Wellness. Your Goal. Our Mission.

Health Centered
SPINE & WELLNESS GROUP

Patient Name _____ Address _____

City _____ State _____ Zip _____ Home Phone _____

Email address _____ Cell Phone _____

DOB _____ Age _____ (M) (F) SS# _____ Marital Status: (M) (S) (D) (W)

How did you hear about our office? **Newspaper Radio Internet Friend Phonebook Physician Health Fair**

Circle: Employed FT Employed PT Self Employed Homemaker Retired Unemployed due to pain Unemployed for other reasons

Are you on disability? Reason and when did it start _____

Is your visit following an automobile accident? Yes No If yes, what is the date of the accident?_____

Employer _____ Employer's Address_____

Work Phone _____ Type of Work_____ # of Hours Worked per Week _____

Spouse Name _____ Name/Ages of Children _____

Name of Emergency Contact _____ **Relationship** _____

Emergency Contact Phone Number _____ **Cell Phone Number** _____

Responsible party/ Parent/ Guardian (if different from above) Name _____

Address _____ City _____ State ____ Zip _____ DOB_____

Employer _____ Address_____ Work Phone _____

PRIMARY INSURANCE			
NAME OF PRIMARY INSURANCE COMPANY		POLICY #	
NAME OF INSURED		GROUP #	
ADDRESS OF INSURANCE COMPANY		COPAY $	
CITY, STATE, ZIP	PHONE	DEDUCTIBLE	
RELATIONSHIP TO PATIENT Spouse		EFFECTIVE DATE	EXPIRATION DATE

SECONDARY INSURANCE (IF APPLICABLE)			
NAME OF PRIMARY INSURANCE COMPANY		POLICY #	
NAME OF INSURED		GROUP #	
ADDRESS OF INSURANCE COMPANY		COPAY $	
CITY, STATE, ZIP	PHONE	DEDUCTIBLE	
RELATIONSHIP TO PATIENT		EFFECTIVE DATE	EXPIRATION DATE

CURRENT MEDICAL CONDITION INFORMATION

Your answers on this form will help your health care provider better understand your medical concern and conditions. If you cannot remember specific details, please approximate. Add any notes you think are important. **ALL QUESTIONS CONTAINED IN THIS QUESTIONNAIRE ARE OPTIONAL AND WILL BE KEPT STRICTLY CONFIDENTIAL.**

Main reason for today's visit: _____

Other concerns: _____

_____

HEALTH HISTORY

ALLERGIES (Medications, Food, Bee Stings, Etc…)

Allergy	Reaction
1 _____	_____
2 _____	_____
3 _____	_____
4 _____	_____

MEDICATIONS/VITAMINS/HERBAL SUPPLEMENTS (Can attach a list of medications if you have several)

Drug Name	Strength	Frequency Taken
Prenatal Vitamins		1 Daily

PAST MEDICAL HISTORY

Please check all that apply:

○ Anxiety Disorder	○ Diverticulitis	○ Kidney Disease
○ Arthritis	○ Fibromyalgia	○ Kidney Stones
○ Asthma	○ Gout	○ Leg/Foot Ulcers
○ Bleeding Disorder	○ Has Pacemaker	○ Liver Disease
○ Blood Clots (or DVT)	○ Heart Attack	○ Osteoporosis
○ Cancer	○ Heart Murmur	○ Polio
○ Coronary Artery Disease	○ Hiatal Hernia or Reflux Disease	○ Pulmonary Embolism
○ Claustrophobic	○ HIV or AIDS	○ Reflux
○ Diabetes - Insulin	○ High Cholesterol	○ Stroke
○ Diabetes – Non-Insulin	○ High Blood Pressure	○ Tuberculosis
○ Dialysis	○ Overactive Thyroid	○ Other

PAST SURGICAL HISTORY

Surgery	Reason	Year	Hospital
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

FAMILY HEALTH HISTORY

Father	Living: Y / N	Age:	○ Alcoholism ○ Arthritis ○ Depression ○ Cancer ○ Diabetes ○ Genetic disease ○ Heart Disease ○ Hypertension ○ Osteoporosis ○ Stroke ○ Scoliosis
Mother	Living: Y / N	Age:	○ Alcoholism ○ Arthritis ○ Depression ○ Cancer ○ Diabetes ○ Genetic disease ○ Heart Disease ○ Hypertension ○ Osteoporosis ○ Stroke ○ Scoliosis
Brother/Sister	Living: Y / N	Age:	○ Alcoholism ○ Arthritis ○ Depression ○ Cancer ○ Diabetes ○ Genetic disease ○ Heart Disease ○ Hypertension ○ Osteoporosis ○ Stroke ○ Scoliosis
Brother/Sister	Living: Y / N	Age:	○ Alcoholism ○ Arthritis ○ Depression ○ Cancer ○ Diabetes ○ Genetic disease ○ Heart Disease ○ Hypertension ○ Osteoporosis ○ Stroke ○ Scoliosis

SOCIAL HISTORY

Caffeine	◉ None ○ Occasional ○ Moderate ○ Heavy # of cups/cans per day? _____
Alcohol	Do you drink alcohol? ○ Yes ○ No If Yes, how often? ○ Occasionally ○ < 3 times a week ○ > 3 times a week How many weekly? _____
Tobacco	Do you use tobacco? ○ Yes ○ No If not currently, have you ever used tobacco? ○ Yes ○ No ○ Cigarettes ___ pks/day ○ Chew _____/day ○ Cigars ____/day # of years _____ Month/Year Quit ____/____
Drugs	Do you currently use recreational or street drugs? ○ Yes ○ No

PREFERRED PHARMACY

Pharmacy: _____

Address: _____

City/State: _____ **Phone**: _____

AUTHORIZATION TO RELEASE CONFIDENTIAL INFORMATION TO OTHER PERSONS AND/OR LEAVE MESSAGES

It is the policy of Health Centered Spine and Wellness Group to not release confidential patient information about you, unless it is for the patient care and treatment, payment, or operations. If you wish for our physician and/or office staff to leave messages for you on your home voice mail, work telephone, cell phone or to any other person, then you must complete the following:

I authorize Health Centered Spine and Wellness Group to release confidential patient information about me by the following methods and agree it is my responsibility for notifying my physician or office staff whenever I want this to change:

We can call your home?	Yes	No
We can leave a message on your home voice mail?	Yes	No
We can call you at work?	Yes	No
We can leave a message on your cell phone?	Yes	No
We can fax copies of information to other offices if necessary?	Yes	No

Please list the names of people and their relationship to you, if you wish us to release confidential patient information to them:

Name **Relationship (spouse, parents, friend, neighbor)**

_____

_____

_____

_____ / _____ _____ / _____

Patient Signature/Legal Representative **Date** **Witness Signature** **Date**

CONSENT FOR CARE

As a patient of Health Centered Spine & Wellness Group, I give the providers permission and authority to care for me or the above named minor in accordance with tests, diagnosis, and analysis. In rare cases, underlying physical defects, deformities or pathologies may render the patient susceptible to injury. The doctor, of course, will not give any treatment or health care if he is aware that such care may be contra-indicated. Again, it is the responsibility of the patient to make it known, or to learn through health care procedures whatever the patient is suffering from: latent pathological defects, illnesses, or deformities which would otherwise not come to the attention of the provider. The Provider provides a specialized, non-duplicating health care service.

I understand that if I am accepted as a patient by a provider at Health Centered Spine & Wellness Group, I am authorizing them to proceed with any treatment that may be necessary. Furthermore, any risk involved, regarding treatment, will be explained to me upon my request.

I hereby give my consent for evaluation and treatment to Health Centered Spine and Wellness Group. In the event the patient is a minor, I hereby consent to treatment of the minor patient.

_____ _____

Signature of Patient/Guardian Date

HIPAA Notice of Privacy Policies

Health Centered Spine & Wellness Group

600 S. Jackson Park Drive Seymour, IN 47274 812-519-2963
905 W. Keegan's Way, Ste. 7, Greensburg, IN 47240 812-663-7640

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present, or future physical or mental health or condition and related health care services.

Uses and Disclosures of Protected Health Information: Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may use or disclose, as-needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

We may use or disclose your protected health information in the following situations without your authorization. These situations include: as required by law, public health issues as required by law, communicable diseases, health oversight, abuse or neglect, food and drug administration requirements, legal proceedings, law enforcement, coroners, funeral directors, organ donation, research, criminal activity, military activity and national security, workers' compensation, inmates, required uses and disclosures. Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

Other Permitted and Required Uses and Disclosures Will Be Made Only With Your Consent, Authorization or Opportunity to Object unless required by law.

You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Your Rights:
Following is a statement of your rights with respect to your protected health information:

You have the right to inspect and copy your protected health information. Under federal law, however, you may not inspect or copy the following records; psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.

HIPAA Notice Cont.

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment, or healthcare operations. You may also request any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Your physician is not required to agree to a restriction that you may request. If the physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.

You have the right to request to receive confidential communications from us by alternative means or at all alternative means or at any alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively i.e. electronically.

You may have the right to have your physician amend your protected health information. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information. We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to Object or withdraw as provided in this notice.

Complaints
You may complain to us or the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. We will not retaliate against you for filing a complaint. This notice was published and becomes effective on/or before April 14, 2003.

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at 812-519-2963.

Signature below is only acknowledgement that you have received this Notice of our Privacy Practices.

_____	_____	_____
Signature	Print Name	Date

STATEMENT TO PERMIT PAYMENT OF MEDICAL BENEFITS TO PROVIDER

I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize my holder of medical or other information about me to release to the Social Security Administration or its intermediaries or carriers any information needed for this or a related Medicare claim. I request the payment of authorized benefits be made on my behalf. I assign the benefits payable for physician services to the physician or organization furnishing the service or authorize such physician or organization to submit to Medicare for payment to me.

I request that the payment under the medical insurance program be made to Health Centered Spine & Wellness Group.

FINANCIAL AGREEMENT
*I authorize the use of this information for insurance billing.
*I authorize the release of information to the insurance company.
*I understand that I am responsible for my charges for services.
*I authorize payment to Health Centered Spine and Wellness Group.
*I permit a copy of this authorization to be used in place of the original.

_____ _____

Signature of Patient/Guardian Date

Our Financial Policy

Thank you for choosing Health Centered Spine and Wellness Group as your health care provider. We are committed to your treatment being successful. Please understand that payment of your bill is considered a part of your treatment. The following is a statement of our Financial Policy, which we require you read and sign prior to any treatment. All patients must complete our New Patient Information form before seeing the doctor.

FULL PAYMENT IS DUE AT TIME OF SERVICE UNLESS OTHER ARRANGEMENTS ARE MADE. WE ACCEPT CASH, MASTERCARD, AND VISA. PAYMENTS PLANS ARE ALSO AVAILABLE.

Regarding Insurance

Health Centered Spine and Wellness Group may accept assignment of insurance benefits after your first visit. However, we do require your co-pay or deductible to be paid at time of service. The balance is your responsibility whether your insurance company pays or not. We cannot bill your insurance company unless you give us your insurance information. Your insurance policy is a contract between you and your insurance company. We are not a party to that contract. In the event we do accept assignment of benefits, we require you be pre-approved on our extended payment plan or provide a credit card with authorization to bill that account for the balance. If your insurance company has not paid your account in full within 45 days, the balance will automatically be transferred to your credit card or the extended payment plan. Please be aware that some, and perhaps all, of the services provided may be non-covered services and not considered reasonable and necessary under the Medicare Program and/or other medical insurance. Regarding insurance plans in which Health Centered Spine and Wellness is a participating provider: All co-pays and deductibles are due prior to treatment. In the event that your insurance coverage changes to a plan where we are not participating providers, refer to the above paragraph.

Usual and Customary Rates

Our practice is committed to providing the best treatment for our patients and the fees that we charge are usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates.

Minor Patients

The adult accompanying a minor and the parents (or guardians of the minor) are responsible for full payment. For unaccompanied minors, non-emergency treatment will be denied unless charges have been pre-authorized to an approved credit plan, Visa/MasterCard, or payment of cash at the time service has been verified.

Durable Medical Equipment

You may be able to find durable medical equipment elsewhere for a less expensive purchase price, but you agreed to purchase this equipment at Health Centered Spine and Wellness Group.

Interest

We reserve the right to charge interest in the amount of 9% monthly as provided by state law. Thank you for understanding our Financial Policy. Please let us know if you have questions or concerns.

Missed Appointments

ALL APPOINTMENTS must be cancelled within 24 HOURS of the appointment or we reserve the right to charge $25 as a MISSED APPOINTMENT CHARGE.

I have read the Financial Policy. I understand and agree to this Financial Policy.

X _____ DATE _____

Signature of Patient or Responsible Party

X _____ DATE _____

Signature of HCSWG Employee

Health Centered
SPINE & WELLNESS GROUP

To all Health Centered Spine and Wellness Group patients receiving medical massage therapy:

All patients will be allowed to miss a maximum of two (2) visits without giving twenty-four (24) hour notice. Upon missing two (2) visits, the patient may be asked to discontinue massage therapy or pay for their massage therapy in advance. We also reserve the right to charge a $25.00 fee for any missed massage therapy appointments without prior notice.

Thank you for your cooperation.

James Galyen, D.C
Brandon Maze, D.C
Eric Lux, D.C
Cassie Hackman, FNP- C
Bridgit Malone, FNP
Emilee Pollmann, DPT
Keith Dyer, PT

I understand the request of giving notice if I am not able to keep my appointment(s) with the massage therapist.

_____ _____

Patient Signature Date

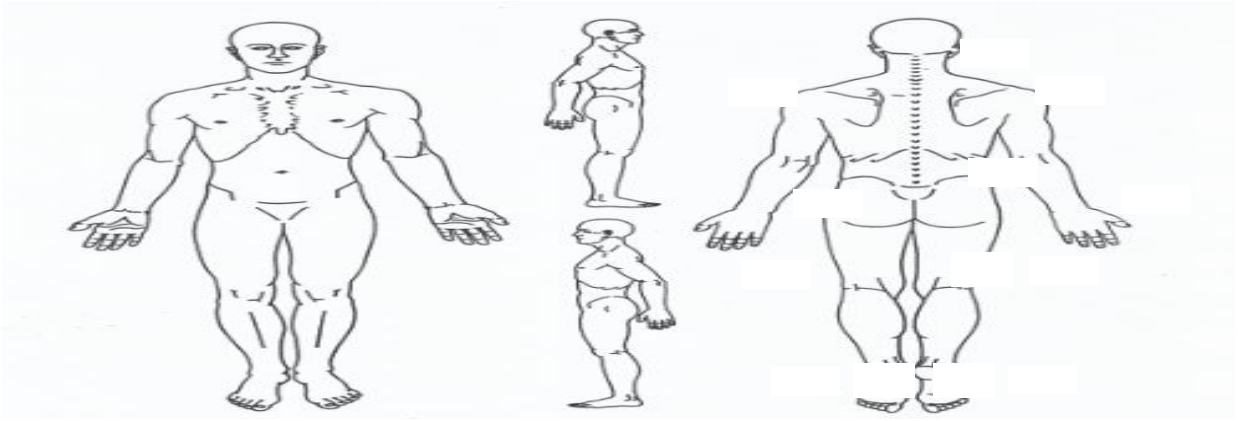
Exacerbation Form

Name: _____ Date: _____

Patient's present complaint/ problem, (Begin with most severe):

_____

On the drawing below, circle the area(s) where you have pain. Then for each area that you have circled, **designate a number from 0 to 10** (with 10 being the most pain) that corresponds to your current pain level. Please indicate where you have pain by marking the areas on your body.
Use the appropriate symbols.



SYMBOLS:

Ache: ^

Numbness: O

Pins/Needles: {}

Burning: X

Radiating Pain: /

Your pain or soreness is: Diffuse/ Spread out or Localized
Character of Pain: Achy Boring Burning Dull Lancing Numb Sharp Shooting Sore Stiff Tingling
Severity: Minimal Mild Moderate Severe Extreme
When did your pain start? _____ **Was it:** Gradually or Suddenly
What caused your pain? _____ **Auto Accident** _____ **Work Accident** _____ **Other**
Frequency of Pain: Occasional Intermittent Frequent Episodic Constant
Symptom: R/L Neck Pain - Mid Back Pain - Headaches - Low Back Pain - R/L Arm Pain - R/L Leg Pain
Have Radiating Pain to: R/L Inside/Outside Front/ Back of: Shoulder Elbow Hand Hip Knee Ankle Foot
Same problem in the past? (Yes / No) **When:** _____
Past Treatment: _____
Past Dr.: _____ **Past Testing:** _____
Better With: Sit Stand Lying down Movement Rest Use Walk Run Work Other: _____
Worse With: Sit Stand Lying down Movement Rest Use Walk Run Work Other: _____
Timing: Better/ Worse AM PM Sleeping Menstrual Cycle Weather Other _____
What home remedies have you tried to relieve your condition? _____

Have you ever had X-rays for this condition? (Yes / No)
Have you ever had, for this or any other conditions prior CAT Scan? (Yes/ No) MRI (Yes/ No)
When/ Why : _____
Have you had any surgeries since your last visit? (What/ When) 1 Daily

Have you had any accidents or broken bones since your last visit? (What/ When) _____

Are you currently taking any medication/ supplements (what/ condition) _____

What specific things do you look forward to being able to do again when this problem is solved?

NECK DISABILITY INDEX

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

Section 1 - Pain Intensity

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

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

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

Section 3 – Lifting

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

Section 4 – Reading

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

Section 5-Headaches

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

Office Use ONLY

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

Section 6 – Concentration

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

Section 7—Work

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

Section 8 – Driving

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

Section 9 – Sleeping

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

Section 10 – Recreation

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

Comments_____

%ADL

LOW BACK DISABILITY QUESTIONNAIRE (REVISED OSWESTRY)

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

Section 1 - Pain Intensity

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

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

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

Section 3 – Lifting

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

Section 4 – Walking

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

Section 5 -- Sitting

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

Office Use ONLY

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

Section 6 – Standing

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

Section 7 -- Sleeping

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

Section 8 – Social Life

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

Section 9 – Traveling

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

Section 10 – Changing Degree of Pain

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

Comments_____

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