



LEWIS FAMILY  
**CHIROPRACTIC**  
& WELLNESS CENTER P.A.

## Welcome to Our Office

Name \_\_\_\_\_

Date \_\_\_\_\_

I am here today for:  
(please only choose one)

\_\_\_\_\_ To meet the Doctor / learn about the office  
(I understand that there is no financial obligation today to meet the doctor and learn about the office.)

\_\_\_\_\_ To become a New patient, receive an exam, get a  
diagnosis, and recommendations from the Doctor to  
resolve my problem.  
(I understand that I am financial responsible for services rendered during today's visit.)

How did you find out about us?

\_\_\_ Office web-site    \_\_\_ Ins web-site    \_\_\_ Carroll Magazine

\_\_\_ Yellow book    \_\_\_ Verizon Book    \_\_\_ Post-card

\_\_\_ Sign/Marke    \_\_\_ Event \_\_\_\_\_  
(location)

\_\_\_ News Paper Insert (city) \_\_\_\_\_

\_\_\_ Carroll County Times Ad    \_\_\_ Health Fair \_\_\_\_\_  
(location)

Friend or Family: \_\_\_\_\_ Doctor \_\_\_\_\_

Gregory C. Lewis, D.C., *President* • Rosemary Luebker, D.C., *Vice President*  
Preventative & Wellness/Family Care • Muscle, Nerve and Joint Disorders  
Non-Surgical, Conservative Care for: Neck Pain, Back Pain, Headaches

403 Malcolm Drive • Westminster, Maryland 21157 • 410-876-8885 • Fax 410-876-5961 • [www.lewisfamilychiro.com](http://www.lewisfamilychiro.com)



**LEWIS FAMILY  
CHIROPRACTIC  
& WELLNESS CENTER P.A.**

First Name: \_\_\_\_\_ Middle Initial: \_\_\_\_\_ Last Name: \_\_\_\_\_

Address Line 1: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Cell Phone: \_\_\_\_\_ Email: \_\_\_\_\_

Date Of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_ Sex: \_\_\_\_ Male \_\_\_\_ Female

Social Security Number \_\_\_\_-\_\_\_\_-\_\_\_\_ Marital Status: \_\_\_\_ Single \_\_\_\_ Married \_\_\_\_ Other

Employment Status: \_\_\_\_ Employed \_\_\_\_ Full Time Student \_\_\_\_ Part Time Student \_\_\_\_ Other

Spouse Data

Is your spouse a patient in the clinic? \_\_\_\_ Yes \_\_\_\_ No

First Name: \_\_\_\_\_ Middle Initial: \_\_\_\_\_ Last Name: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Cell Phone: \_\_\_\_\_ Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_

Employer Data

Employer: \_\_\_\_\_

Address Line 1: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Emergency Contact

Contact Name: \_\_\_\_\_

Contact Phone: \_\_\_\_\_

Primary Care Physician: \_\_\_\_\_ Phone Number: \_\_\_\_\_

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Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_

Describe your symptoms: \_\_\_\_\_

\_\_\_\_\_

When did your symptoms start? Month \_\_\_\_\_ Day \_\_\_\_\_ Year \_\_\_\_\_

How did your symptoms begin? \_\_\_\_\_

\_\_\_\_\_

How often do you experience your symptoms? (Percentage of the day)

\_\_\_\_\_ Constantly(76-100%) \_\_\_\_\_ Frequently(51-75%) \_\_\_\_\_ Occasionally(26-50%) \_\_\_\_\_ Intermittently(0-25%)

What describes the nature of your symptoms?

\_\_\_\_\_ Sharp      \_\_\_\_\_ Dull Ache      \_\_\_\_\_ Numb      \_\_\_\_\_ Shooting

\_\_\_\_\_ Burning      \_\_\_\_\_ Tingling      \_\_\_\_\_ Stabbing

How are your symptoms changing?

\_\_\_\_\_ Getting Better      \_\_\_\_\_ Not Changing      \_\_\_\_\_ Getting Worse

During the past 4 weeks, indicate the average intensity of your symptoms: (0 = None to 10= Unbearable)

0      1      2      3      4      5      6      7      8      9      10

During the past 4 weeks, how much has pain interfered with your normal work (Including both work outside the home and housework):

\_\_\_\_\_ Not at all      \_\_\_\_\_ A little bit      \_\_\_\_\_ Moderately      \_\_\_\_\_ Quite a bit      \_\_\_\_\_ Extremely

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**Patient History** Name: \_\_\_\_\_ Date: \_\_\_\_\_

**In general would you say your overall health right now is...**

\_\_\_ Excellent \_\_\_ Very Good \_\_\_ Fair \_\_\_ Poor

**Who have you seen for your symptoms:**

\_\_\_ No one \_\_\_ Other Chiropractor \_\_\_ Medical Dr. \_\_\_ Physical Therapist \_\_\_ Other

**What treatment did you receive for your symptoms?**

\_\_\_ Adjustments \_\_\_ Physical Therapy \_\_\_ Medication \_\_\_ Surgery \_\_\_ Other

**When did you receive treatment?**

\_\_\_ In the last Month \_\_\_ 2-3 Months ago \_\_\_ 3-6 Months ago \_\_\_ 6 Months - yr ago \_\_\_ 1-2 yrs ago

\_\_\_ 2-5 yrs ago \_\_\_ 5-10 yrs ago

**What tests have you had for your symptoms?**

\_\_\_ X-ray \_\_\_ MRI \_\_\_ CT Scan \_\_\_ Other

**When were these tests done?**

\_\_\_ In the last Month \_\_\_ 2-3 Months ago \_\_\_ 3-6 Months ago \_\_\_ 6 Months - yr ago \_\_\_ 1-2 yrs ago

\_\_\_ 2-5 yrs ago \_\_\_ 5-10 yrs ago

**Have you had similar symptoms in the past?**

\_\_\_ Yes \_\_\_ No

**Medical Conditions:**

\_\_\_ Arthritis \_\_\_ Cancer \_\_\_ Diabetes \_\_\_ Heart disease \_\_\_ Hypertension \_\_\_ Psychiatric illness \_\_\_ Skin Disorder \_\_\_ Stroke

**Surgeries:**

\_\_\_ Appendectomy \_\_\_ Cardiovascular Procedure \_\_\_ Cervical disc procedure \_\_\_ Hysterectomy \_\_\_ Joint Replacement \_\_\_ Back Surgery \_\_\_ Radical Prostatectomy \_\_\_ Transurethral Prostate Surgery

**Allergies:**

\_\_\_ Eggs \_\_\_ Fish/Shellfish \_\_\_ Milk/Lactose \_\_\_ Peanut \_\_\_ Soy \_\_\_ Sulfites

**Social History:**

\_\_\_ Caffeine used occasionally \_\_\_ Caffeine used often \_\_\_ Chew tobacco occasionally \_\_\_ Chew tobacco often \_\_\_ Drink alcohol occasionally \_\_\_ Drink alcohol often \_\_\_ Exercise often \_\_\_ Exercise occasionally \_\_\_ Exercise not at all \_\_\_ Experience Stress often \_\_\_ Experience Stress occasionally \_\_\_ Smoke 1 pk or less per day \_\_\_ Smoke more than 1 pk per day \_\_\_ Wear seat belt always \_\_\_ Wear seat belt usually \_\_\_ Wear seat belt never

**Family History:**

\_\_\_ Arthritis (parent) \_\_\_ Arthritis (sibling) \_\_\_ Cancer (parent) \_\_\_ Cancer (sibling) \_\_\_ Cholesterol (parent) \_\_\_ Cholesterol (sibling) \_\_\_ Diabetes (parent) \_\_\_ Diabetes (sibling) \_\_\_ Heart problems (parents) \_\_\_ Heart problems (sibling) \_\_\_ Hypertension (parent) \_\_\_ Hypertension (sibling) \_\_\_ Psychiatric (parent) \_\_\_ Psychiatric (sibling) \_\_\_ Stroke (parent) \_\_\_ Stroke (sibling) \_\_\_ Thyroid (parent) \_\_\_ Thyroid (sibling)

**Substance Use:**

\_\_\_ Alcohol (past) ( present) \_\_\_ Amphetamines (past) (present) \_\_\_ Barbiturates (past) (present)

\_\_\_ Cocaine (past) (present) \_\_\_ Crystal Meth (past) (present) \_\_\_ Heroin (past) (present) \_\_\_ Marijuana (past) (present)

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**LEWIS FAMILY  
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& WELLNESS CENTER P.A.**

Effective Date: This notice is effective 03/03/03

I acknowledge receipt of this Notice of HIPAA Privacy Practices:

Sign: \_\_\_\_\_ Date: \_\_\_\_\_

Print Name of Patient: \_\_\_\_\_

If you are signing as the patient representative:

Print your name: \_\_\_\_\_

Describe your authority: \_\_\_\_\_

Please list any other family members you would like to allow to be a recipient of your health information:

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Notice Of Privacy Practice (3/03)

This notice describes how health information about you may be used and disclosed and how you can get access to this information. It is effective April 14, 2003, and applies to all protected health information contained in your health records maintained by us. We have the following duties regarding the maintenance, use and disclosure of your health records:

- (1) We are required by law to maintain the privacy of the protected health information in your records and to provide you with this Notice of our legal duties and privacy practices with respect to that information.
(2) We are required to abide by the terms of this Notice currently in effect.
(3) We reserve the right to change the terms of this Notice at any time, making the new provisions effective for all health information and records that we have and continue to maintain. All changes in this Notice will be prominently displayed and available at our office.

There are a number of situations in which we may use or disclose to other persons or entities your confidential health information. Certain uses and disclosures will require you to sign an acknowledgement that you received this Notice of Privacy Practices. These include treatment, payment, and health care operations. Any use or disclosure of your protected health information required for anything other than treatment, payment, or health care operations require you to sign an Authorization. Certain disclosures that are required by law, or under emergency circumstances, may be made without your Acknowledgement or Authorization. Under any circumstance, we will use or disclose only the minimum amount of information necessary from your medical records to accomplish the intended purpose of the disclosure.

We will attempt in good faith to obtain your signed Acknowledgement that you received this Notice to use and disclose your confidential medical information for the following purposes. These examples are not meant to be exhaustive, but to describe the types of uses and disclosures that may be made by our office once you have provided the Consent.

Treatment: We will use your health information to make decisions about the provision, coordination, or management of your healthcare, including analyzing or diagnosing your condition and determining the appropriate treatment for that condition. It may also be necessary to share your health information with another health care provider whom we need to consult with respect to your care. These are only examples of uses and disclosures of medical information and treatment purposes that may or may not be necessary in your case.

Patient Name: \_\_\_\_\_

Patient Signature: \_\_\_\_\_

Date: \_\_\_\_\_

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**Payment:** We may need to use or disclose information in your health record to obtain reimbursement from you, from your health insurance carrier, or from another insurer for our services rendered to you. This may include determinations of eligibility or coverage under the appropriate health plans, pre-certification and pre-authorization of services or review of services for the purpose of reimbursement. This information may also be used for billing, claims management and collection purposes, and related healthcare data processing through our system.

**Operations:** Your health records may be used in our business planning and development operations, including improvements in our methods of operation, and general administrative functions. We may also use information in our overall compliance planning, healthcare review activities, and arranging for legal and auditing functions.

There are certain circumstances under which we may use or disclose your health information without first obtaining your Acknowledgement or Authorization. Those circumstances generally involve public health and oversight activities, law-enforcement activities, judicial and administrative proceedings, and in the event of death. Specifically, we may be required to report certain agencies information concerning certain communicable diseases, sexually transmitted diseases or HIV/AIDS status. We may also be required to report instances of suspected or documented abuse, neglect, or domestic violence. We are required to report to appropriate agencies and law-enforcement officials information that you or another person is in immediate threat of danger to health or safety as a result of violent activity. We must also provide health information when ordered by a court of law to do so. We may contact you from time to time to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

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

**Communication Barriers and Emergencies:** We may use and disclose your protected health information if we attempt to obtain consent from you but are unable to do so because of substantial communication barriers and we determine, using professional judgment, that you intend to consent to use or disclose under the circumstances. We may use or disclose your protected health information in an emergency treatment situation. If this happens, we will try to obtain your consent as soon as reasonably practicable after the delivery of treatment. If we are required by law or as a matter of necessity to treat you, and we have attempted to obtain your consent but have been unable to obtain your consent, we may still use or disclose your protected health information to treat you.

Except as indicated above, your personal health information will be used or disclosed to any other person or entity without your specific Authorization, which may be revoked at any time. In particular, except to the extent disclosure has been made to governmental entities required by law to maintain the confidentiality of the information, information will not be further disclosed to any other person or entity with respect to information concerning mental-health treatment, drug and alcohol abuse, HIV/AIDS or sexually transmitted diseases that may be contained in your health records. We likewise will not disclose your health-record information to an employer for purposes of making employment decisions, to a liability insurer or attorney as a result of injuries sustained in an automobile accident, or to educational authorities, without your written authorization.

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You have certain rights regarding your health record information, as follows:

- (1) You may request that we restrict the uses and disclosures of your health record information for treatment, payment and operations, or restrictions involving your care or payment related to that care. We are not required to agree to the restriction; however, if we agree, we will comply with it, except with regard to emergencies, disclosure of the information to you, or if we are otherwise required by law to make a full disclosure without restriction.
- (2) You have a right to request receipt of confidential communications of your medical information by an alternative location. If you require such an accommodation, you may be charged a fee for the accommodation and will be required to specify the alternative address or method of contact and how payment will be handled.
- (3) You have the right to inspect, copy, and request amendments to your health records. Access to your health records will not include psychotherapy notes contained in them, or information compiled in anticipation of or for use in a civil, criminal, or administrative action or proceeding to which your access is restricted by law. We will charge a reasonable fee for providing a copy of your health records, or a summary of those patient records, at your request, which includes the cost of copying, postage and preparation or an explanation or summary of the information.
- (4) All requests for inspection, copying, and/or amending information in your health records, and all requests related to your rights under this Notice, must be made in writing and addressed to the Privacy Officer at our address. We will respond to your request in a timely fashion.
- (5) You have a limited right to receive an accounting of all disclosures we make to other persons or entities of your health information except for disclosures required for treatment, payment, and healthcare operations, disclosures that require an Authorization, disclosure incidental or another permissible use or disclosure, and otherwise as allowed by law. We will not charge you for the first accounting in any twelve-month period; however, we will charge you a reasonable fee for each subsequent request for an accounting within the same twelve-month period.
- (6) If this notice was initially provided to you electronically, you have the right to obtain a paper copy of this notice and to take one home with you if you wish.

You may file a written complaint to us or to the Secretary of Health and Human Services if you believe that your privacy rights with respect to confidential information in your health records have been violated. All complaints must be in writing and must be addressed to the Privacy Officer (in the case of complaints to us) or to the person designated by the U.S. Department of Health and Human Services if we cannot resolve your concerns. You will not be retaliated against for filing such a complaint.

All questions concerning this Notice or requests made pursuant to it should be addressed to:

Lewis Chiropractic Center, P.A.- 403 Malcolm Drive - Westminster, MD 21157 – (410)876-8885

Patient Name \_\_\_\_\_ Date \_\_\_\_\_

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**LEWIS FAMILY  
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& WELLNESS CENTER P.A.**

**Release of Medical Records**

Date \_\_\_\_\_

I \_\_\_\_\_, hereby authorize \_\_\_\_\_  
\_\_\_\_\_ to release the following medical  
records to Lewis Family Chiropractic Center.

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Patient Name

\_\_\_\_\_  
Date of Birth

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9.06.12



**LEWIS FAMILY  
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& WELLNESS CENTER, P.A.**

**AUTHORIZATION TO TREAT AND INFORMED CONSENT:**

I, the undersigned, do hereby authorize Lewis Chiropractic Center to perform such exam and treatment, as they deem necessary per my condition. I affirm that all of the information that I have been given pertaining to my current health status is truthful and accurate to the best of my knowledge. I fully understand that there is a possibility of muscle soreness and/or injury as a result of participating in this program. I understand that it is my responsibility to monitor my own condition throughout each treatment session, and should any unusual symptoms occur, I will inform a Lewis Chiropractic Center professional immediately.

**MEDICAL RELEASE:**

Lewis Chiropractic Center is authorized to release any information they deem appropriate in regards to my physical condition to any insurance company, attorney, or adjustor for purpose of reimbursement of charges or claim incurred by me.

**ASSIGNMENT OF BENEFITS:**

I hereby authorize payment for medical services performed by Lewis Chiropractic Center directly to the provider. I understand that my insurance company and I have a contract with one another, not the facility or provider and the insurance company. If I receive a check for payment of services rendered at Lewis Chiropractic Center immediately. In the event that my insurance company does not pay my bill, either in part or in it's entirety, I UNDERSTAND THAT I AM RESPONSIBLE FOR ANY AND ALL UNPAID BALANCE DUE ON MY ACCOUNT. I agree to pay any collection costs and/or attorney fees accumulated by Lewis Chiropractic Center in the recovery of said account, if applicable.

**REFUND POLICY:**

Any refunds issued to patients for non-completion of pre-paid care will be refunded via check within 30 days.

**PATIENT AGREEMENT:**

I understand that all records established by this office are the sole property of Lewis Chiropractic Center. I hereby give Lewis Chiropractic Center consent to treat myself/my minor child and to take a copy of my photo I.D. and insurance card. My signature is acknowledgement that I have read and understand the above stated office policies and agree to abide by the same. This will serve as my signature on file for this office.

\_\_\_\_\_  
SIGNATURE OF PATIENT/PARENT/GUARDIAN

\_\_\_\_\_  
DATE

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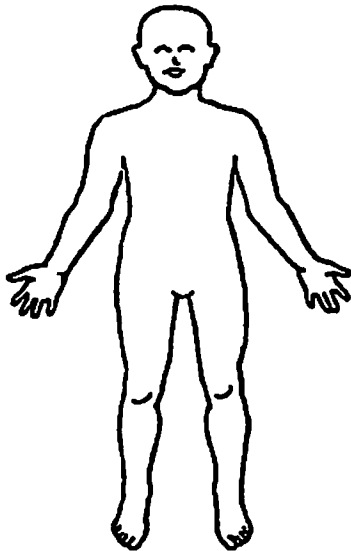
## VISUAL ANALOG SCALE

Please draw the location of your pain or discomfort on the images below. Use the letters shown to represent the type of pain.

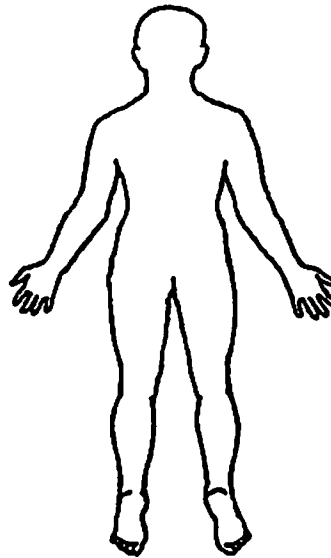
**D =Dull      S =Stabbing/Cutting      B=Burning      N =Numb      T=Tingling (Pins & Needles)      C=Cramping**



**RIGHT**



**FRONT**



**BACK**



**LEFT**

Please circle one number in each of the following categories: 1 being very little pain & 10 being the worst pain

**Neck**

Rate the pain you have now:

Mild 0 1 2 3 4 5 6 7 8 9 10 Severe

**Neck**

Rate your pain at its best this week:

Mild 0 1 2 3 4 5 6 7 8 9 10 Severe

**Neck**

Rate your pain at its worst this week:

Mild 0 1 2 3 4 5 6 7 8 9 10 Severe

**Back**

Rate the pain you have now:

Mild 0 1 2 3 4 5 6 7 8 9 10 Severe

**Back**

Rate your pain at its best this week:

Mild 0 1 2 3 4 5 6 7 8 9 10 Severe

**Back**

Rate your pain at its worst this week:

Mild 0 1 2 3 4 5 6 7 8 9 10 Severe

**Other:** \_\_\_\_\_

Rate the pain you have now:

Mild 0 1 2 3 4 5 6 7 8 9 10 Severe

**Other:** \_\_\_\_\_

Rate your pain at its best this week:

Mild 0 1 2 3 4 5 6 7 8 9 10 Severe

**Other:** \_\_\_\_\_

Rate your pain at its worst this week:

Mild 0 1 2 3 4 5 6 7 8 9 10 Severe

Name: \_\_\_\_\_

Lewis Chiropractic and Wellness Center

Date: \_\_\_\_\_

403 Malcolm Drive; Westminster, MD 21157

\_\_\_\_\_  
Patient's Signature

LEWIS CHIROPRACTIC CENTER, P.A.  
403 MALCOLM DRIVE  
WESTMINSTER, MD 21157  
410-876-8885

# NECK DISABILITY INDEX QUESTIONNAIRE

Patient's Name: \_\_\_\_\_

Today's Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

SS# \_\_\_\_\_

DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_

Member ID # \_\_\_\_\_

**Instructions:** This questionnaire has been designed to give your 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 with the ONE answer that applies best to you. We realize you may consider that two of the statements in any one section relate to you; but please mark the answer that most closely describes your problem.

### 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.

### Lifting

- I can lift heavy weights without 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 they are conveniently positioned, for example on a table.
- Pain prevents me from lifting heavy weights, 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.

### Headaches

- I have no headaches at all.
- I have slight headaches, which come infrequently.
- I have moderate headaches, which come infrequently.
- I have moderate headaches, which come frequently.
- I have severe headaches, which come frequently.
- I have headaches almost all the time.

### 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 help every day in most aspects of self-care.
- I need some help every day in most aspects of self-care.
- I do not get dressed, I wash with difficulty and stay in bed.

### Reading

- I can read as much as I want with no pain in my neck.
- I can read as much as I want with slight pain in my neck.
- I can read as much as I want 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 because of severe pain in my neck.

### Concentration

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

### Work

- 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 cannot do my usual work.
- I can hardly do any work at all.
- I can't do any work at all.

### Sleeping

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

### 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.

### Recreation

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

Patient's Signature: \_\_\_\_\_

DOCTOR Last Name: \_\_\_\_\_ First: \_\_\_\_\_ MI: \_\_\_\_\_

Please Print Legibly

# REVISED OSWESTRY LOW BACK PAIN QUESTIONNAIRE

Patient's Name: \_\_\_\_\_

Today's Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_ Member ID # \_\_\_\_\_

**Instructions:** This questionnaire has been designed to give your doctor information as to how your low back pain has affected your ability to manage everyday life. Please answer every section and mark in each section the ONE answer that applies to you best. We realize you may consider that two of the statements in any one section relate to you; but please mark the answer that most closely describes your problem.

## Pain Intensity

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

## Lifting

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

## Sitting

- I can sit in any chair as long as I like without pain.
- I can only sit in my favorite chair as long as I like.
- Pain prevents me from sitting more than one hour.
- Pain prevents me from sitting more than ½ hour.
- Pain prevents me from sitting more than ten minutes.
- Pain prevents me from sitting at all.

## Personal Care (Washing, Dressing, etc.)

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

## Walking

- Pain does not prevent me from walking any distance.
- Pain prevents me from walking more than one mile.
- Pain prevents me from walking more than ½ mile.
- Pain prevents me from walking more than ¼ mile.
- I can only walk while using a cane or on crutches.
- I am in bed most of the time and have to crawl to the toilet.

## Standing

- I can stand as long as I want without pain.
- I have some pain while standing, but it does not increase with time.
- I cannot stand for longer than one hour without increasing pain.
- I cannot stand for longer than ½ hour without increasing pain.
- I cannot stand for longer than ten minutes without increasing pain.
- I avoid standing because it increases the pain straight away.

## Sleeping

- I get no pain in bed.
- I get pain in bed, but it does not prevent me from sleeping well.
- Because of pain, my normal night's sleep is reduced by less than one-quarter.
- Because of pain, my normal night's sleep is reduced by less than one-half.
- Because of pain, my normal night's sleep is reduced by less than three-quarters.
- Pain prevents me from sleeping at all.

## Traveling

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

## Social Life

- My social life is normal and gives me no pain.
- My social life is normal, but increases the degree of my pain.
- Pain has no significant effect on my social life apart from limiting my more energetic interests, e.g., dancing, etc.
- Pain has restricted my social life and I do not go out very much.
- I have hardly any social life because of the pain.
- I can't drive my car at all because of the pain.

## Changing Degree of Pain

- My pain is rapidly getting better.
- My pain fluctuates, but overall is definitely getting better.
- My pain seems to be getting better, but improvement is slow at present.
- My pain is neither getting better nor worse.
- My pain is gradually worsening.
- My pain is rapidly worsening.

Patient's Signature: \_\_\_\_\_

DOCTOR Last Name: \_\_\_\_\_ First: \_\_\_\_\_ MI: \_\_\_\_\_

Please Print Legibly