Wise Chiropractic, Inc

Eat Wise • Move Wise • Think Wise

6332 S. Rainbow Blvd #120 Las Vegas, NV 89118 (702)248-6292

GENERAL INFORMATION

Full Name _____ Age _____ DOB ____/____/____

Home Phone _____Cell _____E-mail_____

Home Address _____ City _____ State ___ Zip _____

Marital Status S M D W Name of Spouse _____

Occupation _____ Business Phone _____

Whom may we thank for referring you to our office _____

Names and ages of children _____

Have your children received previous Chiropractic care? Yes No

Have you ever received Chiropractic care? Yes No With whom? _____

How often did you go?_____ Date of last visit: ____/_____/_____

Reason for ending care _____

Have you had spinal x-rays? Yes No What did they show?_____

Have you ever received Chiropractic Wellness care? Yes No

What hobbies or activities do you enjoy?_____

Name of current medical doctor: _____Phone # (__) _____

Date of last medical consultation _____/_____/_____ Reason _____

Do you consult your M.D. on a regular basis? Yes No If so, why? _____

For women: Are you pregnant? Yes No

GENERAL PHYSICAL TRAUMA

Have you had accidents related to the following: (Circle all that apply and give dates.)

Automobile Motorcycle Bicycle Sports Other: _____

If yes, please explain: _____

_____

Have you ever injured your nerve system or spine? (Head, neck, back, pelvis, hips): Yes No

If yes, please explain: _____

Have you broken any bones or sprained any part of your body? Yes No

If yes, please explain: _____

Have you ever had surgery or have you been hospitalized? Yes No

If yes, please explain: _____

CHEMICAL STRESS

Do you currently take any of the following? Prescription Drugs - Over the Counter - Recreational

Please list_____

Do you consume? Alcohol Coffee Tobacco Diet Soda Fast Food Candy

REASON FOR SEEKING CHIROPRACTIC CARE

What is the main reason for your visit to our office today?

_____

_____

Please circle the symptoms you either have now or have had within the past year.

Back pain	Leg/knee/foot pain	Elbow/wrist pain	Dizziness
Numbness	Asthma	Indigestion	Hormone problems
Fatigue	Chest pain	Skin problems	Sinus problems
Hair loss	Nail fungus	Constipation	Arthritis
Neck pain	Shoulder pain	Headaches	Insomnia
Cold hands/feet	Allergies	Hot flashes	High blood pressure
Ears ring	Food cravings	Earaches	Feeling old
Depression	Catch colds easy	Diarrhea	Other_____

Is your current health affecting any of the activities below? (Please circle)

Work: Yes No	**Social life:** Yes No	**Exercise:** Yes No	**School:** Yes No
Recreation: Yes No	**Walking:** Yes No	**Eating:** Yes No	**Marriage:** Yes No
Sleep Yes No	**Sitting:** Yes No	**Family:** Yes No	**Finances:** Yes No

If your current health condition was allowed to continue for the next 5 years, how do you think it would affect you? _____

Terms of Acceptance

Wise Chiropractic is a Family Wellness Center specializing in the detection, correction and prevention of vertebral subluxations (spine and nerve system problems). We do not treat or diagnose medical conditions nor dispense drugs. Today you will have a consultation and examination to evaluate the health of your spine and nerve system. The information will be analyzed. You will then be scheduled for a special visit with the doctor to discuss the results of your exam. If we accept your case, you will receive written recommendations outlining the steps needed to improve your health. Our methods include spinal adjustments, nutrition, rehabilitative exercises, orthotics, weight loss, NAET (allergy elimination) and stress reduction, etc… If accepted as a patient, I give consent to any and all treatment rendered to Myself or my Children. I have been given my HIPPA rights. They are also posted on the wall for review. I have been informed of the possible risks involved with chiropractic care.

By signing below, I understand and agree to these terms

Signature _____ Date _____/_____/_____

Signature of Parent (for minor): _____ Date _____/_____/_____

Printed Name of Parent (for minor): _____

Wise Chiropractic Inc

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Informed Consent to Chiropractic Treatment

The nature of chiropractic treatment: The doctor will use his/her hands or a mechanical device in order to move your joints. You may feel a "click" or "pop", such as the noise when a knuckle is "cracked", and you may feel movement of the joint. Various ancillary procedures may also be used.

Possible Risks: As with any health care procedure, complications are possible following a chiropractic manipulation. Complications could include fractures of bone, muscular strain, ligamentous sprain, dislocations of joints, or injury to intervertebral discs, nerves or spinal cord. Cerebrovascular injury or stroke could occur upon severe injury to arteries of the neck. A minority of patients may notice stiffness or soreness after the first few days of treatment. The ancillary procedures could produce skin irritation, burns or minor complications.

Probability of risks occurring: The risks of complications due to chiropractic treatment have been described as "rare", about as often as complications are seen from the taking of a single aspirin tablet. The risk of cerebrovascular injury or stroke, has been estimated at one in one million to one in twenty million, and can be even further reduced by screening procedures. The probability of adverse reaction due to ancillary procedures is also considered "rare".

Other treatment options which could be considered may include the following:
• *Over-the-counter analgesics.* The risks of these medications include irritation to stomach, liver and kidneys, and other side effects in a significant number of cases.
• *Medical care*, typically anti-inflammatory drugs, tranquilizers, and analgesics. Risks of these drugs include a multitude of undesirable side effects and patient dependence in a significant number of cases.
• *Hospitalization* in conjunction with medical care adds risk of exposure to virulent communicable disease in a significant number of cases.
• *Surgery* in conjunction with medical care adds the risks of adverse reaction to anesthesia, as well as an extended convalescent period in a significant number of cases.

Risks of remaining untreated: Delay of treatment allows formation of adhesions, scar tissue and other degenerative changes. These changes can further reduce skeletal mobility, and induce chronic pain cycles. It is quite probable that delay of treatment will complicate the condition and make future rehabilitation more difficult.

Unusual risks: I have had the following unusual risks of my case explained to me.
I have read the explanation above of chiropractic treatment. I have had the opportunity to have any questions answered to my satisfaction. I have fully evaluated the risks and benefits of undergoing treatment. I have freely decided to undergo the recommended treatment and herby give my full consent to treatment.

_____	_____	_____
Printed Name	**Signature**	**Date**

AUTHORIZATION FOR RELEASE OF INFORMATION

Current Address:

Street: _____ City: _____ State: _____ Zip: _____

Phone: _____ Reason for Disclosure: _____

Name of Recipient: _____ Phone: _____ Fax: _____

Street: _____ City: _____ State: _____ Zip: _____

Dates of Treatments being disclosed: From: _____ To: _____

I hereby authorize the use or disclosure of my health information as described below. I understand that this authorization is voluntary and I may refuse to sign it. I understand that the information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer protected by federal privacy regulations.

Patient Name: _____ Social Security Number: _____

Date of Birth: _____ Medical Records Number (if known): _____

Facility name, title and name of person releasing my health information:

Person(s) receiving my health information (Example: "My employer"):

Description of information being disclosed for the following date(s) of service:

☐ Complete Health Record ☐ Radiology Reports ☐ Discharge Summary ☐ Consultation Reports
☐ History and Physical Exam ☐ Abstract/Pertinent Information ☐ Progress Notes ☐ Laboratory Tests
☐ Emergency Department Record ☐ HIV/AIDS Information ☐ Drug and Alcohol Treatment Information
☐ Other: _____

Purpose of the Disclosure (Example: "At the request of the patient"):

Expiration: If the health information to be disclosed contains HIV/AIDS or drug and alcohol abuse treatment records, this authorization expires in 60 days. Otherwise, you may select either of the following expiration events:

☐ 1 year from the date in which, I, or my legal representative, signs this authorization;
☐ upon the happening of the following event: _____
(Example: "Upon release of the above records.")

Right to Revoke: I understand that I may revoke this authorization at any time by providing written notice to the Director of Medical Records at the address of the facility in which I received my medical care. I understand that my revocation won't have any affect on any action taken by the organization before they received the revocation and is not effective if the authorization was obtained as a condition of obtaining insurance coverage and the insurer has the legal right to contest a claim under my insurance policy.

I understand that the organization will not condition my treatment, payment, enrollment in a health plan, or eligibility for benefits on my signing this authorization.

I understand that I have the right to inspect or copy the health information to be used or disclosed pursuant to this authorization.

TO BE COMPLETED BY THE ORGANIZATION IF THIS AUTHORIZATION IS FOR MARKETING: The organization will receive financial or in-kind compensation in exchange for using or disclosing the health information described above.

☐ Yes ☐ No

Signature: _____ Date: _____

If signed by the patient's legal representative:

Printed name of representative: _____

Relationship to the patient: _____

PROVIDE COPY TO THE PATIENT AND MAINTAIN A COPY IN THE PATIENT'S RECORD

Wise Chiropractic, Inc

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MEDICAL LIEN

I, the undersigned patient (or legal guardian of a minor), grant to Wise Chiropractic, Inc. (hereafter "medical facility") a lien upon the recovery of any and all proceeds from any source obtained through settlement, judgment, for any medical services rendered to me or the minor, for treatment of injuries sustained or the exacerbation of any medical condition(s) (hereafter "treatment") that I or the minor have indicated, believe or did in fact arise out of an incident that occurred on or about the date set forth below (hereafter "incident"). I further authorize the medical facility to furnish my attorney with a full report of the examinations, diagnoses, treatments, prognoses, as well as billings for treatment from this incident. I hereby notify and authorize you, my attorney, to pay directly to the medical facility the unpaid amount due for services rendered.

I understand that apart from this lien, I am directly and fully responsible to the medical facility for all medical bills submitted by it for services rendered, even for bills incurred for the minor (as indicated below) who may reach the age of majority, for which I may be required to make a lump sum or periodic payments, at the election of the medical facility. This lien is made solely for said medical facility's additional protection, and in consideration of its awaiting payment. Except as otherwise provided below, I intend for this lien to continue until all charges have been satisfied. I agree that the statute of limitations of my obligation to pay is tolled and does not begin to run while the medical facility is awaiting payment by way of this lien. I further understand that the payment of services is not contingent upon any settlement, judgment, or verdict that the minor or I may eventually recover.

Except as provided below, I agree never to rescind this lien, and I do not grant any attorney that may represent the minor or me the right to rescind it. However, if my first attorney does not promptly sign, acknowledge and return this lien to the medical facility within 10 (ten) days of receipt of this lien, or if the first attorney for any reason (e.g., withdraws, resigns, is released by me, or substituted by another attorney) no longer represents me or the minor child for injuries arising from this incident, then the Irrevocable Assignment of Proceeds that I have signed with this medical facility supersedes this lien and takes immediate effect. Alternatively, if an attorney modifies this lien in any way, then the Assignment of Proceeds supersedes this lien and takes immediate effect when the modification occurs. I agree to promptly notify medical facility of any change of my address or change or addition of attorney(s).
To my attorney: Please acknowledge this medical lien by signing below and returning it to the medical facility's office.

Date of Incident: _____

_____
Print Name

Date: _____

_____
Signature of Patient or Legal Guardian of Minor

I, the undersigned attorney, state that I am the attorney of record for the this patient; I acknowledge that I am in receipt of this lien; and I agree to observe its terms by withholding the sums from any settlement, judgment or verdict that are owed to the medical facility, for their compensation or benefit. I also agree to promptly (1) notify the medical facility if I discontinue representation of this patient/client, and to (2) provide any subsequent attorney of the patient for this incident a copy of this lien, along with all of the medical facility's records and billings in my or my law firm's possession. In the event this lien is litigated, the prevailing party will be awarded attorney's fees and costs.

_____ _____

Attorney Signature Attorney Name

Please sign, date and return one copy to medical facility's office within 10 days after receipt. Also keep one for your records

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Patient:_____

DOB: _____ SSN (last four):_____ DL State and No:_____

Insurance Company(ies):_____

Claim No(s):_____

Irrevocable Assignment of Proceeds

I, the undersigned Patient (or legal guardian of a minor), (also referred to below as "Patient") of Wise Chiropractic, Inc. ("Medical Facility"), **forever and irrevocably assign any and all proceeds** that Patient receives from the Insurance Company(ies) above-states, to be paid directly to the Medical Facility for services rendered to Patient in connection with the Date of Incident indicated below. I authorize and direct Insurance Company(ies) to withhold from any settlement, judgment or verdict the full amount of the unpaid medical services rendered to Patient by Medical Facility. I understand and agree that said law firm (CRAIG K. PERRY & ASSOCIATES) is authorized to contact me on behalf of Medical Facility to obtain information concerning the facts and status of Patient's case (e.g., completion of care, settlement status, insurance company information, etc.).

I authorize and direct Medical Facility to furnish the Insurance Company(ies) with all reports, finding, interpretations, impressions, treatments, diagnoses, or diagnostic studies that Medical Facility may perform on Patient in connection with any injury in which Patient was involved on or about the Date of Incident.

I fully understand that I am directly and fully responsible to Medical Facility for all medical bills associated with the services rendered to me, whether or not there is any financial recovery from the Insurance Company(ies) or other source. I also understand and agree that this Assignment tolls any statute of limitations that commences the time to take action to collect amounts I owe Medical Facility for any unpaid services rendered, and that my obligation to pay these bills are not contingent of obtaining a recovery of proceeds in Patient's care.

If Patient does not have an attorney and later decides to retain one then I agree to promptly (1) furnish Medical Facility with contact information concerning that attorney and (2) notify that attorney concerning existence of this Irrevocable Assignment of Proceeds. In the event that Patient is paid by way of settlement, judgment or verdict, I agree NOT TO ACCEPT any money from either the Insurance Company(ies) or Patient's attorney from any of the proceeds that I have assigned to and is intended for this Medical Facility. Medical Facility shall be paid in full out of the first proceeds received paid by Insurance Company(ies) or the attorney.

_____ _____

Date of Incident Print Name of Patient

_____ _____

Date Signature of Patient or Legal Guardian of Minor Patient

Medical Facility acknowledges that the law firm of CRAIG K. PERRY & ASSOCIATED is the Medical Facility's attorney and grants the law firm limited power of attorney to enforce this Irrevocable Assignment of Proceeds, and to receive, endorse and deposit into its trust account any funds received.

_____ _____

Date Authorized Representative of Medical Facility

Wise Chiropractic, Inc

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Patient Name: _____

DOB: _____ SSN (last four): _____ DL State and No. _____

Insurance Company(ies): _____

Claim No(s).: _____ _____

Irrevocable Assignment of Proceeds

I, the undersigned Patient (or legal guardian of a minor), (also referred to below as "Patient") of Wise Chiropractic, Inc. ("Medical Facility"), **forever and irrevocably assign any and all proceeds** that Patient receives from the Insurance Company(ies) above-stated, to be paid directly to Medical Facility's attorney, CRAIG K. PERRY & ASSOCIATES, for services rendered to Patient in connection with the Date of Incident indicated below. I authorize and direct Insurance Company(ies) to withhold from any settlement, judgment or verdict the full amount of the unpaid medical services rendered to Patient by Medical Facility. I understand and agree that said law firm is authorized contact me on behalf of Medical Facility to obtain information concerning the facts and status of Patient's case (e.g., completion of care, settlement status, insurance company information, etc.).

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I fully understand that I am directly and fully responsible to Medical Facility for all medical bills associated with the services rendered to me, whether or not there is any financial recovery from the Insurance Company(ies) or other source. I also understand and agree that this Assignment tolls any statute of limitations that commences the time to take action to collect amounts I owe Medical Facility for any unpaid services rendered, and that my obligations to pay these bills are not contingent on obtaining a recovery of proceeds in Patient's case.

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Date of Incident: _____ _____
Print Name of Patient

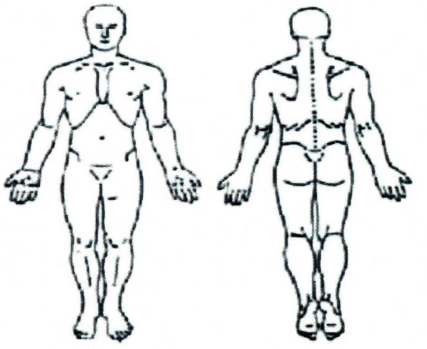
Date: _____ _____
Signature of Patient or Legal Guardian of Minor Patient

Medical Facility acknowledges that the law firm of CRAIG K. PERRY & ASSOCIATES is the Medical Facility's attorney and grants the law firm limited power of attorney to enforce this Irrevocable Assignment of Proceeds, and to receive, endorse and deposit into its trust account any funds received.

_____ _____
Date Authorized Representative of Medical Facility

Patient Health Questionnaire

NAME _____ DATE _____



PLEASE MARK THE AREAS OF YOUR COMPLAINT OR SYMPTOMS

What is the primary reason for your visit today: _____

1. Please describe your complaint: •Sharp Pain •Dull Pain •Ache •Weak •Throbbing •Numbness & Tingling •Shooting •Burning
2. Frequency: •Constant (76-100%) •Frequent (51-75%) •Occasional (26-50%) •Intermittent (25% or less)
3. Indicate intensity of your pain at its lowest and highest level (No Pain)0 1 2 3 4 5 6 7 8 9 10 (Most Pain)
4. Are your symptoms •Decreasing •Not changing •Getting worse
5. Symptoms are worse in the •Morning •Afternoon •Night •Same all day.
6. Does the problem/pain radiate or travel(shoot) to any other areas in your body? Where? _____
7. Do you have any numbness or tingling in your body? Where? _____
6. When did your problem begin: GIVE SPECIFIC DATE IF POSSIBLE? _____
7. Describe how your problem began: _____
8. Have you been treated for this condition before •Yes •No
   If yes, by whom? •Chiropractor •Medical Doctor •Physical Therapist • Massage Therapist •Other _____ Are you currently being seen? • Yes •No If so, How often and what treatments _____
9. What makes your problem better? •Nothing •Lying down •Walking •Standing •Sitting •Movement/Exercise •Inactivity
10. What makes your problem worse? •Nothing •Lying down •Walking •Standing •Sitting •Movement/Exercise •Inactivity
11. How would you rate your general stress level? •Little or No Stress •Minimal Stress •Moderate Stress •Greatly Stressed
12. General Physical Activity: •No regular exercise •Light exercise •Moderate exercise •Strenuous exercise
13. Are your complaints affecting your ability to be active? Check appriote box below

•No effect •Able to perform light duty work and household tasks. •Need limited assistance to perform tasks. •Need assistance often. •Have a significant inability to function without assistance. • I am totally disabled (impaired). Cannot care for self.

14. Physical activity at work: •Sitting 50% or more of work day •Light manual labor •Manual labor •Heavy manual labor •Repeatetive motion
15. Has your work status changed because of this complaint •YES •NO
16. What is your current work status? •Full time, no restrictions. •Full time, with restrictions. •Part time, no restrictions. •Part time, with restrictions. • Off work due to restrictions. •Unemployed. •Retired. restrictions •Full time homemaker. •Full time student
17. Do You Have a Permanent Disability: Location _____ Rating Percentage _____ % Date received _____

Automobile Accident History Form

Your Name: _____ Today's Date: _____

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

Road conditions at the time of accident: WET DRY ICY OTHER

Did the police come to the accident scene? YES NO

Is there a report? YES NO Did you request the report? YES NO

Did you go to the hospital? YES NO _____

If yes, what Hospital? _____

How did you get to the hospital? _____

What parts of your body were x-rayed at the hospital? _____

What did the hospital do for your injuries? _____

How long did you stay at the hospital? _____

What bleeding cuts did you sustain during this accident? _____

What bruises did you sustain during this accident? _____

Where were you seated in the vehicle?

DRIVER FRONT PASSENGER LEFT REAR MIDDLE REAR RIGHT REAR

Were you aware of the approaching collision prior to impact, or did impact catch you by surprise?

AWARE SURPRISED

Did you lose consciousness (black out) upon impact? YES NO; How long:

Did you experience a flash of light or explosion in your head? YES NO

Did you become one of the following from the accident?

CONFUSED	DISORIENTED	LIGHTHEADED	DIZZY
NAUSEATED	BLURRED VISION	RING/BUZZ IN EARS	

If you still have any of those symptoms, which ones? _____

_____

Are you currently suffering from any of the following:

DIFFICULT CONCENTRATING	RESTLESSNESS	SLEEPLESSNESS
REDUCED TOLERANCE TO HEAT	DIFFICULTY WITH MEMORY	CHILLS
REDUCED TOLERANCE TO ALCOHOL	IRRITABLE	FORGETFULNESS

How far is the top of the headrest or seat back from the top of your head (approximately):

_____ inches above or below

Were you wearing a seat belt? YES NO

If yes, was it a LAP SEATBELT or a SHOULDER-LAP SEATBELT

List the year, make and model of the the vehicle you were in:

Year_____ Make _____ Model _____

Was you car stopped at the time of impact? YES NO

If yes, was the driver's foot also on the brake? YES NO

If no, then estimate the speed of the vehicle you were in: _____mph

If your vehicle was moving at the time of impact, was it:

Slowing Down? YES NO

Gaining Speed? YES NO

Traveling at a steady rate of speed? YES NO

On what part of the automobile did your following body parts hit?

Head Hit _____ chest hit _____

right/left shoulder hit _____ right/left arm hit _____

right/left hip hit _____ right/left leg hit _____

right/left knee hit _____ other _____

Did you receive any injury or bruise from the seat belt? YES NO

If YES then describe: _____

What is the estimated cost damage to the vehicle you were in? $ _____

Which of the following car parts broke during the accident?

WINDSHIELD FRONT SEAT BACK RIGHT/LEFT SIDE WINDOW

STEERING WHEEL OTHER

Was the trunk of your body pointed straight forward at the time of the collision? YES NO

If no, how was it turned? _____

Was you head pointed straight forward? YES NO

If no, what direction was it turned and by how much? _____

What is the year, make and model of the the other vehicle?

Year _____ Make _____ Model _____

Was the other vehicle moving at the time of the collision? YES NO

If yes, what was its approximate speed? _____mph

If the other vehicle was moving at the time of the collision, was it:

SLOWING DOWN GAINING SPEED TRAVELING AT A STEADY SPEED

Please describe, to the best of your knowledge, what happened during this accident:

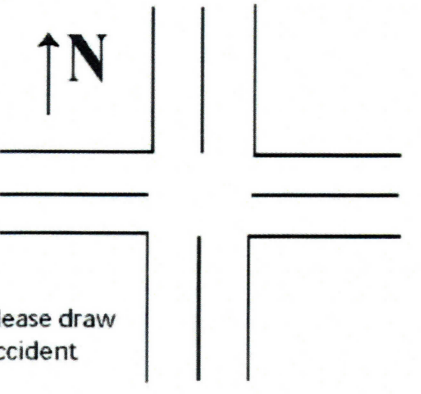
_____

_____

_____

_____

_____



Thank you for taking the time to fill out this form.

NECK PAIN AND DISABILITY INDEX

Patient Name:_____ Date:_____/_____/_____

Please read instructions carefully.
This questionnaire has been designed to give the doctor information as to how your neck pain has affected your ability to manage everyday life. Please read all statements in each section and then mark the box that 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 worse than 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 objects without any extra pain.
- ❑ I can lift heavy objects, but it gives extra pain.
- ❑ Pain prevents me from lifting heavy objects off the floor but I can manage if they are conveniently positioned on a table.
- ❑ Pain prevents me from lifting heavy objects but I can manage light to medium objects.
- ❑ I can lift very light objects.
- ❑ 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 light pain in my neck.
- ❑ I can read as much as I want to with moderate pain in my neck.
- ❑ I can't read as much as I want to 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 headache at all.
- ❑ I have slight headaches which come infrequently.
- ❑ I have moderate headaches which come infrequently.
- ❑ I have moderate headaches which come frequently.
- ❑ I have severe headaches which come frequently.
- ❑ I have headaches almost all the time.

SECTION 6 - CONCENTRATION

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

SECTION 7 - WORK

- ❑ I can do as much work as I want.
- ❑ I can do only 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 work at all.
- ❑ I can't do any work at all.

SECTION 8 - DRIVING

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

SECTION 9 - SLEEPING

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

SECTION 10 - RECREATION

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

NECK PAIN SCALE

Rate the severity of your **Neck Pain** by indicating on the following scale.

Absence I----------I **Extreme**

LOW BACK PAIN AND DISABILITY INDEX (REVISED OSWESTRY)

Patient Name: _____ Date: _____/_____/_____

Please read instructions carefully.
This questionnaire has been designed to give the doctor information as to how your low back pain has affected your ability to manage everyday life. Please read all statements in each section and mark the box which most closely describes your problem.

SECTION 1 - PAIN INTENSITY

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

SECTION 2 - PERSONAL CARE

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

SECTION 3 - LIFTING

- ❑ I can lift heavy objects without any extra pain.
- ❑ I can lift heavy objects, but it gives extra pain.
- ❑ Pain prevents me from lifting heavy objects off the floor.
- ❑ Pain prevents me from lifting heavy objects off the floor but I can manage if they are conveniently positioned on a table.
- ❑ Pain prevents me from lifting heavy objects but I can manage light to medium objects.
- ❑ I can only lift very light objects at the most.

SECTION 4 - WALKING

- ❑ I have no pain on walking.
- ❑ I have some pain but it does not increase with distance.
- ❑ I cannot walk more than one mile without increasing pain.
- ❑ I cannot walk more than 1/2 mile without increasing pain.
- ❑ I cannot walk more than 1/4 mile without increasing pain.
- ❑ I cannot walk at all without increasing pain.

SECTION 5 - SITTING

- ❑ I can sit in any chair as long as I like.
- ❑ I can 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 half an hour.
- ❑ Pain prevents me from sitting more than 10 minutes.
- ❑ I avoid sitting because it increases pain.

SECTION 6 - STANDING

- ❑ I can stand as long as I want without pain.
- ❑ I have some pain on standing but it does not increase with time.
- ❑ I cannot stand for longer than one hour without increasing pain.
- ❑ I cannot stand for longer than 1/2 hour without increasing pain.
- ❑ I cannot stand longer than 10 minutes without increasing pain.
- ❑ I avoid standing because it increases the pain.

SECTION 7 - SLEEPING

- ❑ I get no pain in bed.
- ❑ I get pain in bed but it does not prevent me from sleeping well.
- ❑ Pain reduces my normal sleep by 1/4 each night.
- ❑ Pain reduces my normal sleep by 1/2 each night.
- ❑ Pain reduces my normal sleep by 3/4 each night.
- ❑ Pain prevents me from sleeping at all.

SECTION 8 - SOCIAL LIFE

- ❑ My social life is normal and gives me no pain.
- ❑ My social life is normal but increases the degree of pain.
- ❑ My social life is unaffected by pain apart form limiting more energetic interests.
- ❑ Pain has restricted my social life and I do not go out very often.
- ❑ Pain has restricted my social life to my home.
- ❑ I have hardly any social life because of the pain.

SECTION 9 - DRIVING / RIDING IN CAR, ETC.

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

SECTION 10 - CHANGING DEGREE OF PAIN

- ❑ My pain is rapidly getting better.
- ❑ My pain fluctuates but overall is definitely getting better.
- ❑ My pain seems to be getting better but improvement is slow at present.
- ❑ My pain is neither getting better or worse.
- ❑ My pain is gradually worsening.
- ❑ My pain is rapidly worsening.

LOW BACK PAIN SCALE

Rate the severity of your **Low Back Pain** by indicating on the following scale.

Absence I----------I **Extreme**