Please Print all Answers

NEW PATIENT INFORMATION

Name _____ Age _____ Sex _____ Date _____

Address _____ City _____ Zip _____

Phone _____ Work _____ Cell _____

Best time to Call _____ Which # _____ E-mail _____

Social Security # _____ Birthdate _____ Family Doctor _____

☐ Married ☐ Single ☐ Sep ☐ Divorced ☐ Widowed Spouse's Name _____

Employer _____ Spouse's Employer _____

Employer Address _____ Spouse's Birthdate _____

Employer Phone _____ Spouse's Social Security _____

Parent's Employer If Patient Is Minor / Child _____

Parents Social Security # If Patient Is Child _____

Emergency: Who Do We Call? _____ Relationship _____

Name of Relative or Friend Not Living with You Phone

REFERRAL INFORMATION

WHO recommended you to our office? ☐ My Doctor ☐ Family / Friend ☐ Other _____

Name _____ Address or Phone _____

HEALTH INSURANCE INFORMATION

Name of Insurance Company _____ Group Number _____

Name of Insured (Policy Holder) _____ Policy Number _____

Insured Birthdate _____

ACCIDENT INSURANCE INFORMATION

Name of YOUR Auto Insurance Company _____

Agent Name _____ Adjuster's Name _____

Accident Claim Number _____ Phone Number _____

Name of LIABLE Insurance Company _____ Adjuster's Name _____

Claim Number _____ Phone Number _____

Attorney Name _____ Phone Number _____

WORK OR INJURY INSURANCE INFORMATION

Employer or Responsible Party _____

Contact Person _____ Phone Number _____

Please provide the receptionist with your driver's license & insurance card to be photocopied for your permanent medical record.

Welcome to our multi-specialty group practice, offering family practice & pain management medical care, chiropractic, physical therapy, rehabilitation, acupuncture, massage therapy, nutritional & psychological counseling. We will strive to help restore or improve your health but there are no guarantees or promises of improvement or complete recovery. Patients are encouraged to leave valuables at home or with an accompanying family member or friend. This Facility shall not be liable for the loss of or damage to any personal property including, but not limited to money, credit cards, clothing, jewelry, glasses/contacts, dental devices, hearing aids, furs, documents or any other items.

Your signature on this document fully authorizes our staff & doctors to perform any examinations, diagnostic tests &/or treatment as we may consider medically necessary & to release all information pertinent to your health, insurance or benefits to any & all applicable parties on your behalf. Our office and staff are committed to providing all patients regardless of race, color, national origin, age, sex, disability or religious or political beliefs quality health care services delivered with dignity and concern. HIPAA requires that we have you read & sign the federally governed Health Care Privacy Notice. This Notice is detailed on page -3- of this document. The Health Care Privacy Notice will explain when, where and why your confidential health information may be used, stored and/or shared and is a part of this document that is a permanent part of your medical records which is maintained in this office. You may receive a free photocopy of this document that you have signed just by asking one of our staff.

Your signature on this document confirms that you have read, understand and agree to comply with all of the terms & conditions of the Health Care Privacy Notice and all policies, consents, terms & conditions regarding your responsibilities to this Facility and that you grant the physicians, therapists and/or all staff of this Facility to use and share your confidential health information with others in order to treat you and/or in order to arrange for payment of your bill and/or for issues that concern this Facility operations and responsibilities. Please direct any questions or concerns to a member of our staff. We encourage questions and/or concerns to avoid misunderstandings. Office hours allow our patients convenience to schedule appointments before & after work as well as during lunch. If you must miss an appointment please notify us. If you do not show up for your scheduled appointment you will be charged $15.00 as a missed appointment fee that you must pay before you are seen or treated again. We are available to immediately see new patients the same day or through our 24 hour - 7-day emergency service. As a courtesy for you, we may call you on the telephone when an appointment is missed and/or you have not been in for a while. If you do not wish for us to call you or mail you reminder cards please let us know in writing for your file.

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SYMPTOM SURVEY

What is your chief problem or symptoms? _____

What caused the problem or symptoms to occur? _____

When did the problem or symptoms begin? _____

Have you seen another doctor for this problem? □ No, If yes, who _____

What tests/procedures have been performed? □ X-Ray □ MRI □ Surgery □ Hospitalization □ _____

Have you had this problem or symptoms in the past? □ No, If yes, explain _____

Have you tried any other treatments for this? □ No, If yes, explain _____

Is the problem or symptoms getting worse? □ No, If yes, explain _____

Please explain any personal loss you have sustained due to these injuries:

_____

_____

_____

Please explain any social loss you have sustained due to these injuries:

_____

_____

_____

Please explain any work loss you have sustained due to these injuries:

_____

_____

_____

PATIENT & FAMILY HISTORY

What is your occupation? _____ ☐ Full Time ☐ Part Time

What is your employment status? ☐ Working ☐ Sick Leave ☐ Unemployed ☐Retired

☐ Temp Disability ☐ Perm Disability Last Day of Work _____

Do you use tobacco? ☐ No ☐Yes Explain: Occasional Light Medium Heavy

Do you use caffeine? ☐ No ☐Yes Explain: Occasional Light Medium Heavy

Do you consume alcohol? ☐ No ☐Yes Explain: Occasional Light Medium Heavy

Do you have a history of substance abuse? ☐ No ☐Yes Explain: _____

Do you exercise? ☐ No ☐Yes Explain: Never Occasionally 3-5 X's/wk Daily

List all past surgeries _____

List all drug allergies _____

List all current and past medications / drugs

Drug Name: _____ _____

_____ _____

_____ _____

List all physicians you have seen in the past 5 years?

Name _____ For What? _____

_____ _____

_____ _____

_____ _____

History

Self	□ Heart Attack	□ Stroke	□ Vascular Disease	□ High Blood Pressure	□ Birth Control Pill	
Father	□ Heart Attack	□ Stroke	□ Vascular Disease	□ High Blood Pressure	□ Cause of Death	_____
Mother	□ Heart Attack	□ Stroke	□ Vascular Disease	□ High Blood Pressure	□ Cause of Death	_____
Brother	□ Heart Attack	□ Stroke	□ Vascular Disease	□ High Blood Pressure	□ Cause of Death	_____
Brother	□ Heart Attack	□ Stroke	□ Vascular Disease	□ High Blood Pressure	□ Cause of Death	_____
Sister	□ Heart Attack	□ Stroke	□ Vascular Disease	□ High Blood Pressure	□ Cause of Death	_____
Sister	□ Heart Attack	□ Stroke	□ Vascular Disease	□ High Blood Pressure	□ Cause of Death	_____

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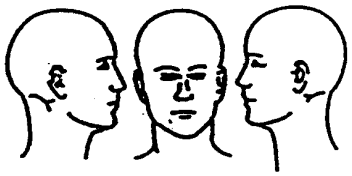
PAIN DRAWING

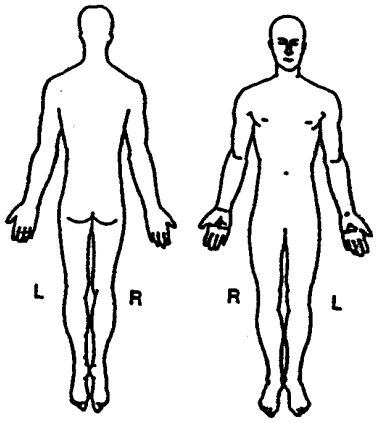
Circle location(s) of your symptoms on body drawing. Outline using the symbols for the type of sensation.

Describe your pain (check all that apply):

□ Constant □ Throbbing
□ Intermittent □ Tingling
□ Recurring □ Daily
□ Stabbing □ Nightly
□ Dull Ache □ While Resting
□ Deep Ache □ During Exercise
□ Sharp □ _____

PAIN	: : : : : : : : :
NUMBNESS	+ + + + + +
BURNING	/ / / / / / / / / /
ACHE	X X X X X X





Onset of Pain:

□ Sudden
□ Gradual

On a scale (1 = Mild, 10 = Intense) how would you rate your pain level now? ___/10 At its worst? ___/10 At its best? ___/10 Average? ___/10 What, if anything, gives you relief? _____

IF YOUR PROBLEM OR SYMPTOMS ARE DUE TO AN ACCIDENT OR INJURY PLEASE COMPLETE BELOW

□ **AUTO ACCIDENT** Date _____ Time ____ [am] [pm] Location_____

Type and Year of your vehicle _____

Your auto insurance co _____

Your auto agent _____His/her phone number _____

This claim number _____

Adjusters name _____ Adjusters phone no. _____

Person who hit you _____ Type/Yr. of Vehicle _____

Their phone number _____Their auto ins. co. _____

This claim number _____

Your attorney _____

Telephone number _____

Address (if known) _____

How did you feel 24 hours before the accident? □ FINE — NO PAIN □ _____

Were you	□ Driver	□ Passenger	Did seat back break	□ No	□ Yes
Others in car	□ No	□ Yes	Did glass break	□ No	□ Yes
Were they hurt	□ No	□ Yes	Do you have any cuts/bruises	□ No	□ Yes
Wearing seat belt	□ No	□ Yes	Police report made	□ No	□ Yes
Wearing eye glasses	□ No	□ Yes	Did you go to ER	□ No	□ Yes
Where were you hit	□ Behind	□ Front/Side	Ambulance Transport	□ No	□ Yes
Were you surprised	□ No	□ Yes	Had accident before	□ No	□ Yes
Were you leaning forward	□ No	□ Yes	Missed any work	□ No	□ Yes
Was your headrest	□ High	□ Low □ Center	Was car totaled	□ No	□ Yes
Your head was facing	□ Forward	□ Right □ Left	Was there a police report	□ No	□ Yes
Did you lose consciousness	□ No	□ Yes	Was your vehicle towed	□ No	□ Yes
Did you feel pan immediately	□ No	□ Yes	Damage to vehicle	$_____	

Speed of your vehicle _____ Speed of the vehicle that hit you _____

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HEALTH CARE PRIVACY NOTICE – INFORMED CONSENT – ASSIGNMENT OF BENEFITS – AUTHORIZATION & LIEN

This office is committed to providing patients with quality health care services delivered with dignity and concern. Fulfilling this commitment requires the efforts of the doctors, therapists, staff and patient working together as a team to obtain the maximum results. Patient satisfaction is a vital interest to our staff.

This Facility is required by law to abide by the terms of this Health Care Privacy Notice as well as other applicable federal and state laws governing privacy practices in health care. Our Facility may change and/or modify the terms of this Notice at anytime without additional notice to you except to publicly post in our Facility and/or make available to patients any updated notices. Photocopy of this Notice is available to you upon request. The term Facility refers to this office or clinic. The term Provider refers to doctors and/or licensed professionals of this Facility.

Our Facility & staff are committed to maintaining the privacy of your protected health information (PHI). PHI is information about you, including demographic information that may identify you and that may be related to your present, future and past physical or mental health or condition and the care and treatment you receive from our practice. This Notice describes how medical information about you may be used and disclosed and how you can obtain access to this information. Please read this Notice and direct questions, misunderstandings or concern to the Compliance Officer of this Facility.

Our Facility may use & disclose your PHI for health care delivery purposes. Your PHI may be used and/or disclosed without your written authorization by the doctors and staff of this Facility for the purposes of your care and treatment; paying your health care bills; and to support the operations of this practice. Your doctor and the staff will take all reasonable measures to maintain the confidentiality of your PHI.

The Privacy Rule allows you the right to review and receive copies of your health care records as it relates to your health care. The request must in writing, allowing your provider 30 days to respond. Your provider may deny your request if it will cause harm to you or to another person. Your provider may charge a copy fee, which will be in compliance with State law. Your provider will comply with any reasonable request to have confidential communication by alternative means or at an alternative location if not doing so endangers you.

You may request to have an amendment placed in your record if you disagree with anything in your record. This does not mean that anything will be removed or changed and the provider has the right to respond with a rebuttal statement if he/she feels it is necessary. You may revoke authorization, in writing, at any time, except in the event that the provider has acted as indicated in the doctor's Authorization Notice.

You have the right to file a written complaint with our Compliance Officer if you believe that any of your privacy rights have been violated. You can obtain a complaint form from the Compliance Officer and/or the Office of the Civil Rights. All complaints must be filed within 180 days of when you knew or should have known that the violation occurred. The Privacy Law prohibits our Facility from taking any retaliatory actions against anyone who files a complaint. A more detailed, updated & comprehensive Health Care Privacy Notice is available for your review in this Facility.

I understand that this Facility, its doctors & staff are accepting my case based on examination findings & believe the outlined treatment should produce change and/or improvement. However as with any diagnostic test, procedure, examination or doctors care a guarantee of improvement or complete recovery cannot be made and it is even possible that no change will occur.

I further understand that in the practice of medicine, chiropractic, psychological counseling, massage therapy & physical therapy there are some risks including but not limited to fractures, disk injuries, strokes, dislocations, sprains-strains, drug interactions & reactions and/or other injuries or side effects which cannot be pre-determined.

I do not expect the doctor/provider to be able to anticipate and explain all risks and/or complications, and I wish to rely on the doctor/provider to exercise judgment during the course of the procedure(s) which the doctor/provider feels at the time is in my best interest.

In addition, because psycho-social, spiritual, and cultural values affect a patient's response to care, patients are allowed to express and follow spiritual beliefs and cultural practices that do not harm others or interfere with the planned course of treatment.

Patients have the right to refuse treatment, but must be aware of the probable consequences of refusing treatment and/or failing to cooperate with the prescribed treatment. Should you refuse and/or fail to comply with prescribed treatment your provider will discuss specific consequences with you.

Therefore I give my full consent to the doctor/provider to render treatment on me or the minor for whom I am legally responsible by a health care provider of this Facility.

I, the assignee, being the patient or legal guardian for said minor listed below, do hereby irrevocably authorize, direct, assign and give a full lien to the office named above and listed below, hereinafter referred to as the "Facility" against any & all insurance benefits, proceeds of any settlement, judgment or verdict which may be paid to the undersigned as a result of the injuries or illness for which I have been treated by the Facility.

I, the assignee further authorizes any and all insurance company, attorney and any & all third party payer to pay directly to the Facility all sums of money due them for any & all services rendered to me or minor by whom I am responsible for by reason of accident, illness and by any & all reason of any other bills that are due or may become due, and to withhold such sums from any health & accident, workers compensation and or including all insurance or third party benefits.

Assignee agrees that this Facility & staff may deliver medical records, consultations, depositions and/or court appearances which must be paid in full in advance and authorizes this Facility to release any information pertinent to said health care to any insurance company, adjuster, attorney or legal service bureau to facilitate collections under the terms of this document. Assignee grants the Facility a full power of attorney to endorse &/or sign my name on any & all checks for payment of any indebtedness owed this office & assignee.

INSURANCE BENEFITS – CREDIT POLICIES – PAYMENT TERMS & CONDITIONS

As a courtesy, the Facility will obtain a verification of applicable insurance benefits as they are quoted to us but some third party payers misquote benefits, coverage and liability. Our Facility & staff are not responsible for what a third party payer and/or representative may tell us. Any contractual, written, verbal or other obligations or arrangements between you and an attorney, insurance company, liable or third party payer are between you and said person.

1. Our Facility will file initial insurance claims for you. Secondary claim submission and/or additional reports or documents sent for your benefit may result in an additional filing or medical report charges, which you are responsible to pay.
2. Co-pays, deductibles and all non-covered service charges are due the day the service is rendered.
3. Patients are responsible for charges on all service(s) and/or product(s) which may exceed the maximum allowable and/or when a third party and/or insurance carrier does not reimburse this Facility enough to meet our cost of service.
4. All account balances, including automobile and work injury claims must be paid in full within 90 days of treatment. Patients are fully responsible for all money owed this office and such payment is not contingent on any settlement, claim, judgment, or verdict by which they may eventually recover said fee and it is also regardless of any attorney liens or pending settlement(s). If a third party payer fails to pay said balance in full within the 90-day period, the patient must pay the balance in full. Assignee is fully responsible for all money owed this Facility for any and all treatment, products & services rendered to the patient or minor shown below.
5. A non-discriminatory "Time of Service Discount" is offered to anyone who pays for services the day they are rendered. The "TOS" is only offered on the day the service is rendered. This discount does not apply to orthopedic supports, orthotics, physical therapy equipment rentals or purchases, vitamins, supplements, ointments, acupuncture treatments, weight loss programs, psychological counseling services and massage therapy.
6. A service charge is computed by a 'periodic rate' of 1½ % per month – 18% per annum & is added to all balances owed 60+ days. Any balance past due 90 days or more may be submitted to an attorney and/or agency for legal collection for which the undersigned agrees to be 100% responsible for all monthly service charges, interest, costs related to but not limited to all collection related expenses, attorney fees, court & filing fee's. Returned checks, debit & credit charges made payable to this Facility for insufficient funds, stop payments or other reasons of non-payment will be assessed a $30.00 charge.
8. Patients are eligible for a maximum $250 personal credit limit when approved. For your convenience we accept most major credit & debit cards.

PATIENT CONSENT & SIGNATURE

By my signature below I acknowledge that I have read or have had read to me and have received a photocopy upon my request of this document including the Health Care Privacy Notice, Facility terms & conditions, credit policies and Informed Consent and fully understand and have had all of my questions answered to my satisfaction. A photocopy of this document shall be considered as effective and valid as an original.

Print Name of Patient

X

Signature (if minor, parent must sign)

Date

OFFICE FINANCIAL POLICY

Our policy is to extend to you the courtesy of allowing you to assign your insurance benefits directly to us. This policy reduces your out-of-pocket expense and allows you to place your family under care. In an effort to maintain compliance with various state and federal regulations, managed care and preferred provider agreements, as well as billing and coding guidelines, we have established a single fee schedule that applies to all patients for each service provided. Discounts can only be given under the following circumstances:

1. We are a participating provider in your health plan.

2. You are covered by a State or Federal program with a mandated fee schedule.

3. You are a member of ChiroHealthUSA (CHUSA), or any other Discount Medical Plan Organization that we may join. CHUSA is a terrific option for patients with no insurance, limited insurance benefits, or high deductibles. (CHUSA is NOT insurance and may not be used concurrently with insurance in most cases)

Below are the payment options available:

1. Payment up front for a discount of up to 20%. (NOTE: This discount is not available for Medicare, other federally funded health plans, and some other health plans due to contract restrictions.)

2. Mutually agreed upon monthly payments with a debit/credit card on file that will be charged at the agreed upon time.

3. Payment in full at the time of service. (NOTE: This is easy for cash patients but proves to be difficult for insurance patients due to the multitude of insurance plans and pricing.)

4. Payment after insurance processes. This is where a patient MUST have a benefits/HSA card, credit card, or debit card ON FILE. Once the insurance processes we will charge the card on file. We will do our best to give you an estimate of the expected charge if asked on the date of service. Please realize that we can never plan to be 100% correct when an insurance company is processing your claims.)

Initial Visit Payment: Due to the individualized treatment offered and the multitude of insurance plans, our policy is to collect the lesser of the patient's copay or $79 on their first visit. If the patient has insurance or is not a member of CHUSA, the remaining balance will be charged according to #4 above. If the patient is a member of CHUSA, their initial evaluation, x-rays, and report are capped at $79.

No-Show Fee: To consistently provide our patients with the best massage therapists, we require 24-hour notice of change to any and all massage appointments. Failure to provide 24-hour notice will result in a $25 charge to your card on file. All massage patients are required to have a debit/credit card on file.

Our fees are considered usual, customary and reasonable by most companies, and therefore are covered up to the maximum allowance determined by each carrier. This statement does not apply to companies who reimburse based on an arbitrary schedule of fees bearing no relationship to the current standard and of care in this area. If your carrier has not paid a claim within sixty (60) days of submission, you agree to take an active part in the recovery of your claim. If your insurance carrier has not paid within ninety (90) days of submission, you accept responsibility for payment in full of any outstanding balance and authorize us to use your credit card to collect full payment. When your schedule of visits is once per month or longer, you will not be eligible for insurance assignment. Charges for services rendered will be due as they are rendered. We will continue to provide you with an insurance claim form. If you discontinue care for any reason other than discharge by the doctor, all balances will become immediately due and payable in full by you, regardless of any claim submitted.

Patient's Printed Name: _____

Signature: _____ Date: _____

Finance Counselor: _____ Date: _____

Front Desk: _____ Date: _____

The Neck Disability Index

Patient name: _____ File#_____ Date:_____

Please read instructions:

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 answer every section and mark in each section only the ONE box that applies to you. We realize that you may consider that two of the statements in any one section relate to you, but please just 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 the worst imaginable at the moment.

SECTION 2-PERSONAL CARE (Washing, Dressing, etc.)

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

SECTION 3-LIFTING

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

SECTION 4-READING

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

SECTION 5-HEADACHES

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

SECTION 7-WORK

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

SECTION 8-DRIVING

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

SECTION 9-SLEEPING

- ☐ I have no trouble sleeping.
- ☐ My sleep is slightly disturbed (less than 1 hr sleepless).
- ☐ My sleep is mildly disturbed (1-2 hrs sleepless).
- ☐ My sleep is moderately disturbed (2-3 hrs sleepless).
- ☐ My sleep is greatly 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 recreation activities, with no neck pain at all.
- ☐ I am able to engage in all my recreation activities, with some neck pain at all.
- ☐ I am able to engage in most, but not all, of my usual recreation activities, because of pain in my neck.
- ☐ I am able to engage in few of my recreation activities, because of pain in my neck.
- ☐ I can hardly do any recreation activities, because of pain in my neck.
- ☐ I can't do any recreation activities at all.

Instructions:

1. The NDI is scored in the same way as the Oswestry Disability Index.

2. Using this system, a score of 10-28% (i.e., 5-14 points) is considered by the authors to constitute mild disability; 30-48% is moderate; 50-68% is severe; 72% or more is complete.

Oswestry Low Back Pain Scale

Please rate the severity of your pain by circling a number below:

No pain | 0 1 2 3 4 5 6 7 8 9 10 | ***Unbearable pain***

Name _____ **Date** _____

Instructions: Please circle the **ONE NUMBER** in each section which most closely describes your problem.

Section 1 – Pain Intensity
0. The pain comes and goes and is very mild.
1. The pain is mild and does not vary much.
2. The pain comes and goes and is moderate.
3. The pain is moderate and does not vary much.
4. The pain comes and goes and is severe.
5. The pain is severe and does not vary much.

Section 2 – Personal Care (Washing, Dressing, etc.)
0. I would not have to change my way of washing or dressing in order to avoid pain.
1. I do not normally change my way of washing or dressing even though it causes some pain.
2. Washing and dressing increase the pain but I manage not to change my way of doing it.
3. Washing and dressing increase the pain and I find it necessary to change my way of doing it.
4. Because of the pain I am unable to do some washing and dressing without help.
5. Because of the pain I am unable to do any washing and dressing without help.

Section 3 – Lifting
0. I can lift heavy weights without extra pain.
1. I can lift heavy weights but it gives extra pain.
2. Pain prevents me lifting heavy weights off the floor.
3. Pain prevents me lifting heavy weights off the floor, but I can manage if they are conveniently positioned, e.g., on a table.
4. Pain prevents me lifting heavy weights but I can manage light to medium weights if they are conveniently positioned.
5. I can only lift very light weights at most.

Section 4 – Walking
0. I have no pain on walking.
1. I have some pain on walking but it does not increase with distance.
2. I cannot walk more than 1 mile without increasing pain.
3. I cannot walk more than ½ mile without increasing pain.
4. I cannot walk more than ¼ mile without increasing pain.
5. I cannot walk at all without increasing pain.

Section 5 – Sitting
0. I can sit in any chair as long as I like.
1. I can sit only in my favorite chair as long as I like.
2. Pain prevents me from sitting more than 1 hour.
3. Pain prevents me from sitting more than ½ hour.
4. Pain prevents me from sitting more than 10 minutes.
5. I avoid sitting because it increases pain immediately.

Section 6 – Standing
0. I can stand as long as I want without pain.
1. I have some pain on standing but it does not increase with time.
2. I cannot stand for longer than 1 hour without increasing pain.
3. I cannot stand for longer than ½ hour without increasing pain.
4. I cannot stand for longer than 10 minutes without increasing pain.
5. I avoid standing because it increases the pain immediately.

Section 7 – Sleeping
0. I get no pain in bed.
1. I get pain in bed but it does not prevent me from sleeping well.
2. Because of pain my normal nights sleep is reduced by less than one-quarter.
3. Because of pain my normal nights sleep is reduced by less than one-half.
4. Because of pain my normal nights sleep is reduced by less than three-quarters.
5. Pain prevents me from sleeping at all.

Section 8 – Social Life
0. My social life is normal and gives me no pain.
1. My social life is normal but it increases the degree of pain.
2. Pain has no significant effect on my social life apart from limiting my more energetic interests, e.g., dancing, etc.
3. Pain has restricted my social life and I do not go out very often.
4. Pain has restricted my social life to my home.
5. I have hardly any social life because of the pain.

Section 9 – Traveling
0. I get no pain when traveling.
1. I get some pain when traveling but none of my usual forms of travel make it any worse.
2. I get extra pain while traveling but it does not compel me to seek alternate forms of travel.
3. I get extra pain while traveling which compels to seek alternative forms of travel.
4. Pain restricts me to short necessary journeys under ½ hour.
5. Pain restricts all forms of travel.

Section 10 – Changing Degree of Pain
0. My pain is rapidly getting better.
1. My pain fluctuates but is definitely getting better.
2. My pain seems to be getting better but improvement is slow.
3. My pain is neither getting better or worse.
4. My pain is gradually worsening.
5. My pain is rapidly worsening.

TOTAL _____

The Roland-Morris Low Back Pain and Disability Questionnaire

Patient name: _____ File #_____ Date:_____

Please read instructions: When your back hurts, you may find it difficult to do some of the things you normally do. Mark only the sentences that describe you today.

- ☐ I stay at home most of the time because of my back.
- ☐ I change position frequently to try to get my back comfortable.
- ☐ I walk more slowly than usual because of my back.
- ☐ Because of my back, I am not doing any jobs that I usually do around the house.
- ☐ Because of my back, I use a handrail to get upstairs.
- ☐ Because of my back, I lie down to rest more often.
- ☐ Because of my back, I have to hold on to something to get out of an easy chair.
- ☐ Because of my back, I try to get other people to do things for me.
- ☐ I get dressed more slowly than usual because of my back.
- ☐ I only stand up for short periods of time because of my back.
- ☐ Because of my back, I try not to bend or kneel down.
- ☐ I find it difficult to get out of a chair because of my back.
- ☐ My back is painful almost all of the time.
- ☐ I find it difficult to turn over in bed because of my back.
- ☐ My appetite is not very good because of my back.
- ☐ I have trouble putting on my sock (or stockings) because of the pain in my back.
- ☐ I can only walk short distances because of my back pain.
- ☐ I sleep less well because of my back.
- ☐ Because of my back pain, I get dressed with the help of someone else.
- ☐ I sit down for most of the day because of my back.
- ☐ I avoid heavy jobs around the house because of my back.
- ☐ Because of back pain, I am more irritable and bad tempered with people than usual.
- ☐ Because of my back, I go upstairs more slowly than usual.
- ☐ I stay in bed most of the time because of my back.

Instructions:

1. The patient is instructed to put a mark next to each appropriate statement.

2. The total number of marked statements are added by the clinician. Unlike the authors of the Oswestry Disability Questionnaire, Roland and Morris did not provide descriptions of the varying degrees of disability (e.g., 40%-60% is severe disability).

3. Clinical improvement over time can be graded based on the analysis of serial questionnaire scores. If, for example, at the beginning of treatment, a patient's score was 12 and, at the conclusion of treatment, her score was 2 (10 points of improvement), we would calculate an 83% (10/12 x 100) improvement.