INITIAL HEALTH STATUS

Milwaukie Chiropractic Center

Keith D. Johns, D.C. • Joseph Brignac III, D.C. • Theresa White, D.C. • Tanner Johns, D.C. • Nicole Brown, D.C

Patient Name: _____ **Birthdate:** _____ **Sex: M / F**

DESCRIBE YOUR CURRENT PROBLEM AND HOW IT BEGAN:

_____

_____

_____

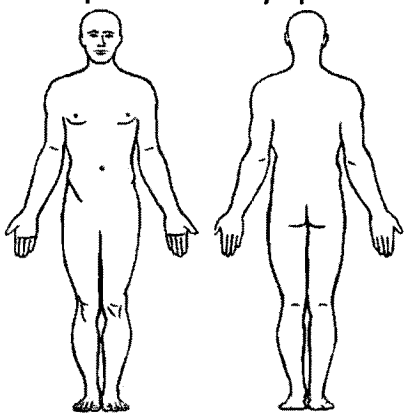
DATE PROBLEM BEGAN: _____

Is this ☐ Work Related or ☐ Auto Related?

How do you feel today? _____

(No Pain) **0 1 2 3 4 5 6 7 8 9 10** *(Excruciating)*
(Please Circle)

Mark an X on the picture where you have pain or other symptoms



How often are your symptoms present? ☐ 0 - 25% ☐ 26 - 50% ☐ 51 – 75% ☐ 76 – 100%

Can you perform your daily activities? ☐ Yes ☐ No

If **NO**, describe: _____

HAVE YOU HAD ANY SPINAL X-RAYS, MRI OR CT SCANS? ☐ **Yes Date(s) taken:** _____ ☐ **No**

What areas were taken? _____

FAMILY HISTORY ☐ **Cancer** ☐ **Diabetes** ☐ **High Blood Pressure** ☐ **Cardiovascular Problems/Stroke**

Past	Present	CHECK ALL THAT APPLY	Past	Present	
☐	☐	Numbness in Groin/Buttocks	☐	☐	Visual Disturbances
☐	☐	History of Recent Infection	☐	☐	Low/Mid Back Pain
☐	☐	High Blood Pressure	☐	☐	Frequent Urination
☐	☐	Corticosteroid Use	☐	☐	Prostate Problems
☐	☐	Dizziness/Fainting	☐	☐	Epilepsy/Seizures
☐	☐	Urinary Retention	☐	☐	Tobacco Use
☐	☐	Birth Control Pills	☐	☐	Alcohol Use
☐	☐	Aortic Aneurysm	☐	☐	Neck Pain
☐	☐	Cancer/Tumor	☐	☐	Arthritis
☐	☐	Osteoporosis	☐	☐	Pregnancy, # of births:
☐	☐	HIV/AIDS	☐	☐	Abnormal Weight Gain Loss
☐	☐	Diabetes	☐	☐	Surgeries/Medications *Please List:*
☐	☐	Trauma			_____
☐	☐	Fever			_____

I certify that the above information is complete and accurate. If the health plan information is not accurate, or if I am not eligible to receive a health care benefit through this provider, I understand that I am liable for all charges for services rendered and I agree to notify the doctor immediately whenever I have changes in my health condition or health plan coverage in the future

Patient Signature _____ **Date** _____

POLICY AND PATIENT DATA

- **PAYMENT** is due at the time of service, unless other arrangements have been made
- An **INSURANCE CONTRACT** is between the patient and the patient's insurance company; therefore, it is the responsibility of the patient to keep the account current
- Patients involved in **LITIGATION** (lawsuits) are, as others, responsible for their services at the clinic
- We reserve the right to **BILL FOR MISSED APPOINTMENTS**
- Personal cleanliness is requested do to the close interpersonal nature of this work
- **SMOKING IS PROHIBITED**

PATIENT INFORMATION ☐MALE ☐FEMALE ☐ SINGLE ☐ MARRIED ☐ OTHER

PATIENT'S NAME (Last, First, Middle Initial)			DATE OF BIRTH	AGE	SSN	
PATIENT'S ADDRESS (No., Street)			DRIVER'S LICENSE NUMBER	STATE OF ISSUE	HEIGHT	WEIGHT
CITY	STATE	ZIP CODE	EMAIL ADDRESS		WERE YOU REFERRED? ☐Y ☐N If yes, by:	
HOME PHONE NUMBER (Include Area Code)	WORK PHONE NUMBER (Include Area Code)		MOBILE PHONE NUMBER (Include Area Code)		OCCUPATION	
EMPLOYER OR SCHOOL NAME	FULL TIME PART TIME		EMPLOYER/SCHOOL ADDRESS			

EMERGENCY CONTACT INFORMATION *In the event of an emergency, who should we contact?*

NAME	RELATIONSHIP	DAYTIME PHONE NUMBER (Include Area Code)

INSURANCE SUBSCRIBER INFORMATION (CIRCLE ONE IF APPLICAPLE) ☐ SPOUSE ☐ PARENT ☐ OTHER:

NAME (Last, First, Middle Initial)		DATE OF BIRTH	AGE	SSN
HOME PHONE NUMBER (Include Area Code)	MOBILE PHONE NUMBER (Include Area Code)	EMAIL ADDRESS		
OCCUPATION	EMPLOYER OR SCHOOL NAME	EMPLOYER/SCHOOL ADDRESS		

PATIENT SIGNATURE X	DATE

THE ABOVE SIGNATURE IS AN ACKNOWLEDGMENT THAT I HAVE READ THE POLICIES ABOVE AND AGREE TO ABIDE BY THEM

GUARDIAN'S SIGNATURE (IF APPLICABLE) X	DATE

IF THE PATIENT IS A MINOR: AS LEGAL GUARDIAN, PERMISSION IS HEREBY GIVEN BY ME, TO YOUR PROVIDER TO TREAT THE PATIENT.

YOU ARE AUTHORIZED TO RELEASE ANY INFORMATION YOU DEEM APPROPRIATE CONCERNING MY PHYSICAL CONDITION(S) TO ANY INSURANCE COMPANY, ATTORNEY, PRIMARY CARE PROVIDERS, OR ADJUSTER IN ORDER TO PROCESS ANY CLAIM FOR REIMBURSMENT OF CHARGES INCURRED BY ME AS A RESULT OF PROFESSIONAL SERVICES RENDERED BY YOU, AND I HEREBY RELEASE KEITH D. JOHNS, D.C., P.C. DBA MILWAUKIE CHIROPRACTIC CENTER, ITS PROVIDERS AND ASSOCIATES OF ANY CONSEQUENCES THEREOF.

PATIENT SIGNATURE	DATE

MY SIGNATURE IS AN ACKNOWLEDGMENT THAT I HAVE READ THE ABOVE STATEMENT AND PERMISSION IS HEREBY GIVEN BY ME

OFFICE POLICIES & FINANCIAL AGREEMENT

Welcome to Milwaukie Chiropractic Center. We are committed to providing you with the best possible services. We also want you to understand our policies regarding professional fees, your financial responsibility, and our billing practices. Please feel free to ask the office staff or your doctor for clarification should you have any questions. A copy of this signed financial agreement will be given to you for your records upon request.

Professional Fees

Our fee schedule is based on prevailing standards in the community. Some fees vary slightly because they are governed by contracts with managed health care companies. Fees may be charged for, but not limited to:

1. Examination and consultation
2. Medical services rendered:

Electrical Muscle Stimulation	Ultrasound	Lab
Massage Therapy	Traction	X-rays
Manipulation	Exercise Instruction	Supplements

3. Telephone consultation with attorneys or other providers regarding a case
4. Appointments that are broken without notice or rescheduled with less than a 12 hour notice

Financial Agreement

The health insurance contract is between the patient and their insurance company, therefore, the patient is responsible for payment of all fees incurred regardless of insurance coverage. As a courtesy to our patients we bill all insurance companies if chiropractic services are covered. If using health insurance, complete information about coverage and a copy of the insurance card must be supplied. If part of a managed health care plan, all co-payments are due at time of service. If your insurance has not paid for covered services within 60 days of the service, a full payment to this office will be needed with the ability to be reimbursed when insurance pays.

Monthly statements showing any balances due are run and sent out to patients within the first week of each month. After three months of being billed with no payment the patient account will become delinquent and may be referred for collection if payment is not received in a timely manner.

Patients that are not insured are expected to pay fees in full at the time of service unless other arrangements have been made with the office. Payments accepted are cash, check, Visa, Mastercard, or money orders.

I acknowledge that I am financially responsible for all charges whether or not they are covered by insurance. If I am using my health insurance benefits, I hereby assign my insurance benefits to Milwaukie Chiropractic Center and I authorize the staff to provide to my insurance company any information regarding myself or my minor child that is required or necessary to for the submission of a claim for services provided. I understanf that I have access to any all information provided. I agree to the above terms and conditions and I acknowledge that I have received a copy of these office policies and financial agreement upon request.

PATIENT NAME _____

PATIENT SIGNATURE	DATE

INFORMED CONSENT TO CHIROPRACTIC TREATMENT

Milwaukie Chiropractic Center

PLEASE READ THIS CONSENT FORM. IF THERE ARE ANY QUESTIONS FEEL FREE TO DISCUSS WITH THE DOCTOR.

Clinicians who use spinal manual therapy techniques - e.g. joint adjustment, manipulation, or mobilization - are required to inform patients that there are risks associated with such treatment, though rare. In particular:

1. While rare, some patients have experienced muscle and ligament sprains or rib fractures following spinal manipulation therapy.
2. There have been reported cases of injury to a vertebral artery following neck adjustment, manipulation and mobilization. Such vertebral artery injuries may on rare occasions cause stroke which may result in serious neurological injury and/or physical impairment. This form of complication is an extremely rare event occuring about one per one million treatments.
3. There have been reported cases of disc injuries following spinal manipulation therapy, although no specific scientific study has ever demonstrated that such injuries are caused or may be caused by adjustments or manipulative techniques and such cases are also very rare.

Treatment provided at this clinic including spinal adjustment, manipulation and/or mobilization have been subject of much research over many years and have been demonstrated to be appropriate and effective treatments for many common forms of spinal pain, pain in the shoulders/arms/legs, headaches and other similar symptoms. Treatment provided at this clinic may also contribute to your overall well-being. The risk of injury or complications from manual treatment is substantially lower than the risk associated with many medications, other treatments and procedures frequently given as alternative treatments for the same forms of musculorskeletal pain and other associated syndromes.

The doctor will evaluate your individual case; provide an explanation of care and a suggested treatment plan or alternatively a referral for consultation and/or further evaluation if deemed necessary.

Acknowledgment: I acknowledge I have discussed or have been given the opportunity to discuss with the doctor the nature of chiropractic treatment in general and my treatment in particular as well as the contents of this consent.

Consent: I consent to the chiropractic treatment(s) offered or recommended to me by the doctor including joint adjustment or manipulation or mobilization to the joints of my spine (neck and back), pelvis and extremities (shoulder, upper and lower limbs). I intend this consent to apply to all my present and future treatments at this clinic.

PATIENT NAME _____

PATIENT SIGNATURE	DATE

PARQ _____ _____ DATE _____

PROVIDER SIGNATURE

NOTICE OF PRIVACY PRACTICES

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.

The privacy of your medical information is important to us. We understand that your medical information is personal, required to provide you with quality care and to comply with certain legal requirements. We also describe your rights and certain duties we have regarding the use and disclosure of medical information. By law we are required to keep your medical information private, give you this notice describing our legal duties, privacy practices, and your rights regarding your medical information. We have the right to change our privacy practices and the terms of this notice anytime, provided the changes are permitted by law. Before we make an important change in our privacy practices we will change this notice and make the new notice available to you upon request. Any specific written authorization you provide may be revoked by writing to us.

USE AND DISCLOSURE OF MEDICAL INFORMATION

Your protected health information may be used and disclosed by our office to others outside of our office who are involves in your care and treatment for the purpose of providing health care services to you, e.g., referrals to other physicians. Your protected health information may also be used and disclosed to pay your healthcare bills and to support the operation of the physician's practice, e.g., insurance companies often require chart notes for payment or authorization of treatment, managed care groups require release of information for physician performance evaluation.

OTHER PERMITTED AND REQUIRED USES AND DISCLOSURES THAT MAY BE MADE WITHOUT YOUR AUTHORIZATION OR OPPORTUNITY TO AGREE OR OBJECT:

- **Required by law**: We may disclose your protected health information to the extent that the use or disclosure is required by law
- **Public Health**: Disclosure for public health activities and purposes to a public health authority, e.g., to prevent or control a disease.
- **Communicable Disease**: Disclosure pertaining to risk of contracting or spreading a communicable disease or condition.
- **Health Oversight**: Disclosure to agencies authorized by law such as government agencies, regulatory programs, etc. for audits, inspections, investigations, etc.
- **Abuse or Neglect**: Disclosure to a public health authority authorized by law to receive reports of child abuse or neglect. In addition, we may disclose this information if we believe you have been a victim of abuse, neglect or domestic violence to the government entity or agency authorized to receive this information and will be made consistent with applicable state and federal laws.
- **Food and Drug Administration**: Disclosure for the purpose of quality, safety, or effectivness of FDA related products or activities.
- **Legal Proceedings**: Disclosure for judicial or administrative proceedings, in response to a court order, response to subpoena, discovery request or their lawful process.
- **Law Enforcement**: Disclosure for legal legal processes, limited information for identification and location purposes, pertaining to victims of a crime, suspicion that death has occurred as a result of criminal conduct, if a crime occurs on our premises, medical emergency (not on our premises) that it is likely a crime has occurred.
- **Coroners, Funeral Directors, Organ Donation**: Disclosure for identification purposes, cause of death or for the entity to perform their dutied authorized by law. Disclosure also for cadaveric organ, eye or tissue donation purposed.
- **Research**: Disclosure to researchers when approved by institutional review board which has established the research protocols to ensure the privacy of your protected health information.
- **Criminal Activity**: Disclosure consistent with applicable federal and state laws.
- **Military Activity and National Security**: Disclosure for Armed Forces personnel for activities deemed necessary by military command authorities, determination of eligibilty benefits by the Department of Veteran Affairs, foreign military authority if you are a member of that service. Disclosure to authorized federal officials for national security and intelligence activities.
- **Workers' Compensation**: Disclosure as authorized to comply with workers' compensation laws and other similar programs.
- **Inmates**: Disclosure for correctional facilities.

OTHER PERMITTED AND REQUIRED USES AND DISCLOSURES THAT REQUIRE PROVIDING YOU THE OPPORTUNITY TO AGREE OR OBJECT:

Others Involved in Your Health Care or Payment for Your Care: Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person you identify, your protected health information that directly relates to that person's involvement in your health care. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it's in your best interest based on our professional judgement. We may use or disclose this information to notify or assist in notifying a family member, personal representative or any other person responsible for your care of your location, general condition or death. Finally, we may use or disclose this information to an authorized public or private entity to assist in disaster relief efforts and coordinate uses and disclosures to family or other individuals involved in your health care.

YOUR INDIVIDUAL RIGHTS:

- **The Right to Inspect and Copy Your Protected Health Information**: You must make your request in writing and submit it to the contact listed at the end of this notice. If you request copies, there is a charge of $3.50 for each page, plus postage if you would like the copies mailed to you.
- **You Have the Right to Request a Restriction of Your Protected Health Information**: You may ask us not to use or disclose any part of your information not to be disclosed to family members or friends who may be involved in your care or for notification purposes as described in the Notice of Policy Practices. Your request must state the specific restrictionand to whom you want the restrictions to apply. This must be requested in writing. Your physician is not required to agree to a restriction, however, if they do agree that restriction may be voided for the purposes of providing emergency treatment.
- **You May Have the Right to Have Your Physician Amend Your Protected Health Information**: You may request an amendment in your health record. In certain cases we may deny this and you will have the right to file a statement of disagreement to which we may prepare a rebuttal and provide you a copy of any such rebuttal. Please inform the contact at the end of this notice for specific questions about amending records.
- **You Have the Right to Receive an Accounting of Any Certain Disclosures We Have Made of Your Protected Health Information**: This right applies to disclosures for which other than treatment, payment or health care operations as described in this Notice of Privacy Practices. It excludes disclosures made to you, if authorized by us, to make the disclosure to family members or friends involved in your care, or for notification purposes, for national security or intelligence, to law enforcement as provided in the privacy rule or correctional facilities, as part of a limited data disclosure.

QUESTIONS AND COMPLAINTS:

If you have any questions about this notice or think that we may have violated your privacy rights, contact the person named below. You must also submit a written complaint to the US Department of Health and Human Services. We will not retaliate against you for filing a complaint.

Milwaukie Chiropractic Center
3716 SE International Way
Milwaukie, OR 97222
(P) 503-659-0073 • (F) 503-659-7471

ACKNOWLEDGMENT FORM:

I acknowledge that I have reviewed, understand and agree to the Notice of Privacy Practices of Milwaukie Chiropractic Center.

PATIENT SIGNATURE	DATE

AUTHORIZATION FOR RELEASE OF INFORMATION

Milwaukie Chiropractic and Massage Center

PATIENT NAME	DATE OF BIRTH

Many of our patients allow family members, relative, or close friend such as a spouse or parents to call and request medical or billing information. Under the requirements of of HIPPA we are not allowed to give this information to anyone without the patient's consent. If you wish to have your medical or billing information released or be released to those listed in this form. Signing this form will only give information to those indicated below.

I authorize Milwaukie Chiropractic Center to release my medical and/or billing information to the following:

NAME: _____

RELATION TO PATIENT: _____

CONTACT NUMBER: _____

NAME: _____

RELATION TO PATIENT: _____

CONTACT NUMBER: _____

NAME: _____

RELATION TO PATIENT: _____

CONTACT NUMBER: _____

PATIENT INFORMATION:

I understand I have the right to revoke this authorization at any time and that I have the right to inspect or copy the protected health information to be disclosed. I understand that information disclosed to any above recipient is no longer protected by federal or state law and may be subject to redisclosure by the above recipient(s). You have the right to revoke this consent in writing.

☐ There is no one I am authorizing to be given medical or billing information

PATIENT SIGNATURE	DATE

CANCELLATION POLICY

Milwaukie Chiropractic and Massage Center

Thank you for choosing our office for your healthcare needs. We respect and understand that you have the choice of going anywhere for treatment to improve your function and help with pain and dysfunction.

We have been blessed with being able to attend to our communities needs for over 30 years and with that blessing we have become a busy office.

All our doctors and massage therapists have a busy daily schedule with patients who are trying to schedule an appointment even on the same day. When someone schedules an appointment and fails to call in to cancel, availiblity was taken away from someone who wanted that appointment time.

Because of our need to make sure we have appointments available to those who need it while still maintaining covid standards we have developed a cancellation policy.

We now require an advance notice of at least 24 hours if you need to cancel your appointment.

There will be a $25.00 fee for a no-call or no show or a late chiropractic appointment cancelation. For massage, a 24 hour notice is required, otherwise there will be a $50 fee for a 60 minute massage, and $75 fee for a 90 minute massage appointment. Insurance will not cover no-call, no-show or late fees.

We respect your time as we hope you respect ours. Thank you for understanding.

With All Due Respect,
The Entire MCC & MMC Staff

PATIENT SIGNATURE	DATE

MY SIGNATURE IS AN ACKNOWLEDGMENT THAT I HAVE READ THE ABOVE STATEMENT

NECK PAIN DISABILITY INDEX QUESTIONS

PLEASE READ: This questionnaire is designed to enable us to understand how much your neck pain has affected your ability to manage your everyday activities. **Please answer every section by CIRCLING THE ONE CHOICE that most applies to you.** We realize you may feel that more than one statement may relate to you but **PLEASE CIRCLE THE ONE CHOICE THAT MOST CLOSELY DESCRIBES HOW YOUR PROBLEM RIGHT NOW.**

SECTION 1 – *PAIN INTENSITY*

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

SECTION 2 – *PERSONAL CARE* *(e.g., washing, dressing,etc.)*

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

SECTION 3 – *LIFTING*

A I can lift heavy weights without extra pain
B I can lift heavy weights, but it gives extra pain
C Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conviently placed (e.g., on a table)
D Pain prevents me from lifting heavy weights, but I can manage light to medium weights if conviently placed
E I can lift very light weights
F I cannot lift or carry anything at all

SECTION 4 – *READING*

A I can read as much as I want to with no pain in my neck
B I can read as much as I want with slight pain in my neck
C I can read as much as I want with moderate pain in my neck
D I cannot read as much as I want due to moderate neck pain
E I cannot read as much as I want due to severe neck pain
F I cannot read at all

SECTION 5 – *HEADACHES*

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

SECTION 6 – *CONCENTRATION*

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

SECTION 7 – *WORK*

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

SECTION 8 – *DRIVING*

A I can drive my car without any neck pain
B I can drive my car as long as I want with slight neck pain
C I can drive my car as long as I want with moderate pain
D I cannot drive my car as long as I want due to moderate neck pain
E I can hardley drive at all because of severe pain in my neck
F I cannot drive at all

SECTION 9 – *SLEEPING*

A I have no trouble sleeping
B My sleep is slightly disturbed (<1 hour sleepless)
C My sleep is mildly disturbed (1-2 hours sleepless)
D My sleep is moderately disturbed (2-3 hours sleepless)
E My sleep is greatly disturbed (3-5 hours sleepless)
F My sleep is completley disturbed (5-7 hours sleepless)

SECTION 10 – *RECREATION*

A I am able to engage in all my recreational activites with no neck pain
B I am able to engage in all of my recreational activities with some pain in my neck
C I am able to engage in most of my recreational activities due to neck pain
D I am able to engage is some of my recreational activities due to pain in my neck
E I can hardly do any recreational activities due to neck pain
F I cannot do any recreational activities at alll

COMMENTS: _____

SCORE:

DATE:

NAME:

OSWESTRY DISABILITY INDEX (FOR BACK PAIN)

PLEASE READ: This questionnaire is designed to enable us to understand how much your back pain has affected your ability to manage your everyday activities. **Please answer every section by CIRCLING THE ONE CHOICE that most applies to you**. We realize you may feel that more than one statement may relate to you but **PLEASE CIRCLE THE ONE CHOICE THAT MOST CLOSELY DESCRIBES HOW YOUR PROBLEM RIGHT NOW.**

SECTION 1 – *PAIN INTENSITY*

A The pain comes and goes and is very mild

B The pain is mild and does not vary much

C The pain comes and goes and goes

D The pain is severe but comes and goes

E The pain is severe and does not vary

F The pain is the worst imaginable at the moment

SECTION 2 – *PERSONAL CARE (e.g., washing, dressing,etc.)*

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

SECTION 3 – *LIFTING*

A I can lift heavy weights without extra pain
B I can lift heavy weights, but it gives extra pain
C Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conviently placed (e.g., on a table)
D Pain prevents me from lifting heavy weights, but I can manage light to medium weights if conviently placed
E I can lift very light weights
F I cannot lift or carry anything at all

SECTION 4 – *WALKING*

A Pain does not prevent me from walking any distance

B Pain prevents me from walking more than one mile

C Pain prevents me from walking about a mile

D Pain prevents me from walking more than a ½ mile

E I can only walk while using assistance (e.g. cane, crutches)

F I am in bed most of the time and have to crawl to the toilet

SECTION 5 – *SITTING*

A I can sit in any chair as long as I want without pain
B I can only sit in my favorite chair as long as I like
C Pain prevents me from sitting more than an hour
D Pain prevents me from sitting more than ½ an hour
E Pain prevents me from sitting more than 10 minutes
F Pain prevents me from sitting at all

SECTION 6 – *STANDING*

A I can stand as long as I want without pain
B I have some pain while standing, but it doesn't increase with time
C I cannot stand for longer than one hour without increasing pain
D I cannot stand for longer than a ½ hour without increasing pain
E I can't stand for more than 10 minutes without increasing pain
F I avoid standing because it increases pain immediately

SECTION 7 – *SLEEPING*

A I get no pain in bed
B I get pain in bed, but it doesn't prevent me from sleeping
C Due to pain my normal sleep is reduced by less than 1/4
D Due to pain my normal sleep is reduced by less than 1/2
E Due to pain my normal sleep is reduced by less than 3/4
F Pain prevents me from sleeping at all

SECTION 8 – *SOCIAL LIFE*

A My social life is normal and gives me no pain
B My social life is normal, but increases the degree of pain
C Pain has no significant effect on my social life other than Limiting my more energetic interests
D Pain has restricted my social life and I do not go out often
E Pain has restricted my social life to my home
F I have no social life due to pain

SECTION 9 – *TRAVELLING*

A I get no pain while travelling
B Travelling causes some pain but none of my usual travel makes it worse
C Travelling causes extra pain but not enough to seek alternative forms of travel
D Travelling causes extra pain compelling me to seek alternative forms of travel
E Pain restricts all forms of travel
F Pain prevents all forms of travell besides while laying down

SECTION 10 – *CHANGING DEGREE OF PAIN*

A My pain is rapidly getting better
B My pain fluctuates but is overall getting better
C My pain seems to be getting better but is slowly improving
D My pain is neither getting better or worse
E My pain is gradually worsening
F My pain is rapidly worsening

SCORE:

PATIENT NAME:

DATE: