√	I authorize direct payment to above Doctor.
√	I authorize use of this form on all my insurance submissions (billings).

LIMITED POWER OF ATTORNEY FOR PAYMENT OF CHIROPRACTIC BILLS

I herby, give limited Power of Attorney, for said Doctor/Clinic, to cash and deposit any sums paid by the above insurance carrier for only the specific injury indicated on this form.

Date: _____

Patient Name (Please Print): _____

Signature of Patient (Policyholder): _____

Signature of Patient/Guardian, if other than Policyholder: _____

Date of Injury: _____

Witness Signature: _____

MULTIPLE REGION FUNCTIONAL CAPACITY QUESTIONNAIRE

Name: _____ Date:_____

Patient: Fill out sections 1 to 10. In each category, check one box that best applies to your current condition.

1. CURRENT PAIN INTENSITY (0-5 Score)

☐	I have no pain currently.
☐	I have occasional pain which mildly disturbs me at work and at home.
☐	I have frequent annoying pain with an occasional pain that slows me down.
☐	I have frequent moderate level pain and occasional severe pain that stop me from performing more strenuous activities.
☐	I have some degree of pain at all times, with frequent bouts of severe pain that prevent me from performing many normal activities.
☐	I have pain all of the time, mostly severe, and because of that, I am unable to do most activities for myself. Medications don't help.

2. WORK ABILITY (0-5 Score)

☐	I am currently able to work full time with no pain.
☐	I work full time and have slight (annoying) symptoms that occasionally may slow, me down thus taking slightly longer to perform.
☐	I work full time. My work output quality and/or quantity are reduced 10-20%. Symptoms vary from slight to moderate levels, which cause intermittent halting. I require assistance occasionally at work.
☐	I am able to work part time. I am not able to work at a normal pace beyond 2 hours and at a slower pace beyond 4 hours. My performance output quality and/or quantity is reduced by 30-60%.
☐	I am able to work part time. I am not able to work at a normal pace for more than 30-60 minutes at a time. I can work at a slower pace beyond 2 hours. My ability to perform in output is reduced by over 70%.
☐	I am not able to work at a normal or a slower pace at all. Job quality and quantity output are reduced by more than 90%. I am unable to work on part-time status even with a flexible work schedule.

3. SPORTS, HOBBIES, AND SOCIAL ACTIVITIES (0-5 Score)

☐	I can perform normal sports, hobby activities, and social activities with my friends, family, or business acquaintances.
☐	My sports, hobby, and social life is normal, but pain slows me down occasionally.
☐	Pain or other symptoms limit my more energetic or competitive sports, hobbies, and social activities such as dancing and running.
☐	Severe pain or other symptoms limit moderate energetic sports, hobby, and social activities. I do not go out as often.
☐	Pain or other symptoms limit me to only minimal sports, hobby, and social activity. I usually stay at home.
☐	I am unable to participate in any sports, hobby, or social activity due to pain.

4. HOME ACTIVITIES (0-5 Score)

☐	I can perform normal home activities such as vacuuming, cooking, cleaning, mowing the lawn, and doing laundry with no pain.
☐	I am able to do all normal home duties, but pain slows me down occasionally with very strenuous activities.
☐	Pain prohibits very strenuous home activities. I am able to do light to moderately strenuous home activities.
☐	Severe pain or other symptoms limit moderate and strenuous home activities. I need help doing some activities.
☐	I am able to do only light home activities. I am unable to vacuum the floor, do dishes, sweep, mop, and do laundry.
☐	I am unable to do any home activities due to pain or other symptoms. I need help putting on clothes and taking a bath.

5. SLEEPING (0-5 Score)

☐	I normally have no difficulty sleeping due to pain or other symptoms.
☐	I have occasional difficulty sleeping due to pain or other symptoms. I wake up at night, resulting in 30 minute loss of sleep.
☐	I have occasional difficulty sleeping due to pain or other symptoms. I lose 10-15% of normal sleeping hours a night.
☐	I have frequent difficulty sleeping due to pain or other symptoms. I am restless most of the night. I lose 25% of hours of sleep a night.
☐	My sleeping hours are around reduced about 50% . I usually need medications to sleep well.
☐	I have no normal sleeping hours. I am never able to sleep more than 2-3 hours without heavy medication. I never feel rested.

6. SITTING (0-5 Score)

☐	I can sit at my desk or drive my car normally with no pain.
☐	I can sit at my desk or drive my car with occasional annoying pain. I need to take breaks on long trips.
☐	Sitting or driving causes frequent annoying pain. Pain becomes severe if sitting for more than 2 hours where I need to change position.
☐	I can sit or drive for 3-4 hours but I need frequent breaks to change my body position. I am unable to sit constantly over 1 hour.
☐	I cannot sit or drive for more than 30 minutes at a time due to pain severity.
☐	I cannot sit at my desk, chair at home, or drive my car at any time due to pain severity.

7. UPPER BODY FUNCTION (neck and arms) (0-5 Score)

☐	I am able to use my neck, shoulders, arms, and hands in all normal activities with no pain.
☐	I am able to use my neck, shoulders, arms, and hands in all normal activities with occasional annoying pain.
☐	I am able to lift and move my head and neck, lift arms over my head, reach over my head, carry objects, and grip objects with my hands. I have occasional pain when lifting heavy objects over my head, which causes me to stop. Occasionally will have difficulty feeling/gripping objects with my hands due to either weakness or numbness. I am limited to light to moderate weights in my hands.
☐	I am able to lift my arms up to the height of my shoulder for short periods but not over my head, carry light to moderate weight objects, grip objects with my hands. I get occasional pain when lifting heavy objects over my head. Occasionally, I will have difficulty typing, feeling, or gripping objects with my hands due to either weakness or numbness. I drop objects two or three times a week. I have to use two hands for some activities that I could do with one hand before. I am limited to moderate weights.
☐	I am able to carry and grip light weight objects only. I get frequent pain when lifting any object above my waist and sometimes I am unable to lift to the height of my shoulder. I am not able to lift my arms up to the height of my shoulder and lift over my head. I frequently have difficulty feeling or gripping objects with my hands due to either weakness or numbness. I drop objects daily unless I am very careful. I have to use two hands for most activities that I could do with one hand before. I have frequent difficulty typing, using a computer, and writing letters. I am limited to light weights. I have lost 75% of hand lifting ability.
☐	I am able to lift my arms to the level of my shoulders only, and just lifting my arms above my waist causes severe pain. I am unable to lift any object over the height of my waist. Every time I lift my arms I get severe pain in my neck, shoulders, or arm, and I have to lower my arm or arms immediately. I am unable to write letters. I am unable to lift 5 pounds in my hands.

8. LOWER BODY FUNCTION (Low back and legs) (0-5 Score)

☐	I can sit, drive, stand, squat, stoop, walk, bend my knees, use my feet, and lift normal heavy weights with no low back/leg pain.
☐	I can sit, drive, stand, squat, stoop, walk, bend my knees, use my feet, and lift normal heavy weights with occasional annoyance of mild pain. I can do all of these activities, but more slowly if demands are high.
☐	Moderate levels of low back/leg pain happen if I do prolonged or repeated sitting, driving, standing, stooping, walking, or bending. I can lift heavy objects if properly positioned. Pain limits me to walking to ½ mile. I am unable to stand for more than 45 minutes at a time. Repeated stooping or bending for more than 20 minutes will cause me to slow down.
☐	Moderate to severe levels of low back/leg pain happen if I do prolonged or repeated sitting, driving, standing, stooping, walking, or bending. I can't lift heavy objects at all and am able to lift moderately heavy objects (¼ my body weight) if properly positioned. Pain limits me to walking to ¼ mile. I am unable to stand for more than 30 minutes at a time.
☐	I experience severe levels of pain if I do short-term sitting, driving, standing, stooping, walking, or bending. I can't lift moderate or heavy objects at all and am able to lift light objects only (10-15 pounds). I need lumbar belt support and/or a cane for support to walk. Pain limits me to walking to one block. I am unable to stand for more than 10 minutes at a time.
☐	I experience severe levels of pain if I do sitting, driving, standing, stooping, walking, or bending. I am able to walk only with use of a cane, crutches, or a wheelchair. I need to lie down frequently to relieve pain. I am unable to lift or carry any object over 5 lbs. I need lumbar belt support and/or a cane for support to move about in my home. During the daytime I lie down for 3-4 hours.

9. HEADACHES (0-5 Score)

☐	I have no headaches normally.
☐	I have headaches occasionally, which only annoy me at work or at home.
☐	I have occasional headaches that are intense enough to slow me down at work and home occasionally.
☐	I have occasional headaches that cause me to stop and rest for short periods of time frequently.
☐	I have frequent headaches that stop all of my activity. I frequently lose time at work or have delays in work production due to pain.
☐	I have frequent headaches that cause my not being able to go to work, school, or home, or participate in recreational activities.

10. MENTAL ABILITY (0-5 Score)

☐	My memory and mental function are normal. I have no difficulty with work or home demands.
☐	I am able to perform most mental activities and am able to function at work, at home, and in society. I have occasional slight difficulty with complex tasks, memory, and math.
☐	I am able to function normally in most work, home, and society activities. Complex tasks, multiple tasks, and intense concentration tasks are difficult, often resulting in mistakes. I have noticed about a 10-25% memory loss and a job performance decline recently.
☐	I am not able to handle difficult or complex tasks. I have notable memory loss and difficulty making decisions. My friends, family, and I have noticed recent personality changes. It takes much longer to do work and home tasks. I can handle one simple task at a time. I have to write down my daily tasks to remember. My job performance ratings are poor. I have noticed about a 26-50% memory loss and a job performance decline recently.
☐	I am able to handle only simple tasks one at a time. I am unable to keep full time job. My job performance ratings are poor. My reaction times have slowed down a lot. I have noticed about a 51-75% memory loss and job performance decline recently.
☐	I am unable to hold any job at all. I am unable to balance my checkbook and need help. I am unable to shop without a shopping list. I have severe performance difficulties. I am unable to remember instructions.

TOTAL SCORE: (1-10) _____ X2= _____