OSWESTRY (BACK) QUESTIONNAIRE

Name: _____ Date: _____

Please read carefully: This questionnaire has been designed to give the doctor information as to how your back pain has affected your ability to manage everyday life. Please answer every section by marking the ONE box that most applies to you. We realize you may feel that more than one statement may relate to you, but PLEASE JUST MARK THE ONE CHOICE WHICH MOST CLOSELY DESCRIBES YOUR PROBLEM RIGHT NOW.

SECTION 1--PAIN INTENSITY
__ I can tolerate the pain I have without having to use pain killers
__ The pain is bad but I manage without taking pain killers.
__ Pain killers give complete relief from pain.
__ Pain killers give moderate relief from pain.
__ Pain killers give very little relief from pain.
__ Pain killers have no effect on the pain and I do not use them.

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

SECTION 3--LIFTING
__ I can lift heavy weights without extra pain.
__ I can lift heavy weight, but it gives me extra pain.
__ Pain prevents me from lifting heavy weight off the floor.
__ Pain prevents me from lifting heavy weight 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 lift only very light weights.
__ I cannot lift or carry anything at all.

SECTION 4--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 1/2 mile.
__ Pain prevents me from walking more than 1/4 mile.
__ I can only walk when using a cane or crutches.
__ I am in bed most of the time and have to crawl to the toilet.

SECTION 5--SITTING
__ I can sit in any chair as long as I like without pain.
__ I can sit only 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.

SECTION 6--STANDING
__ I can stand as long as I want without extra pain.
__ I can stand as long as I want but it gives me extra pain.
__ Pain prevents me from standing for more than one hour.
__ Pain prevents me from standing for more than 1/2 hour.
__ Pain prevents me from standing for more than 10 minutes.
__ Pain prevents me from standing at all.

SECTION 7--SLEEPING
__ Pain does not prevent me from sleeping well.
__ I can sleep well only by using tablets.
__ Even when I take tablets I have less than 6 hours sleep.
__ Even when I take tablets I have less than 4 hours sleep.
__ Even when I take tablets I have less than 2 hours sleep.
__ Pain prevents me from sleeping at all.

SECTION 8—SEX LIFE
__ My sex life is normal and causes no extra pain.
__ My sex life is normal but causes extra pain.
__ My sex life is nearly normal but is very painful.
__ My sex life is severly restricted by pain.
__ My sex life is nearly absent because of pain.
__ Pain prevents any sex life at all.

SECTION 9--SOCIAL LIFE
__ My social life is normal and gives me no extra pain.
__ My social life is normal, but increases the degree of 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 as often.
__ Pain has restricted my social life to my home.
__ I have no social life because of the pain.

SECTION 10--TRAVELING
__ I can travel anywhere without extra pain.
__ I can travel anywhere but it gives me extra pain.
__ Pain is bad but I manage journeys over 2 hours.
__ Pain restricts me to journeys of less than 1 hour.
__ Pain restricts me to short necessary journeys under 20 minutes.
__ Pain restricts me from traveling except to the doctor or hospital.

OTHER COMMENTS:

Visual Analogue Pain Scale

Because of your condition, how much pain have you had in the past week?

Please mark on the line to indicate how severe your pain has been.

NO PAIN I----------I SEVERE PAIN

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Nathan Marsh, DC

NECK DISABILITY INDEX

Patient Name:_____ Today's Date: _____

Date of Birth: _____ Examiner: _____

How long have you had neck pain? ____ Years ____ Months ____ Weeks

How long have you had headaches? ____ Years ____ Months ____ Weeks

Please read carefully:

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 LINE** which 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 one line which most closely describes your problem.**

SECTION 1 --- Pain Intensity

0__ I have no pain at the moment.
1__ The pain is very mild at the moment.
2__ The pain is moderate at the moment.
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.

SECTION 2 --- Personal Care (washing, dressing, etc.)

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 manage most of my personal care.
4__ I need help every day in most aspects of self care.
5__ I do not get dressed, wash with difficulty and stay in bed.

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 from lifting heavy objects 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 but I can manage light to medium weights if they are conveniently positioned.
4__ I can lift very light weights.
5__ I cannot lift or carry anything at all.

SECTION 4 --- Reading

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

SECTION 5 --- 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.

SECTION 6 --- Concentration

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

SECTION 7 --- Work

0__ I can do as much work as I want to.
1__ I can only do my usual work, but no more.
2__ I can 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.

SECTION 8 --- Driving

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

SECTION 9 --- Sleeping

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

SECTION 10 --- Recreation

0__ I am able to engage in all my recreation activities with no neck pain at all.
1__ I am able to engage in all my recreation activities with some pain in my neck.
2__ I am able to engage in most, but not all of my usual recreation activities because of pain in my neck.
3__ I am able to engage in a few of my usual recreation activities because of pain in my neck.
4__ I can hardly do any recreation activities because of pain in my neck.
5__ I cannot do any recreation activities at all.

OTHER COMMENTS:

Visual Analogue Pain Scale

How much pain have you had because of your condition in the past week? Please mark on the line to indicate how severe your pain has been.

NO PAIN I_____IPAIN AS BAD AS COULD BE

Slight Severe

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Pain Disability Questionnaire (PDQ)

NAME: _____ DATE: _____

Please read:

This survey asks for your views about how your pain now affects how you function in everyday activities. This information will help you and your doctor know how you feel and how well you are able to do your daily tasks at this time

Please answer every question by making an "X" along the line to show how much your pain problem has affected you (from having no problems at all to having the most severe problems you can imagine).

BE SURE TO ANSWER *ALL* QUESTIONS.

1. Does your pain interfere with your normal work inside and outside the home?
   Work normally — Unable to work at all
2. Does your pain interfere with personal care (such as washing, dressing, etc.)?
   Take care of myself completely — Need help with all my personal care
3. Does your pain interfere with your traveling?
   Travel anywhere I like — Only travel to see doctors
4. Does your pain affect your ability to sit or stand?
   No problems — Cannot sit/stand at all
5. Does your pain affect your ability to lift overhead, grasp objects, or reach for things?
   No problems — Cannot do at all
6. Does your pain affect your ability to lift objects off the floor, bend, stoop, or squat?
   No problems — Cannot do at all
7. Does your pain affect your ability to walk or run?
   No problems — Cannot walk/run at all
8. Has your income declined since your pain began?
   No decline — Lost all income
9. Do you have to take pain medication every day to control your pain?
   No medication needed — On pain medication throughout the day
10. Does your pain force you to see doctors much more often than before your pain began?
    Never see doctors — See doctors weekly
11. Does your pain interfere with your ability to see the people who are important to you as much as you would like?
    No problem — Never see them
12. Does your pain interfere with recreational activities and hobbies that are important to you?
    Normal activity — No recreation/hobbies at all
13. Do you need the help of your family and friends to complete everyday tasks (including both work outside the home and housework) because of your pain?
    Never need help — Need help all the time
14. Do you now feel more depressed, tense, or anxious than before your pain began?
    No depression/tension — Severe depression/tension
15. Are there emotional problems caused by your pain that interfere with your family, social, or work activities?
    No problems — Severe problems

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PERSONAL DATA SHEET

Please fill out both sides of form completely. USE BLACK INK ONLY-NO PENCILS PLEASE!
PLEASE ADVISE FRONT DESK IF YOU'VE HAD A RECENT AUTO OR WORK RELATED INJURY

Patient Name: First _____ MI _____ Last _____ Date: _____
Address: _____ City: _____ St: ____ ZIP _____-____
Billing Address if different: _____ E-Mail: _____
Marital Status: S M W D **Sex**: F M **Date of Birth**: _____ Children's Ages _____
Home Phone ( ) _____ **Cell** Phone ( ) _____ Soc Sec #: _____
Your Employer: _____ Work Address: _____
Work Phone: ( ) _____ Occupation: _____
Spouse Name: _____ SSN: _____
Spouse's Employer: _____ Address: _____
Spouse's Work # ( ) _____ Spouse date of birth: _____
Responsible Party (if patient is a minor): _____ SSN _____
Date of Birth: _____ Employer: _____ Work Phone ( ) _____
Please list two persons we may contact in an emergency (required):
1. _____
Name Address Phone
2. _____
Name Address Phone

Who may we thank for referring you to our office? _____
Family Physician: _____ City: _____

Patient Insurance Information (Please show your card to the receptionist)

Primary Insurance **(If we're seeing you for an auto accident or a work injury, put your auto/work comp carrier here)**:
Name of Insurance/Auto Carrier/Work Comp Carrier: _____
Name of Insured (if someone other than patient): _____ **Birthdate**: _____
Policy/ID or Claim#: _____ Date of Injury _____ Group #: _____
Secondary Insurance **(If we're seeing you for an auto or work comp injury, put your health insurance info here)**:
Name of Insurance Company: _____
Name of Insured (if someone other than patient): _____ Birthdate: _____
Policy or ID #: _____ Group #: _____

AGREEMENT

I understand and agree that health insurance is an arrangement between my insurance company and me. Furthermore, I understand this office will prepare any necessary reports and forms to assist me in receiving reimbursement from the insurance company. I authorize the release of any medical or other information necessary to process insurance claims. I also request payment of government or Medicare benefits either to myself or to the party who accepts assignment. I authorize payment of other medical benefits to Chiropractic Physicians, PC. I clearly understand and agree that all services rendered me are charged directly to me and I am personally responsible for payment, including interest and late fees should my account become delinquent. **I understand I may be charged for a missed massage appointment if I cancel or no-show without a 24-hour notice**. I may also be terminated after three no-show/no call appointments with my doctor within a calendar year. I acknowledge receiving a copy of the Patient Privacy Notice.

Patient's Signature _____ Date: _____

Responsible Party's Signature _____ Date: _____

Purpose of this appointment or major complaints: _____

_____

What other doctors have you seen for this condition? _____

Treatment given: _____

Is this complaint from a work injury? (Notify staff) _____ **Date of Injury** _____

Describe how work-related injury occurred: _____

Have you reported this injury to your employer? _____

Is this complaint from an auto accident? (Notify staff) _____ **Date of Injury** _____

Briefly describe auto accident: _____

Is this complaint the result of any other accident (please describe): _____

_____ **Date of Injury** _____

How long have you had this condition? _____

Have you had this or similar conditions in the past? _____

What activities aggravate your condition? _____

Is it getting worse? ( ) Yes ( ) No ( ) Constant ( ) Comes and goes

Is this condition interfering with your: ( ) Work ( ) Sleep ( ) Daily Routine

How long has it been since you felt really good? _____

What do you believe is the problem? _____

List surgical operations and the year performed: _____

List drugs you are taking now: _____

Have you had any other personal injury or accident? _____

Family Health Information (Many health problems are the result of heredity. Therefore, information about your family members will give us a better picture of your total health)

RELATIONSHIP	HEALTH PROBLEM
_____	_____
_____	_____
_____	_____

Have you ever:	YES	NO	Describe briefly
Been knocked unconscious?	( )	( )	_____
Used a cane, crutch or other support?	( )	( )	_____
Been treated for a spine or nerve disorder?	( )	( )	_____
Had a fractured bone?	( )	( )	_____
Been hospitalized for other than surgery?	( )	( )	_____
Do you:			
Now take vitamin or minerals?	( )	( )	_____
Think you may need vitamins/minerals?	( )	( )	_____
Have an allergy to drugs? Other allergies?	( )	( )	_____

Habits:	Heavy	Moderate	Light	None
Alcohol	( )	( )	( )	( )
Caffeine	( )	( )	( )	( )
Tobacco	( )	( )	( )	( )
Sugar/Sweeteners	( )	( )	( )	( )
Drugs	( )	( )	( )	( )
Exercise	( )	( )	( )	( )
Sleep	( )	( )	( )	( )
Appetite	( )	( )	( )	( )

In the event x-rays are taken, is there any possibility that you may be pregnant? _____ Date of last period _____

Please provide any other additional information that you feel may be important to our understanding of your condition: _____

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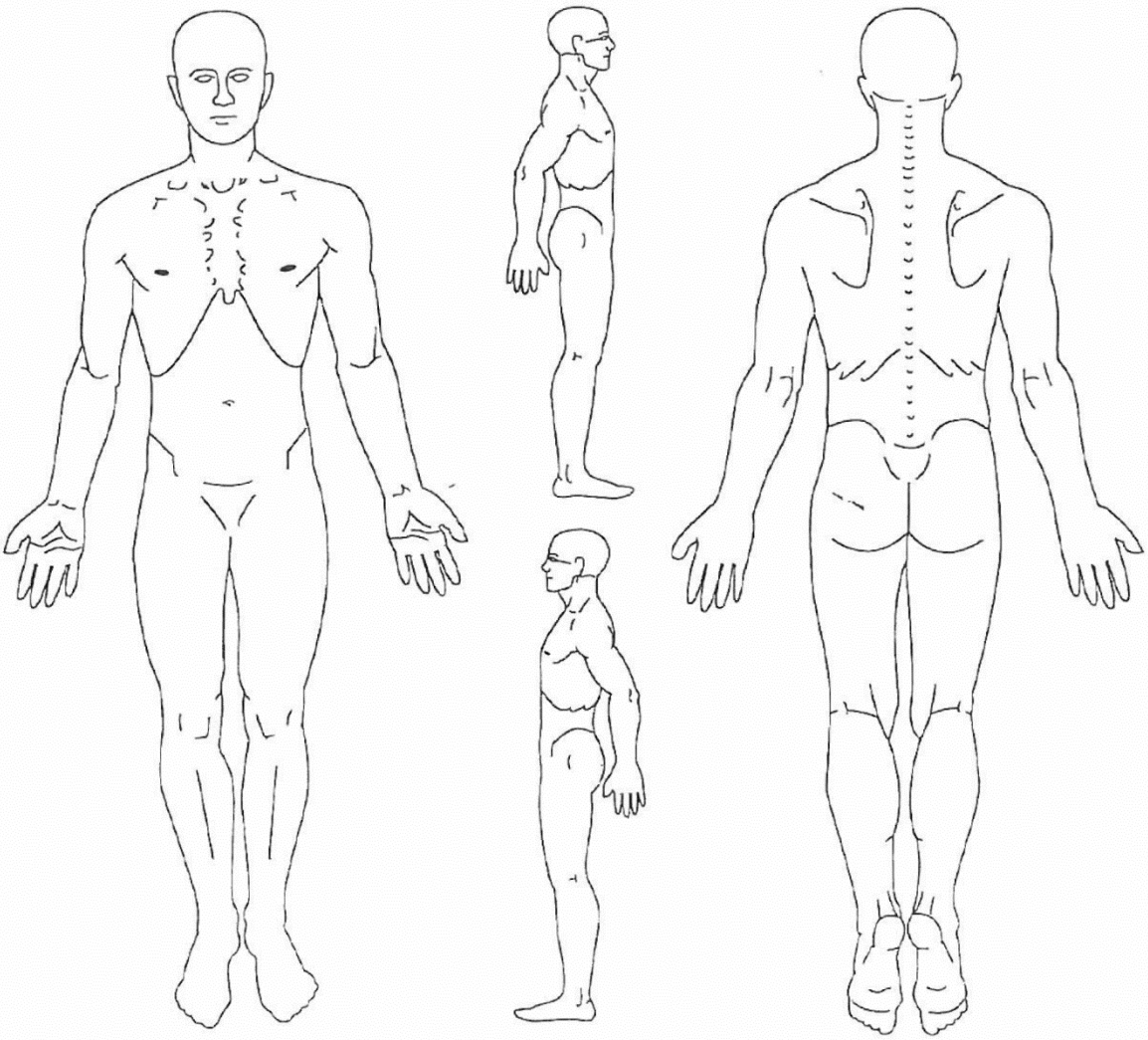
Patient Name (Print)_____ Date_____

Patient date of birth_____ Claim #_____

Please draw the location of your pain or discomfort on the images below. Use the symbols shown to represent the type(s) of pain:

D = Dull
B = Burning
N = Numb
S = Stabbing/Cutting
T = Tingling (Pins and needles)
C = Cramping



On the scales below, please draw a vertical line representing your pain or discomfort:

Rate the pain you have **right now**:
No Pain Unbearable Pain
|0_____10|

Rate your pain at its **best** in the past week:
No Pain Unbearable Pain
|0_____10|

Rate your **average** pain in the past week:
No Pain Unbearable Pain
|0_____10|

Rate your **worst** pain in the last week:
No Pain Unbearable Pain
|0_____10|