Choose the path...
Great Plains chiropractic + wellness
to a healthier life!

Patient Intake

Date of Birth: _____

First Name: _____MI_____Last_____ ☐ Male ☐ Female

Address: _____ **SS#**_____

City: _____ State: _____ Zip: _____ E-Mail: _____

Phone (H): _____ (W) _____ (Cell) _____

Marital Status: M S W D Spouses Name:_____

Occupation: _____ Employer: _____

Who may we thank for referring you?_____

Emergency Contact: _____ Phone: _____

Person Responsible For Account ME OTHER

Will you be using insurance? ___Yes ___No Insurance Company:_____

Was this due to an Auto Accident? ___Yes ___No If Yes, Auto Ins?_____ Is this a Work Related Injury? ___Yes___No

Have you ever visited a Chiropractor? ___No ___Yes If Yes, whom?_____Medical Dr's Name_____

WHEN DOCTORS WORK TOGETHER IT BENEFITS YOU. MAY WE HAVE YOUR PERMISSION TO UPDATE YOUR MEDICAL DOCTOR REGARDING YOUR CARE AT THIS OFFICE?_____

Reason for today's visit 1)_____ 2)_____

3)_____ 4)_____

Please describe what happened:_____

When did this condition begin?_____Is it?_____Constant____Comes/Goes_____Getting Worse

What makes it worse?_____Does anything make it feel better?_____

Is it? ___Burning ___Aching ___Stabbing ___Dull ___Radiating, Where?_____

Worse in: ___Morning ___During work ___Evening after work ___Middle of night ___Other:_____

Have you ever had this before? ____No ____Yes If Yes, when?_____

Have you had recent x-rays? ___Yes ___No

Are you pregnant? ___Yes ___No ___Not sure Date of Last Menstrual Period_____

Past Injuries (include auto, work, home, fractures, etc): _____

_____

Medications/Supplements (include prescription/non-prescription): _____

_____

AUTHORIZATION AND RELEASE: I authorize payment of insurance benefits directly to the chiropractor or chiropractic office. I authorize the doctor to release all information necessary to communicate with personal physicians and other healthcare providers and payers and to secure the payment of benefits. I authorize the release of my medical records and information to other healthcare providers, which this office may utilize or be in contact with such as my Primary Care Physician. I understand that I am responsible for all costs of chiropractic care, regardless of insurance coverage. I also understand that if I suspend or terminate my schedule of care as determined by my treating doctor, any fees for professional services will be immediately due and payable. The patient understand and agrees to allow this chiropractic office to use their Patient Health Information for the purpose of treatment, payment, healthcare operations, and coordination of care.

_____ _____

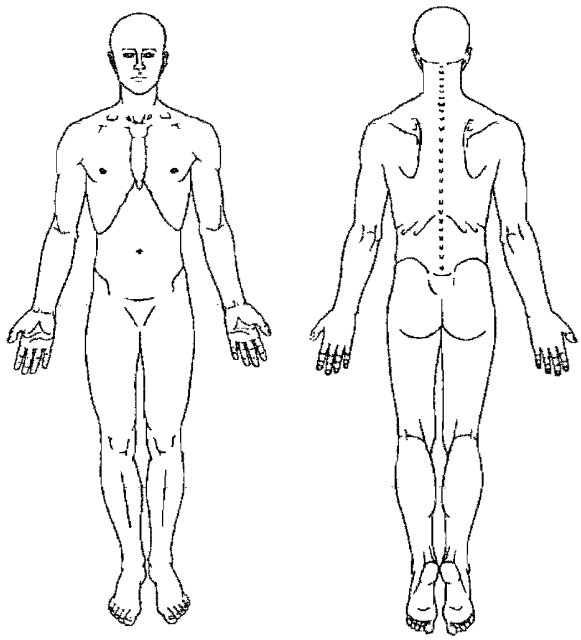
Signature of Patient (or parent, if minor) Date

TELL US WHERE YOU HURT

Please read carefully:

Mark the areas on your body where you feel your pain. Include all affected areas. Mark areas of radiation. If your pain radiates, draw an arrow from where it starts to where it stops. Please extend the arrow as far as the pain travels. Use the appropriate symbol(s) listed below.

Ache> > > > Numbness= = = = = Pins & Needles o o o o
Burning x x x x Stabbing / / / / Throbbing ~ ~ ~ ~



GREAT PLAINS CHIROPRACTIC FINANCIAL POLICY

Dear Patient,

Thank you for choosing us as your health care provider. The following is our financial policy. The complexity of today's medical billing and insurance reimbursement can often make receiving health care very confusing. It is important to us that you understand the process from the beginning of care. Therefore, it you have any questions or concerns about our payment policies, please do not hesitate to ask our office manager.

We do, in most instances, accept assignment of insurance benefits. However you must understand that.

1. Your insurance policy is a contract between you, your employer, and the insurance company. We are not a party of that contract.
2. All charges are your responsibility whether your insurance company pays or not. Some insurance companies select certain services they will not cover. Fee for these services are your responsibility, however we will attempt to make you aware of these situations as soon as possible.
3. Co-payments and co-insurance are due at the time of service.
4. If the insurance company does not pay your balance in full within 30 days, we ask that you contact that carrier to help speed things up.
5. If the insurance company does not pay in full within 45 days. We may ask that you pay the balance due with cash or check.
6. A charge of 1.5% may be assessed on all balances over 30days old.

We understand that temporary financial problems may affect timely payment of your balance. We encourage you to communicate any such problems so that we can assist you in the management of your account.

Thank you again for choosing us. We appreciate your trust, and the opportunity to serve you.

Patients Signature_____ Date _____
(Parents signature if a minor)

Patient Health Information Consent Form

We want you to know how your Patient Health Information (PHI) is going to be used in this office and your rights concerning those records. Before we will begin any health care operations we must require you to read and sign this consent form stating that you understand and agree with how your records will be used. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your Patient Health Information we encourage you to read the HIPAA NOTICE that is available to you at the front desk before signing this consent.

1. The patient understands and agrees to allow this chiropractic office to use their Patient Health Information (PHI) for the purpose of treatment, payment, healthcare operations, and coordination of care. As an example, the patient agrees to allow this chiropractic office to submit requested PHI to the Health Insurance Company (or companies) provided to us by the patient for the purpose of payment. Be assured that this office will limit the release of all PHI to the minimum needed for what the insurance companies require for payment.
2. The patient has the right to examine and obtain a copy of his or her own health records at any time and request corrections. The patient may request to know what disclosures have been made and submit in writing any further restrictions on the use of their PHI. Our office is not obligated to agree to those restrictions.
3. A patient's written consent need only be obtained one time for all subsequent care given the patient in this office.
4. The patient may provide a written request to revoke consent at any time during care. This would not affect the use of those records for the care given prior to the written request to revoke consent but would apply to any care given after the request has been presented.
5. For your security and right to privacy, all staff has been trained in the area of patient record privacy and a privacy official has been designated to enforce those procedures in our office. We have taken all precautions that are known by this office to assure that your records are not readily available to those who do not need them.
6. Patients have the right to file a formal complaint with our privacy official about any possible violations of these policies and procedures.
7. If the patient refuses to sign this consent for the purpose of treatment, payment and health care operations, the chiropractic physician has the right to refuse to give care.

I have read and understand how my Patient Health Information will be used and I agree to these policies and procedures.

Name of Patient Signature of Patient Date

QUADRUPLE VISUAL ANALOGUE SCALE

Patient Name _____ Date _____

Please read carefully:

Instructions: Please circle the number that best describes the question being asked.

Note: If you have more than one complaint, please answer each question for each individual complaint and indicate the score for each complaint. Please indicate your pain level right now, average pain, and pain at its best and worst.

Example:

	Headache				Neck				Low Back			
No pain												**worst possible pain**
0	**1**	**(2)**	**3**	**4**	**(5)**	**6**	**7**	**(8)**	**9**	**10**		

---

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 WORST (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**	

OTHER COMMENTS:

_____

_____

_____
Examiner

Reprinted from *Spine*, 18, Von Korff M, Deyo RA, Cherkin D, Barlow SF, Back pain in primary care: Outcomes at 1 year, 855-862, 1993, with permission from Elsevier Science.

PATIENT REVIEW OF SYSTEMS

Please check the "**current**" box for all conditions that you are now experiencing and mark the "**recent**" box for any condition or symptom(s) experienced at any time in your life. Please do not write in the spaces marked "**Doctor's Notes Only**".

	Current	Recent
GENERAL		
Fever	☐	☐
Sweats	☐	☐
Chills	☐	☐
Fatigue	☐	☐
Weight loss	☐	☐
Weight gain	☐	☐
Sleep disturbance	☐	☐
Change in routine	☐	☐
HEAD		
Headache	☐	☐
Dizziness	☐	☐
Head trauma	☐	☐
Fainting	☐	☐
Blacking out	☐	☐
EYES		
Change in vision	☐	☐
Glasses/Contacts	☐	☐
Blurry vision	☐	☐
Double vision	☐	☐
Cataracts	☐	☐
Sensitive to light	☐	☐
Flashes in vision	☐	☐
Spots in vision	☐	☐
EARS		
Ringing in ears	☐	☐
Frequent infection	☐	☐
Hearing loss	☐	☐
Drainage	☐	☐
Ear pain	☐	☐
NOSE		
Post nasal drip	☐	☐
Nosebleeds	☐	☐
Sinus problems	☐	☐
MOUTH		
Bleeding gums	☐	☐
Cold sores	☐	☐
Dentures	☐	☐
Trouble Swallowing	☐	☐
Sore throat	☐	☐
Jaw pain	☐	☐
Changes in taste	☐	☐
Swelling	☐	☐
Dental problems	☐	☐
Hoarseness	☐	☐
NECK		
Masses	☐	☐
Swelling	☐	☐
Stiffness	☐	☐

	Current	Recent
LUNGS		
Difficulty breathing	☐	☐
Asthma	☐	☐
Pneumonia	☐	☐
Wheezing	☐	☐
Persistent cough	☐	☐
Coughing up phlegm	☐	☐
Coughing up blood	☐	☐
Tuberculosis	☐	☐
VASCULAR		
Chest pain	☐	☐
Palpitations	☐	☐
Ankle swelling	☐	☐
Cold feet or hands	☐	☐
Discolored foot/hand	☐	☐
Hot feet or hands	☐	☐
Leg cramps	☐	☐
Calf pain	☐	☐
Varicose veins	☐	☐
Low blood pressure	☐	☐
High blood pressure	☐	☐
G-I SYSTEM	☐	☐
Gas	☐	☐
Heartburn/Indigestion	☐	☐
Ulcers	☐	☐
Vomiting/Nausea	☐	☐
Abdominal pain	☐	☐
Diarrhea	☐	☐
Constipation	☐	☐
Blood in stool	☐	☐
Hemorrhoids	☐	☐
Gall bladder disease	☐	☐
Liver disease	☐	☐
G-U SYSTEM		
Difficulty urinating	☐	☐
Pain urinating	☐	☐
Blood in urine	☐	☐
Incontinence	☐	☐
Foul odor of urine	☐	☐
Increased urination	☐	☐
Decreased urination	☐	☐
Urinary infection	☐	☐
Genital infection	☐	☐
Kidney stones	☐	☐

Patient Name _____

Date _____

	Curren	Recent
PSYCHOLOGIC		
Excessive Stress	☐	☐
Depression	☐	☐
Anxiety	☐	☐
Mood swings	☐	☐
SKIN	☐	☐
Rash	☐	☐
Bruising	☐	☐
Hair loss	☐	☐
Warts	☐	☐
Brittle nails	☐	☐
Changes in moles	☐	☐
Itching	☐	☐
Peeling	☐	☐
NEUROLOGIC		
Seizures/Epilepsy	☐	☐
Strokes	☐	☐
Tingling sensation	☐	☐
Numbness	☐	☐
Weakness	☐	☐
Difficulty walking	☐	☐
Poor coordination	☐	☐
MUSCLE/BONE		
Joint pain	☐	☐
Stiffness	☐	☐
Muscle ache	☐	☐
Arthritis	☐	☐
Deformity	☐	☐
Bone pain	☐	☐
Fractures	☐	☐
Dislocations	☐	☐
CONDITIONS		
Hypertension	☐	☐
Diabetes	☐	☐
Thyroid condition	☐	☐
Heart condition	☐	☐
Rheumatic arthritis	☐	☐
Rheumatic Fever	☐	☐
Glaucoma	☐	☐
Alcoholism	☐	☐
Cancer / Tumor	☐	☐
Polio	☐	☐
Parkinson's	☐	☐
Multiple Sclerosis	☐	☐
Gout	☐	☐
Anemia	☐	☐
Osteoporosis	☐	☐
VACCINATIONS	**IF AGE > 60 y/o**	
Flu	☐	☐
Varicella	☐	☐
Pneumonia	☐	☐

	Curren	Recent	
MEDICATION			
Prescription medications	☐	☐	(please bring a list).
Non-prescribed medication.	☐	☐	(please bring a list)
Drug allergies	☐	☐	
Recreational drugs	☐	☐	
MEDICAL	☐	☐	
Surgery-any area	☐	☐	
Hospitalization	☐	☐	
Prior prescriptions	☐	☐	
Psychiatric care	☐	☐	
Substance abuse	☐	☐	
Last laboratory test	☐	☐	
Last chest x-ray (for those over age 55)	_____		
SOCIAL			
Consume alcohol	☐	☐	
Consume coffee	☐	☐	
Consume tea	☐	☐	
Consume sodas	☐	☐	
Smoker	☐	☐	
Aerobic exercise	☐	☐	
Water intake/day	☐	☐	
Herbs	☐	☐	
Hobbies	☐	☐	
Vitamins (bring a list)	☐	☐	
Allergies	☐	☐	
Drink ___ glasses water/day			
Sleep _____ hours/night			
OB GYN – For Females	**List Dates as Indicated**		
Age period began	_____		
Last breast exam	_____		
Last PAP date	_____		
Pregnancy(s)- past	_____		
Pregnancy	☐	☐	
Mastectomy	☐	☐	
Lumps in breast	☐	☐	
Nipple discharge	☐	☐	
Hysterectomy	☐	☐	
PMS	☐	☐	
Irregular periods	☐	☐	
Hot flashes	☐	☐	
Menstrual cramps	☐	☐	
FAMILY HISTORY			
Breast Cancer	☐	☐	
Colorectal Cancer	☐	☐	
Alcoholism	☐	☐	
Osteoporosis	☐	☐	
Depression	☐	☐	
Epilepsy	☐	☐	
Alzheimer's	☐	☐	
Heart Disease	☐	☐	

Informed Consent Form

The doctor of chiropractic evaluates the patient using standard examination and testing procedures. A chiropractic adjustment involves the application of a quick, precise force directed over a very short distance to a specific vertebra or bone. There are a number of different techniques that may be used to deliver the adjustment, some of which utilize specially designed equipment. Adjustments are usually performed by hand but may also be performed by hand-guided instruments. Other treatments used by chiropractors include physical therapy modalities (heat, ice, ultrasound, soft-tissue manipulation), nutritional recommendations and rehabilitative procedures.

Chiropractic treatments are one of the safest interventions available to the public demonstrated through various clinical trials and indirectly reflected by the low malpractice insurance paid by chiropractors. While there are risks involved with treatment, these are seldom great enough to contraindicate care. Referral for further diagnosis or management to a medical physician or other health care provider will be suggested based on history and examination findings. Listed below are summaries of both common and rare side-effects/complications associated with chiropractic care:

Common [1]

- Reactions most commonly reported are local soreness/discomfort (53%), headaches (12%), tiredness (11%), radiating discomfort (10%), dizziness, the vast majority of which resolve within 48 hours

Rare [2]

- Fractures or joint injuries in isolated cases with underlying physical defects, deformities or pathologies
- Physiotherapy burns due to some therapies
- Disc herniations
- Cauda Equina Syndrome[3] (1 case per 100 million adjustments)
- Compromise of vertebrobasilar artery (i.e. stroke) (1 case per 400,000 to 1 million cervical spine adjustments [manipulations]). This associated risk is also found with consulting a medical doctor for patients under the age of 42 and is higher for those older than 42 when seeing a medical doctor.[4, 5] These findings suggest that neither chiropractic or medical care is the cause, but rather because patients with a dissection in progress have symptoms of headache or neck pain they seek care from a health care provider. Please indicate to your doctor if you have a headache or neck pain that is the worst you have ever felt.

Reasonable alternatives to these procedures have been explained to me including prescription medications, over-the-counter medications, possible surgery, and non-treatment. Listed below are summaries of concern with the associated alternative procedures.

- Long-term use or overuse of medication carries some risk of dependency with the use of pain medication the risk of gastrointestinal bleeding among other risks
- Surgical risks may include unsuccessful outcome, complications such as infection, pain, reactions to anesthesia, and prolonged recovery.[6]
- Potential risks of refusing or neglecting care may result in increased pain, restricted motion, increased inflammation, and worsening of my condition.[7]

Neck and back pain generally improve in time, however, recurrence is common. Remaining active and positive improve your chances of recovery.

1. Senstad O, Leboeuf-Yde C, Borchgrevink CF. Side-effects of chiropractic spinal manipulation: types frequency, discomfort and course. *Scand J Prim Health Care.* Mar 1996;14(1):50-53.
2. Thiel HW, Bolton JE, Docherty S, Portlock JC. Safety of chiropractic manipulation of the cervical spine: a prospective national survey. *Spine.* Oct 1 2007;32(21):2375-2378; discussion 2379.
3. Shekelle PG, Adams AH, Chassin MR, Hurwitz EL, Brook RH. Spinal manipulation for low-back pain. *Ann Intern Med.* Oct 1 1992;117(7):590-598.
4. Boyle E, Cote P, Grier AR, Cassidy JD. Examining vertebrobasilar artery stroke in two Canadian provinces. *Spine.* Feb 15 2008;33(4 Suppl):S170-175.
5. Cassidy JD, Boyle E, Cote P, et al. Risk of vertebrobasilar stroke and chiropractic care: results of a population-based case-control and case-crossover study. *Spine.* Feb 15 2008;33(4 Suppl):S176-183.
6. Carragee EJ, Hurwitz EL, Cheng I, et al. Treatment of neck pain: injections and surgical interventions: results of the Bone and Joint Decade 2000-2010 Task Force on Neck Pain and Its Associated Disorders. *Spine.* Feb 15 2008;33(4 Suppl):S153-169.
7. Carroll LJ, Hogg-Johnson S, van der Velde G, et al. Course and prognostic factors for neck pain in the general population: results of the Bone and Joint Decade 2000-2010 Task Force on Neck Pain and Its Associated Disorders. *Spine.* Feb 15 2008;33(4 Suppl):S75-82.

Please check any appropriate boxes if it applies to you to help us determine possible risk factors:

GENERAL

Have you ever had an adverse (i.e. bad) reaction to or following chiropractic care? ☐

BONE WEAKNESS

Have you been diagnosed with osteoporosis? ☐
Do you take corticosteroids (e.g. prednisone)? ☐
Have you been diagnosed with a compression fracture(s) of the spine? ☐
Have you ever been diagnosed with cancer? ☐
Do you have any metal implants? ☐

VASCULAR WEAKNESS

Do you take aspirin or other pain medication on a regular basis? ☐
If yes, about how much do you take daily?_____
Do you take warfarin (Coumadin), heparin, or other similar "blood thinners"? ☐
Have you ever been diagnosed with any of the following disorders/diseases?

- Rheumatoid arthritis ☐
- Reiter's syndrome, ankylosing spondylitis, or psoriatic arthritis ☐
- Giant cell arteritis (temporal arteritis) ☐
- Osteogenesis imperfect ☐
- Ligamentous hypermobility such as with Marfan's disease, Ehlers-Danlos syndrome ☐
- Medial cystic necrosis (cystic mucoid degerneation) ☐
- Bechet's disease ☐
- Fibromuscular dysplasia ☐

Have you ever become dizzy or lost consciousness when turning your head? ☐

SPINAL COMPROMISE OR INSTABILITY

Have you had spinal surgery? ☐
If yes, when?_____
Have you been diagnosed with spinal stenosis? ☐
Have you been diagnosed with spondyliolithesis? ☐
Have you had any of the following problems?

- Sudden weakness in the arms or legs? ☐
- Numbness in the genital area? ☐
- Recent inability to urinate or lack of control when urinating? ☐

I also understand that my condition may worsen and referral may be necessary if a course of chiropractic care does not help or improve my condition. I have read the previous information regarding risks of chiropractic care and my doctor has explained my risks (if any) to me and suggested alternatives when those risks exist. I understand the prupose of my care and have been given an explanation of the treatment, the frequency of care, and alternatives to this care. All of my question have been answered to my satisfaction. I agree to this plan of care.

PATIENT'S SIGNATURE:_____DATE:_____
(Parent/Guardian's signature if minor)

Neck Index

ACN Group, Inc. Form NI-100

ACN Group, Inc. Use Only rev 3/27/2003

Patient Name _____ *Date* _____

This questionnaire will give your provider information about how your neck condition affects your everyday life. Please answer every section by marking the one statement that applies to you. If two or more statements in one section apply, please mark the one statement that most closely describes your problem.

Pain Intensity

⓪ I have no pain at the moment.
① The pain is very mild at the moment.
② The pain comes and goes and is moderate.
③ The pain is fairly severe at the moment.
④ The pain is very severe at the moment.
⑤ The pain is the worst imaginable at the moment.

Sleeping

⓪ I have no trouble sleeping.
① My sleep is slightly disturbed (less than 1 hour sleepless).
② My sleep is mildly disturbed (1-2 hours sleepless).
③ My sleep is moderately disturbed (2-3 hours sleepless).
④ My sleep is greatly disturbed (3-5 hours sleepless).
⑤ My sleep is completely disturbed (5-7 hours sleepless).

Reading

⓪ I can read as much as I want with no neck pain.
① I can read as much as I want with slight neck pain.
② I can read as much as I want with moderate neck pain.
③ I cannot read as much as I want because of moderate neck pain.
④ I can hardly read at all because of severe neck pain.
⑤ I cannot read at all because of neck pain.

Concentration

⓪ I can concentrate fully when I want with no difficulty.
① I can concentrate fully when I want with slight difficulty.
② I have a fair degree of difficulty concentrating when I want.
③ I have a lot of difficulty concentrating when I want.
④ I have a great deal of difficulty concentrating when I want.
⑤ I cannot concentrate at all.

Work

⓪ I can do as much work as I want.
① I can only do my usual work but no more.
② I can only do most of my usual work but no more.
③ I cannot do my usual work.
④ I can hardly do any work at all.
⑤ I cannot do any work at all.

Personal Care

⓪ I can look after myself normally without causing extra pain.
① I can look after myself normally but it causes extra pain.
② It is painful to look after myself and I am slow and careful.
③ I need some help but I manage most of my personal care.
④ I need help every day in most aspects of self care.
⑤ I do not get dressed, I wash with difficulty and stay in bed.

Lifting

⓪ I can lift heavy weights without extra pain.
① I can lift heavy weights but it causes extra pain.
② Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned (e.g., on a table).
③ Pain prevents me from lifting heavy weights off the floor, but I can manage light to medium weights if they are conveniently positioned.
④ I can only lift very light weights.
⑤ I cannot lift or carry anything at all.

Driving

⓪ I can drive my car without any neck pain.
① I can drive my car as long as I want with slight neck pain.
② I can drive my care as long as I want with moderate neck pain.
③ I cannot drive my car as long as I want because of moderate neck pain.
④ I can hardly drive at all because of severe neck pain.
⑤ I cannot drive my car at all because of neck pain.

Recreation

⓪ I am able to engage in all my recreation activities without neck pain.
① I am able to engage in all my usual recreation activities with some neck pain.
② I am able to engage in most but not all my usual recreation activities because of neck pain.
③ I am only able to engage in a few of my usual recreation activities because of neck pain.
④ I can hardly do any recreation activities because of neck pain.
⑤ I cannot do any recreation activities at all.

Headaches

⓪ I have no headaches at all.
① I have slight headaches which come infrequently.
② I have moderate headaches which come infrequently.
③ I have moderate headaches which come frequently.
④ I have severe headaches which come frequently.
⑤ I have headaches almost all the time.

Neck Index Score

Back Index

ACN Group, Inc. Form BI-100

ACN Group, Inc. Use Only rev 3/27/2003

Patient Name _____ **Date** _____

This questionnaire will give your provider information about how your back condition affects your everyday life. Please answer every section by marking the one statement that applies to you. If two or more statements in one section apply, please mark the one statement that most closely describes your problem.

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 very severe.
⑤ The pain is very severe and does not vary much.

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 sleep is reduced by less than 25%.
③ Because of pain my normal sleep is reduced by less than 50%.
④ Because of pain my normal sleep is reduced by less than 75%.
⑤ Pain prevents me from sleeping at all.

Sitting

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

Standing

⓪ I can stand as long as I want without pain.
① I have some pain while 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 1/2 hour without increasing pain.
④ I cannot stand for longer than 10 minutes without increasing pain.
⑤ I avoid standing because it increases pain immediately.

Walking

⓪ I have no pain while walking.
① I have some pain while walking but it doesn't increase with distance.
② I cannot walk more than 1 mile without increasing pain.
③ I cannot walk more than 1/2 mile without increasing pain.
④ I cannot walk more than 1/4 mile without increasing pain.
⑤ I cannot walk at all without increasing pain.

Personal Care

⓪ I do 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 increases the pain but I manage not to change my way of doing it.
③ Washing and dressing increases 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.

Lifting

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

Traveling

⓪ I get no pain while traveling.
① I get some pain while traveling but none of my usual forms of travel make it worse.
② I get extra pain while traveling but it does not cause me to seek alternate forms of travel.
③ I get extra pain while traveling which causes me to seek alternate forms of travel.
④ Pain restricts all forms of travel except that done while lying down.
⑤ Pain restricts all forms of travel.

Social Life

⓪ My social life is normal and gives me no extra pain.
① My social life is normal but increases the degree of pain.
② Pain has no significant affect 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.

Changing degree of pain

⓪ My pain is rapidly getting better.
① My pain fluctuates but overall 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.

Back Index Score