LIFESOURCE LLC
HEALTH AND WELLNESS CENTER

1136 Bloomingdale Rd.
Glendale Heights, IL 60139
p. 630.690.4488

Patient Information

Patient Name: _____
LAST *FIRST* *M.I.*

Address: _____
STREET ADDRESS CITY STATE ZIP

Birthdate: _____/_____/_____ Age: _____ Social Security #: _____-_____-_____

Phone: (home)_____ (cell) _____ (work) _____

Email: _____ Is it okay to contact you at work? ☐ Yes ☐ No

Emergency Contact:_____Relationship:_____ Emergency Contact Phone: _____

Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced

Gender : ☐ Female ☐ Male Number of children/ages: _____

Work Status: ☐ Full Time ☐ Part Time ☐ Homemaker ☐ Unemployed ☐ Retired ☐ Student

Employer Name: _____ Employer City, State: _____

Occupation: _____ Years Employed: _____ Physical Work Duties: _____

Have you ever had chiropractic care before? ☐ Yes ☐ No

If yes, please tell us the doctor's name _____ Were you pleased with your care? ☐ Yes ☐ No

How did you find out about our office? _____

Is this appointment related to an auto accident or work? ☐ Yes ☐ No If yes, please fill out the Auto Accident Questionnaire

Are you receiving care from other health professionals? ☐ Yes ☐ No

If yes, please name them and their specialty _____

Who is your family's primary care physician? _____

Health Insurance Information

Please present your Insurance Card to the front desk.

Insurance Company:_____ Insurance ID #:_____Group #:_____

Policy holder's relationship to you:_____ Full Name: _____ Birth Date: _____/_____/_____
LAST *FIRST* *M.I.*

Current Health

Please list any drugs/medications or vitamins/herbs/homeopathics/other you are taking/have taken: _____

_____

_____

What health condition brings you to our office?

1._____

2._____

3._____

How did the problem start? □ Suddenly □ Gradually □ Post-Injury Describe event of onset _____

Please describe your discomfort: Aching Burning Numbness Pins/Needles Stabbing Throbbing

Rate your symptoms? □ Mild □Moderate □ Severe □ Intolerable

Which best describes the frequency of your discomfort?

□ Constant (76%-100%) □ Frequent (51%-75%) □ Occasional (26%-50%) □Intermittent (0%-25%)

When did the symptoms first begin?

1._____

2._____

3._____

Do any symptoms radiate into any other area: No Yes: _____

Which phrases best describe *changes* in your discomfort during the day? (select one or more)

□ it is worse in the morning □ it is worse in the afternoon □ it is worse at night
□ it changes with the weather □ it does not change □ it is worse with activity

Is the condition □ Getting Worse □ Improving □ Not Changing

What makes the problem better? _____

What makes the problem worse? _____

Have you ever had a similar condition? ☐ No ☐Yes, please explain

_____

What activities are limited or affected by the condition? (select one or more)

□ Bending □ Bowel Movements □ Coughing □ Daily Routine
□ Driving □ Changing Positions □ Lifting □ Lying down
□ Pulling □ Pushing □ Reading □ Sitting
□ Sleeping □ Sneezing □ Standing □ Turning my head
□ Urination □ Walking □ Working

□ Other (please describe): _____

Health History

Have you ever been checked for vertebral subluxations? ☐ Yes ☐ No ☐ Don't Know

Has a physician ever diagnosed you with allergies? If so, please specify what type: _____

_____

Please list any broken bones/surgeries/hospitalizations with dates: _____

_____

Have you been struck unconscious? ☐ Yes ☐ No Have you been in an auto accident? ☐ Yes ☐ No If yes, list date: _____

Where applicable, specify the approximate date of your most recent: (month/year)

Physical exam: _____/_____ Dental x-rays: _____/_____
Spinal x-ray: _____/_____ CT scan: _____/_____
MRI: _____/_____ Other scans or x-rays: _____/_____

Female Only

Are you pregnant? ☐ Yes ☐ No
Are you nursing? ☐ Yes ☐ No
Are you taking birth control? ☐ Yes ☐ No
Do you experience painful periods? ☐ Yes ☐ No
Do you have irregular cycles? ☐ Yes ☐ No
Do you have breast implants? ☐ Yes ☐ No
Do you perform regular self-breast exams? ☐ Yes ☐ No

Social History & Life Choices

Alcohol	☐ Daily ☐ Weekly ☐ Occasionally ☐ Never
Diet Food Products	☐ Daily ☐ Weekly ☐ Occasionally ☐ Never
Energy Products or OTC Stimulants	☐ Daily ☐ Weekly ☐ Occasionally ☐ Never
Fresh & Homemade Foods	☐ Daily ☐ Weekly ☐ Occasionally ☐ Never
Soft Drinks	☐ Daily ☐ Weekly ☐ Occasionally ☐ Never
Water	☐ Daily ☐ Weekly ☐ Occasionally ☐ Never
Caffeine Drinks & Products	☐ Daily ☐ Weekly ☐ Occasionally ☐ Never
Drugs	☐ Daily ☐ Weekly ☐ Occasionally ☐ Never
Exercise	☐ Daily ☐ Weekly ☐ Occasionally ☐ Never
Processed, Packaged, Restaurant Foods	☐ Daily ☐ Weekly ☐ Occasionally ☐ Never
Tobacco	☐ Daily ☐ Weekly ☐ Occasionally ☐ Never
Ice Pack Usage	☐ Daily ☐ Weekly ☐ Occasionally ☐ Never

What do you know about chiropractic?

Do you know what a subluxation is? ☐ Yes ☐ No

Do any of your friends or relatives see a chiropractor? ☐ Yes ☐ No

If yes, do they use chiropractic for ☐ Health maintenance/optimization ☐ Health problems ☐ Both

Are you seeking chiropractic for ☐ Health maintenance/optimization ☐ Health problems ☐ Both

What would you like to gain from chiropractic care? _____

_____

Are there other health concerns or anything else you'd like us to know about you? _____

_____

List 3 goals you would like to accomplish but your health does not allow (please be thorough):

1._____

2._____

3._____

Our software enables us to send appointment reminders via text message or email. Please check below which method you prefer.

□ Text Message

Phone Number: _____

Cell Phone Provider:_____ Ex. Verizon, Nextel, etc.

□ Email

Email Address: _____

_____

Signature

Detailed Review of Systems

CARDIOVASCULAR ☐ **N/A**

Past	Present	
☐	☐	Poor Circulation
☐	☐	High Blood Pressure
☐	☐	Aortic Aneurysm
☐	☐	Heart Disease
☐	☐	Heart Attack
☐	☐	Chest Pain
☐	☐	High Cholesterol
☐	☐	Pacemaker
☐	☐	Jaw Pain
☐	☐	Irregular Heartbeat
☐	☐	Swelling of Legs
☐	☐	Stroke

GENITOURINARY ☐ **N/A**

Past	Present	
☐	☐	Kidney Disease
☐	☐	Lower Side Pain
☐	☐	Burning Urination
☐	☐	Frequent Urination
☐	☐	Blood in Urine
☐	☐	Kidney Stones
☐	☐	Bed Wetting/Enuresis
☐	☐	Prostate Problems
☐	☐	Rectal Prolapse

HEMATOLOGICAL/LYMPHATIC ☐ **N/A**

Past	Present	
☐	☐	Lymphoma
☐	☐	Anemia
☐	☐	Leukemia
☐	☐	Mononucleosis
☐	☐	Hemophilia
☐	☐	Other: _____

RESPIRATORY ☐ **N/A**

Past	Present	
☐	☐	Asthma
☐	☐	Shortness of Breath
☐	☐	Upper Resp Infection
☐	☐	Cold/Flu
☐	☐	Pneumonia
☐	☐	Cough/Wheezing
☐	☐	Emphysema
☐	☐	RSV
☐	☐	Tuberculosis

EAR/NOSE/THROAT ☐ **N/A**

Past	Present	
☐	☐	Sinus Congestion
☐	☐	Sinus Infection
☐	☐	Nosebleed
☐	☐	Sore Throat
☐	☐	Difficulty Swallowing
☐	☐	Ear Ache
☐	☐	Ear Infections
☐	☐	Dizziness
☐	☐	Hearing Loss
☐	☐	Bleeding Gums

EYES ☐ **N/A**

Past	Present	
☐	☐	Glaucoma
☐	☐	Double Vision
☐	☐	Blurred Vision
☐	☐	Red, Itchy (Allergy)

ALLERGIC/IMMUNOLOGICAL ☐ **N/A**

Past	Present	
☐	☐	Autoimmune Disorder
☐	☐	Chronic Allergies
☐	☐	Seasonal Allergies
☐	☐	Food Allergies
☐	☐	Environmental Allergies
☐	☐	Allergy Shots
☐	☐	Cortisone Use
☐	☐	HIV/AIDS
☐	☐	Hives
☐	☐	Weak Immune System

GASTROINTESTINAL ☐ **N/A**

Past	Present	
☐	☐	Pancreatitis
☐	☐	Acid Reflux
☐	☐	Bowel Problems
☐	☐	Constipation
☐	☐	Upset Stomach
☐	☐	Gas Pains
☐	☐	Ulcers
☐	☐	Gallbladder Problems
☐	☐	Liver Problems
☐	☐	Diarrhea
☐	☐	Nausea/Vomiting
☐	☐	Poor Appetite
☐	☐	Bloody Stools
☐	☐	Crohn's Disease
☐	☐	Hiatal Hernia

MUSCULOSKELETAL ☐ **N/A**

Past	Present	
☐	☐	Chronic Hip Dislocation
☐	☐	Torticollis
☐	☐	Poor Posture
☐	☐	Neck Pain
☐	☐	Back Pain
☐	☐	Arthritis
☐	☐	Rheumatoid Arthritis
☐	☐	Joint Stiffness
☐	☐	Muscle Weakness
☐	☐	Osteoporosis
☐	☐	Broken Bones
☐	☐	Joint Replacement
☐	☐	Gout

NEUROLOGICAL ☐ **N/A**

Past	Present	
☐	☐	Tic Disorder
☐	☐	Seizures
☐	☐	Head Injury
☐	☐	Brain Aneurysm
☐	☐	Numbness/Tingling
☐	☐	Pinched Nerves
☐	☐	Radiating Pain
☐	☐	Sciatica

NEUROLOGICAL CONTINUED

☐	☐	Parkinson's Disease
☐	☐	Carpal Tunnel
☐	☐	Balance/Coordination
☐	☐	ADHD/ADD/SPD
☐	☐	Autism/Spectrum
☐	☐	Migraine Headaches
☐	☐	Bell's Palsy
☐	☐	Poor Fine/Gross Motor
☐	☐	Epilepsy
☐	☐	Inflammation
☐	☐	Trigeminal Neuralgia
☐	☐	Ear Ringing/Tinnitus
☐	☐	Toe Walking
☐	☐	Auditory Processing
☐	☐	Sinus Headache
☐	☐	Tension Headache
☐	☐	Vertigo/Dizziness
☐	☐	Sensory Integration

ENDOCRINE ☐ **N/A**

Past	Present	
☐	☐	Hyperthyroid Issues
☐	☐	Hypothyroid Issues
☐	☐	Type 1 Diabetes
☐	☐	Type 2 Diabetes
☐	☐	Hair Loss
☐	☐	Menopausal
☐	☐	Menstrual Problems
☐	☐	Hot Flashes
☐	☐	Endometriosis
☐	☐	PCOS
☐	☐	Hashimoto
☐	☐	Graves

PSYCHIATRIC ☐ **N/A**

Past	Present	
☐	☐	Depression
☐	☐	Anxiety Disorder
☐	☐	Unusual Stress
☐	☐	OCD
☐	☐	Bipolar Disorder
☐	☐	Seasonal Affective (SAD)
☐	☐	Mood Swings
☐	☐	Social Anxieties
☐	☐	Memory Loss
☐	☐	Night Tremors

CONSTITUTIONAL ☐ **N/A**

Past	Present	
☐	☐	Weight Loss/Gain
☐	☐	Energy Level Low
☐	☐	Energy Level High
☐	☐	Difficulty Sleeping
☐	☐	Chronic Fatigue
☐	☐	General Malaise
☐	☐	Compulsive Behavior
☐	☐	Behavior Issues
☐	☐	Learning Disabilities
☐	☐	Speech Delays
☐	☐	RLS
☐	☐	Pregnancy/Fertility
☐	☐	Obesity

LifeSource Health & Wellness Center
1136 Bloomingdale Rd.
Glendale Heights, IL 60139

Authorizations and Releases

HEALTH CARE AUTHORIZATION FORM

I have been provided with a copy of the Notice of Privacy Practices for Protected Health Information. The Notice of Privacy Practices describes the types of uses and disclosures of my Protected Health Information (PHI) that will occur in my treatment, payment of my bills or in the performance of health care operations of this chiropractic office. A copy of our notice is attached and we encourage you to read it and request your own copy if you would like one.

This Notice of Privacy Practices also describes my rights and duties of the Chiropractor with respect to my protected health information. I hereby give permission to LifeSource Health & Wellness Center (LSHW) to use and/or disclose Protected Health Information in accordance with the following:

SPECIFIC AUTHORIZATIONS:

- I give permission to LSHW to use my address, phone number and clinical records to contact me with appointment reminders, missed appointment notification, birthday cards, holiday related cards, newsletters, information about treatment alternatives or other health related information.
- If LSHW contacts me by phone, I give them permission to leave a phone message on my answering machine or voice mail.

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- I give permission to LSHW to use my photograph on their patient picture bulletin board and other marketing materials such as their brochure, website and ads in print media.
- I give permission to LSHW to use any testimonial written by me for marketing purposes such as, sharing with other patients or potential patients, in their brochure, on their website or in ads in print media.
- I give LSHW permission to treat me in an open room where other patients are also being treated. I am aware that other persons in the office may overhear some of my protected health information during the course of care. Should I need to speak with doctor at any time in private, the doctor will provide a room for these conversations.
- I understand, for my protection, portions of our office where patients do not disrobe, are under audio and video surveillance.
- By signing this form you are giving LSHW permission to use and disclose your protected health information in accordance with the directives listed above.

The use of this format is intended to make your experience with our office more efficient and productive as well as to enhance your access to quality health care and health information. This authorization will remain in effect for the duration of my care at LSHW plus 7 years or until revoked by me.

RIGHT TO REVOKE AUTHORIZATION:

You have the right to revoke this AUTHORIZATION, in writing, at any time. However, your written request to revoke this AUTHORIZATION is not effective to the extent that we have provided services or taken action in reliance on your authorization.

You may revoke this AUTHORIZATION by mailing or hand delivering a written notice to the Privacy Official of LSHW. The written notice must contain the following information:

Your name, Social Security number and date of birth;
A clear statement of your intent to revoke this AUTHORIZATION;
The date of your request; and
Your signature.

The revocation is not effective until it is received by the Privacy Official.

This AUTHORIZATION is requested by LSHW for its own use/disclosure of PHI. *(Minimum necessary standards apply.)*

I have the right to refuse to sign this AUTHORIZATION. If I refuse to sign this AUTHORIZATION, LSHW will not refuse to provide care however, it will not be possible for LSHW to file third party billing on my behalf and I will be responsible for 1)payment in full at the time services are provided to me 2) scheduling my own appointments since LSHW will be unable to contact me 3) all contact with LSHW regarding my care. *Additionally, any collection activity as permitted by law is not waived by refusal to sign the authorization.*

I have the right to inspect or copy, within boundaries, the protected health information to be used/disclosed. A reasonable fee for copying will apply. A copy of the signed authorization will be provided to me. I have read and understand this Healthcare Authorization Form and acknowledge receipt of The Notice of Privacy Practices for Protected Health Information. My signature below represents agreement with these practices.

Signature_____ Date _____

Consent to Professional Treatment (Informed Consent)

We encourage and support a **shared decision making process** between us regarding your health needs. As a part of that process you have a right to be informed about the condition of your health and the recommended care and treatment to be provided to you so that you can make the decision whether or not to undergo such care with full knowledge of the known risks. This information is intended to make you better informed in order that you can knowledgably give or withhold your consent.

- **Chiropractic** is based on the science which concerns itself with the relationship between structures (primarily the spine) and function (primarily of the nervous system) and how this relationship can affect the restoration and preservation of health.
- **Adjustments** are made by chiropractors in order to correct or reduce spinal and extremity joint subluxations. **Vertebral subluxation** is a disturbance to the nervous system and is a condition where one or more vertebra in the spine is misaligned and/or does not move properly causing interference and/or irritation to the nervous system. The primary goal in chiropractic care is the removal and/or reduction of nerve interference caused by vertebral subluxation.
- A chiropractic examination will be performed which may include spinal and physical examination, orthopedic and neurological testing, palpation, specialized instrumentation, radiological examination (x-rays), and laboratory testing.
- The chiropractic adjustment is the application of a precise movement and/or force into the spine in order to reduce or correct vertebral subluxation(s). There are a number of different methods or techniques by which the chiropractic adjustment is delivered but are typically delivered by hand. Some may require the use of an instrument or other specialized equipment. In addition, physiotherapy or rehabilitative procedures may be included in the management protocol. Among other things, chiropractic care may reduce pain, increase mobility and improve quality of life.

In addition to the benefits of chiropractic care and treatment, one should also be aware of the existence of some risks and limitations of this care. The risks are seldom high enough to contraindicate care and all health care procedures have some risk associated with them. Risks associated with some chiropractic treatment may include soreness, musculoskeletal sprain/strain, and fracture. Risks associated with physiotherapy may include the preceding as well as allergic reaction and muscle and/or joint pain. In addition there are reported cases of stroke associated with visits to medical doctors and chiropractors.

I have been informed of the nature and purpose of chiropractic care, the possible consequences of care, and the risks of care, including the risk that the care may not accomplish the desired objective. Reasonable alternative treatments have been explained, including the risks, consequences and probable effectiveness of each. I have been advised of the possible consequences if no care is received. I acknowledge that no guarantees have been made to me concerning the results of the care and treatment.

I HAVE READ THE ABOVE PARAGRAPH. I UNDERSTAND THE INFORMATION PROVIDED. ALL QUESTIONS I HAVE ABOUT THIS INFORMATION HAVE BEEN ANSWERED TO MY SATISFACTION. HAVING THIS KNOWLEDGE, I KNOWINGLY AUTHORIZE LIFESOURCE HEALTH & WELLNESS CENTER TO PROCEED WITH CHIROPRACTIC CARE AND TREATMENT. DATED THIS ____ DAY OF _____, 20___

Signature_____

Parental Consent for Minor Patient:

Patient Name: _____

Patient age: _____ DOB: _____

Printed name of person legally authorized to sign for Patient: _____

Signature: _____

Relationship to Patient: _____

In addition, by signing below, I give permission for the above named minor patient to be managed by the doctor even when I am not present to observe such care.

Printed name of person legally authorized to sign for

Patient: _____

Relationship to Patient: _____

Remarks:

Signature_____ Date _____

Consent to Perform and Interpret X-rays

The patient consents to the performance of x-rays as deemed necessary by the doctor of this office. The patient acknowledges that certain risks are associated with x-rays. The patient, hereby states that they have no known limitations that would forbid the taking of x-rays. The patient further agrees that this office may seek outside interpretation of patient x-rays by a qualified professional not employed by this office. The patient agrees to any additional fees associated with this service and assigns benefits to be paid directly to that professional by your third-party payer.

INITIAL_____

Assignment of Benefits and Release of Records

The patient hereby assigns benefits to be paid directly to this provider by all of their third party payers. This assignment is irrevocable. Failure to fulfill this obligation will be considered a breach of contract between the patient and this office. Understand that your insurance policy is a contract between you and the insurance company. Any claim that is denied is the responsibility of the patient. I understand that any insurance payment sent to me will be part of my balance due, and therefore it is my responsibility to forward such payment toLifeSource Health & Wellness Center, LLC. The patient authorizes this office to release any information required by a third party payer necessary for reimbursement of charges incurred.

INITIAL_____

Financial Obligation and Appointment Policy

The patient accepts full financial responsibility for services rendered by this practice. This office reserves the right to charge fair market value for missed appointments or appointments canceled without any advanced notification required by this office. Out of consideration for other patients that may want to schedule, we require a minimum of 4 hours advanced notice when changing, rescheduling or canceling an appointment to avoid a charge of $25. Payment in full is required for all services at the time of visit, unless alternative arrangements have been agreed to in advance. Patient accepts full responsibility for any fees incurred, including but not limited to legal fees, collection agency fees, and any and all other expenses incurred in the collection of past due accounts. Should you choose to discontinue care early, the account is refigured on a per visit basis (without any discounts) and you either a) are responsible for the outstanding balance or b) will receive a refund on the care not yet received. Patient should direct any questions regarding this financial obligation and appointment policy to the clinic manager or doctor. The patient further authorizes the practice to retain credit card, debit card, checking account or other payment source(s) supplied by patient to the practice for current and future charges, when incurred.

INITIAL_____

Signature_____ Date _____

Patient Name:_____ Date:_____

NECK DISABILITY INDEX

THIS QUESTIONNAIRE IS DESIGNED TO HELP US BETTER UNDERSTAND HOW YOUR NECK PAIN AFFECTS YOUR ABILITY TO MANAGE EVERYDAY -LIFE ACTIVITIES. PLEASE MARK IN EACH SECTION THE **ONE BOX** THAT APPLIES TO YOU. ALTHOUGH YOU MAY CONSIDER THAT TWO OF THE STATEMENTS IN ANY ONE SECTION RELATE TO YOU, PLEASE MARK THE BOX THAT **MOST CLOSELY** DESCRIBES YOUR PRESENT -DAY SITUATION.

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

- ❑ **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 causing extra pain.**
- ❑ **I can lift heavy weights, but it gives me extra pain.**
- ❑ **Pain prevents me from lifting heavy weights off the floor but I can manage if items are conveniently positioned, ie. on a table.**
- ❑ **Pain prevents me from lifting heavy weights, but I can manage light weights if they are conveniently positioned.**
- ❑ **I can lift only very light weights.**
- ❑ **I cannot lift or carry anything at all.**

SECTION 4 – WORKING

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

SECTION 5 – HEADACHES

- ❑ **I have no headaches at all.**
- ❑ **I have slight headaches that come infrequently.**
- ❑ **I have moderate headaches that come infrequently.**
- ❑ **I have moderate headaches that come frequently.**
- ❑ **I have severe headaches that come frequently.**
- ❑ **I have headaches almost all the time.**

SECTION 6 – CONCENTRATION

- ❑ **I can concentrate fully without difficulty.**
- ❑ **I can concentrate fully with slight difficulty.**
- ❑ **I have a fair degree of difficulty concentrating.**
- ❑ **I have a lot of difficulty concentrating.**
- ❑ **I have a great deal of difficulty concentrating.**
- ❑ **I can't concentrate at all.**

SECTION 7 – SLEEPING

- ❑ **I have no trouble sleeping.**
- ❑ **My sleep is slightly disturbed for less than 1 hour.**
- ❑ **My sleep is mildly disturbed for up to 1-2 hours.**
- ❑ **My sleep is moderately disturbed for up to 2-3 hours.**
- ❑ **My sleep is greatly disturbed for up to 3-5 hours.**
- ❑ **My sleep is completely disturbed for up to 5-7 hours.**

SECTION 8 – DRIVING

- ❑ **I can drive my car without 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't drive as long as I want because of moderate neck pain.**
- ❑ **I can hardly drive at all because of severe neck pain.**
- ❑ **I can't drive my care at all because of neck pain.**

SECTION 9 – READING

- ❑ **I can read as much as I want with no neck pain.**
- ❑ **I can read as much as I want with slight neck pain.**
- ❑ **I can read as much as I want with moderate neck pain.**
- ❑ **I can't read as much as I want because of moderate neck pain.**
- ❑ **I can't read as much as I want because of severe neck pain.**
- ❑ **I can't read at all.**

SECTION 10 – RECREATION

- ❑ **I have no neck pain during all recreational activities.**
- ❑ **I have some neck pain with all recreational activities.**
- ❑ **I have some neck pain with a few recreational activities.**
- ❑ **I have neck pain with most recreational activities.**
- ❑ **I can hardly do recreational activities due to neck pain.**
- ❑ **I can't do any recreational activities due to neck pain.**

Patient Signature _____ Score_____

Patient Name:_____ Date:_____

OSWESTRY INDEX QUESTIONNAIRE

This questionnaire is designed to help us better understand how your back pain affects your ability to manage everyday -life activities. Please mark in each section the **one box** that applies to you. Please mark the box that **most closely** describes your present -day situation.

SECTION 1 - PAIN INTENSITY

- ❑ My pain is mild to moderate. I do not need pain killers.
- ❑ The pain is bad, but I manage without taking pain killers.
- ❑ Pain killers give complete relief from pain.
- ❑ Pain killers give moderate relief from pain.
- ❑ Pain killers give very little relief from pain.
- ❑ Pain killers have no effect on the pain.

SECTION 2 - PERSONAL CARE

- ❑ 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 causing extra pain.
- ❑ I can lift heavy weights, but it gives me extra pain.
- ❑ Pain prevents me from lifting heavy weights off the floor, but I can manage if items are conveniently positioned, ie. on a table.
- ❑ Pain prevents me from lifting heavy weights, but I can manage light weights if they are conveniently positioned.
- ❑ I can lift only very light weights.
- ❑ I cannot lift or carry anything at all.

SECTION 4 – WALKING

- ❑ I can walk as far as I wish.
- ❑ Pain prevents me from walking more than 1 mile.
- ❑ Pain prevents me from walking more than 1/2 mile.
- ❑ Pain prevents me from walking more than 1/4 mile.
- ❑ I can walk only if I use a cane or crutches.
- ❑ I am in bed or in a chair for most of every day.

SECTION 5 – SITTING

- ❑ I can sit in any chair for as long as I like.
- ❑ I can sit in my favorite chair only, but for as long as I like.
- ❑ Pain prevents me from sitting for more than 1 hour.
- ❑ Pain prevents me from sitting for more than 1/2 hour.
- ❑ Pain prevents me from sitting for more than 10 minutes.
- ❑ Pain prevents me from sitting at all.

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 me extra pain.
- ❑ Pain prevents me from standing for more than 1 hour.
- ❑ Pain prevents me from standing more than 1/2 hour.
- ❑ 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 sleep well but only when taking medication.
- ❑ Even when I take medication, I sleep less than 6 hours.
- ❑ Even when I take medication, I sleep less than 4 hours.
- ❑ Even when I take medication, I sleep less than 2 hours.
- ❑ Pain prevents me from sleeping at all.

SECTION 8 - SOCIAL LIFE

- ❑ Social life is normal and causes me no extra pain.
- ❑ Social life is normal, but increases the degree of pain.
- ❑ Pain affects my social life by limiting only my more energetic interests, such as dancing, sports, etc.
- ❑ 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 - SEXUAL ACTIVITY

- ❑ Sexual activity is normal and causes no extra pain.
- ❑ Sexual activity is normal, but causes some extra pain.
- ❑ Sexual activity is nearly normal, but is very painful.
- ❑ Sexual activity is severely restricted by pain.
- ❑ Sexual activity is nearly absent because of pain.
- ❑ Pain prevents any sexual activity at all.

SECTION 10 – 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 restricts me to journeys of less than 1 hour.
- ❑ Pain restricts me to necessary journeys under ½ hr.
- ❑ Pain prevents traveling except to the doctor/hospital.

Patient Signature _____ Score_____

Patient Name:_____ Date:_____

Quadruple Visual Analogue Scale

Instructions: For <u>EACH</u> area of pain you are experiencing, circle the number that represents the amount of pain on a scale from 1 to 10 and label the circle with the first letter of the body part. Repeat this on the same line for all areas of pain. Shoulder=S, Low back=LB, Mid back=MB, Foot=F, Knee=K, Leg=L, Neck=N, Wrist=W, Headache=H

For example, if you are experiencing pain in your knee and neck, you will have 1 circle at the level for the knee pain labeled K and another circle on the same line for the neck labeled N. ***Please ensure each individual area of pain is represented on each line for each question.***

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1. **What is your pain RIGHT NOW?**

No pain _____ **worst possible pain**

0 1 2 3 4 5 6 7 8 9 10

2. **What is your TYPICAL or AVERAGE pain?**

No pain _____ **worst possible pain**

0 1 2 3 4 5 6 7 8 9 10

3. **What is your pain level AT ITS BEST (How close to "0" does your pain get at its best)?**

No pain _____ **worst possible pain**

0 1 2 3 4 5 6 7 8 9 10

4. **What is your pain level AT ITS WORSE (how close to "10" does your pain get at its worst)"**

No pain _____ **worst possible pain**

0 1 2 3 4 5 6 7 8 9 10

Patient Signature _____ Score_____