HealthSource®
Chiropractic & Progressive Wellness®

ENTRANCE APPLICATION

WELCOME!... WE ARE HONORED YOU CHOSE US TO EVALUATE YOUR CONDITION.
SO WE MAY FILE YOUR INSURANCE FORMS FOR YOU, WOULD YOU PLEASE FILL OUT THE PERSONAL INFORMATION BELOW?
IF YOU NEED ASSISTANCE PLEASE INFORM THE FRONT DESK PERSON. THANK YOU!

First Name _____ Middle _____ Last _____

Gender ☐ Male ☐ Female Home Phone _____ Cell Phone _____

Address _____

City _____ State _____ ZIP _____

Social Security Number ___ - ___ - ___ E-mail Address _____

Birthdate _____ Age _____ **Marital Status** S ☐ M ☐ W ☐ D ☐

Job Title _____ Work Phone _____

Spouse's Name _____ Spouse's Birthdate _____

Social Security Number ___ - ___ - ___

Person responsible for this account _____

Name of person on your health insurance card _____

Name of their employer _____ City _____

Employer Phone _____

Children–Names & Ages _____

_____

In case of emergency, whom should we contact? _____

Phone _____

FAMILY PHYSICIAN: _____

What is your primary complaint? _____

_____

IS THIS WORKMAN'S COMPENSATION? _____ **IS THIS PERSONAL INJURY?** _____

Patient Informed Consent

I, _____, the undersigned patient, consent to the treatment(s) provided by this clinic. I understand that my condition may necessitate modifications from time to time of the type of treatment(s) rendered and the portions of my body that may need to be examined. I understand and consent to clinic staff providing me with verbal descriptions, when there are changes to my exam(s) and treatment(s), consent to the clinic staff providing said treatment(s) and exam(s) and hereby consent to any similar subsequent treatment(s) or exam(s). If I do not consent, I will immediately inform clinic staff. There are times when individuals other than staff may see me receive treatment at the clinic or overhear discussions of my condition or insurance. I consent to others perceiving these interactions at the clinic. If additional privacy is required, I will inform the clinic staff.

Patient Signature _____

(Office use only)	Account Number	Date

HS HealthSource® Chiropractic & Progressive Wellness™

NAME: **DATE:** / / **Account#:**

HISTORY OF ILLNESS / INJURY / PAIN

LOCATION

Chief complaint and its location: _____

_____

TIMING & DURATION

How often do you experience this pain? _____Constant _____Frequent _____Intermittent ____Occasional

What caused the onset? _____

_____

Date of onset? / / (Please list your most recent incident (minor or major) that prompted this visit.)

SEVERITY

On a scale of 0 to 10 with 0 representing no pain and 10 being the most severe pain imaginable, use the key below to rate the severity of your pain.

0 = None 1 = Minimal 2 = Very Mild 3 = Mild 4 = Mild to Moderate 5 = Moderate
6 = Moderate to Severe 7 = Mildly Severe, Restricts Some Activity 8 = Severe, Limits Most Activity
9 = Very Severe 10 = Excruciating

Sitting here today, right now, what is the intensity of your pain on a scale of 0 to 10?

_____0 _____1 _____2 _____3 _____4 _____5 _____6 _____7 _____8 _____9 _____10

What is the least intense the symptom has been on a scale of 0 to 10?

_____0 _____1 _____2 _____3 _____4 _____5 _____6 _____7 _____8 _____9 _____10

What is the most intense the symptom has been on a scale of 0 to 10?

_____0 _____1 _____2 _____3 _____4 _____5 _____6 _____7 _____8 _____9 _____10

ASSOCIATED SIGNS & SYMPTOMS

Please check those that apply ➡ _____Inflexibility _____Stiffness _____Spasms _____Cramps

If this pain radiates or travels, please identify where to: _____

_____

QUALITY

How would you best describe the sensation of the pain/symptom:

_____ Sharp _____ Stabbing _____ Aching _____ Pins & Needles _____ Pounding _____ Shooting
_____ Burning _____ Dull _____ Tingling/Numb _____ Throbbing _____ Crawling _____ Stinging

MODIFYING FACTORS

What aggravates the pain/symptom?

_____Sneezing _____Lifting _____Exercising _____Looking up/down _____Walking
_____Coughing _____Sitting _____Stooping _____Looking side/side _____Standing
_____Stress _____Driving _____Getting out of bed _____Pushing _____Pulling
_____Repetitive movement _____Carrying _____Straining at BM _____Climbing stairs _____Getting in/out of car

Other: _____

What relieves this pain/symptom?

_____Resting _____Sleeping _____Lifting _____Exercising _____Looking up/down
_____Shower _____Advil _____Stooping _____Looking side/side _____Mineral Ice
_____Other: _____

Over the past weeks/months this complaint is: _____Improving _____Getting worse _____About the same

Have you seen anyone for this condition? _____YES _____NO WHOM? _____

How did you hear about us? _____

Doctor Signature: _____

Patient Signature: _____

NAME: DATE: / / Account#:

SECONDARY COMPLAINT & LOCATION

Location _____ Sitting here today, right now, what is the intensity of your pain on a scale of 0 to 10?

_____0 _____1 _____2 _____3 _____4 _____5 _____6 _____7 _____8 _____9 _____10

What is the least intense the symptom has been on a scale of 0 to 10?

_____0 _____1 _____2 _____3 _____4 _____5 _____6 _____7 _____8 _____9 _____10

What is the most intense the symptom has been on a scale of 0 to 10?

_____0 _____1 _____2 _____3 _____4 _____5 _____6 _____7 _____8 _____9 _____10

ASSOCIATED SIGNS & SYMPTOMS Please check those that apply ➡ _____Inflexibility _____Stiffness _____Spasms _____Cramps

If the pain radiates or travels, please identify where to: _____

QUALITY

How would you best describe the sensation of the pain/symptom:

_____ Sharp _____ Stabbing _____ Aching _____ Pins & Needles _____ Pounding _____ Shooting
_____ Burning _____ Dull _____ Tingling/Numb _____ Throbbing _____ Crawling _____ Stinging

Over the past weeks/months this complaint is: _____Improving _____Getting worse _____About the same

THIRD COMPLAINT & LOCATION

Location _____ Sitting here today, right now, what is the intensity of your pain on a scale of 0 to 10?

_____0 _____1 _____2 _____3 _____4 _____5 _____6 _____7 _____8 _____9 _____10

What is the least intense the symptom has been on a scale of 0 to 10?

_____0 _____1 _____2 _____3 _____4 _____5 _____6 _____7 _____8 _____9 _____10

What is the most intense the symptom has been on a scale of 0 to 10?

_____0 _____1 _____2 _____3 _____4 _____5 _____6 _____7 _____8 _____9 _____10

ASSOCIATED SIGNS & SYMPTOMS Please check those that apply ➡ _____Inflexibility _____Stiffness _____Spasms _____Cramps

If the pain radiates or travels, please identify where to: _____

QUALITY

How would you best describe the sensation of the pain/symptom:

_____ Sharp _____ Stabbing _____ Aching _____ Pins & Needles _____ Pounding _____ Shooting
_____ Burning _____ Dull _____ Tingling/Numb _____ Throbbing _____ Crawling _____ Stinging

Over the past weeks/months this complaint is: _____Improving _____Getting worse _____About the same

KEY VALUE QUESTIONS

1. What is your pain keeping you from doing that is most important in your life?

_____

_____

2. What do you enjoy doing most in your life?

_____

_____

NOTES / COMMENTS:

_____

_____

_____

Doctor Signature: _____

Patient Signature: _____

NAME: **DATE:** / / **Account#:**

Please place a checkmark by the condition that applies to you: **P** = Present • **N** = Not Present • **PP** = If it has ever been present in the past

P	N	PP	
			Fatigue
			Fever
			Chills
			Night Sweats
			Fainting
			Nervousness
			Concentration Loss

P	N	PP	
			Irritability
			Depression
			Memory Loss
			Headache
			Muscle Pain
			Muscle Weakness
			Muscle Cramps

P	N	PP	
			Joint Stiffness
			Spinal Curvature
			Back Pain
			Hot Joints
			Joint Swelling
			Stiff Neck
			Lumps / Masses

P	N	PP	
			Seizures
			Dizziness
			Tremors
			Loss of Sensation
			Loss of Coordination
			Paralysis
			Difficulty of Speech

P = Present • **N** = Not Present • **PP** = If it has ever been present in the past • Do the same for your family
Family History Key: **F** = Father • **M** = Mother • **B** = Brother • **S** = Sister • **GF** = Grandfather • **GM** = Grandmother

Family History

P	N	PP	Past Problem	When and Explanation of Condition (use back if needed)	F	M	B	S	GF	GM
			Cancer							
			Stroke							
			Thyroid Problems							
			Asthma							
			Heart Attack							
			HIV							
			Angina/Chest Pain							
			Diabetes							
			Arthritis							
			Other							

Do you have a pacemaker? _____YES _____NO

Are you Pregnant? _____YES _____NO
Do you think you may be pregnant? _____YES _____NO

FOR DOCTOR'S USE ONLY – PATIENT PLEASE PROCEED TO PAGE 4

REVIEW OF SYSTEMS

SYSTEM REVIEWED

❑ Allergic / Immunologic
❑ Constitutional
❑ Endocrine
❑ Gastrointestinal
❑ Genitourinary
❑ Integumentary
❑ Neurological
❑ Respiratory
❑ Cardiovascular
❑ Ears / Nose / Mouth
❑ Eyes
❑ All other system reviews negative
❑ Hematological / Lymphatic
❑ Musculoskeletal
❑ Psychiatric

Notes / Comments: _____

_____

_____

_____

_____

Doctor Signature: _____

Patient Signature: _____

NAME: _____ **DATE:** ____/____/____ **Account#:** _____

PLEASE LIST PAST SURGERIES:

1. _____ Year_____ 2. _____ Year_____
3. _____ Year_____ 4. _____ Year_____
5. _____ Year_____ 6. _____ Year_____

List any other key slips, falls or accidents you've had from childhood to present:		**Date**
1)		
2)		
3)		
4)		
5)		
What medications are you currently taking? (Include Date)		
1)	**4)**	
2)	**5)**	
3)	**6)**	

Have you ever taken:	**YES**	**NO**	**YEAR**
Insulin			
Cortisone			
Thyroid Medicine			
Male/Female Hormones			
Blood Pressure			
Tranquilizers/Sedatives			
Birth Control			

Hospitalizations:

Marital Status: ____Married ____Divorced ____Single ____Separated ____Widowed

Number of Children: ____ Children's Name(s): _____

Frequency of Exercise: ____Never ____Rarely ____Occasionally ____Moderately ____Regularly

Intensity of Exercise: ____Low Level ____Medium Level ____High Level ____Competition Level

Sufficient Rest: ____Never ____Rarely ____Occasionally ____Moderately

Hours of Sleep: ____6 ____8 ____10 ____More than 10

Well balanced diet: ____Never ____Rarely ____Occasionally ____Moderately

Do you smoke? ____No ____Occasionally ____1 to 2 ____2 to 3 ____4 to 5 ____More than 5 packs/day

Do you drink caffeinated beverages? ____No ____Occasionally ____1 to 2 ____2 to 3 ____4 to 5 ____More than 5 drinks/day

Do you drink alcoholic beverages? ____No ____Occasionally ____1 to 2 ____2 to 3 ____4 to 5 ____More than 5 drinks/day

Have you ever used street drugs? ____Yes ____No

Hobbies: _____

_____

Patient history was obtained from: _____Patient _____Father _____Mother _____Son _____Daughter

Notes / Comments: _____

_____

_____

_____

_____

_____

_____

Doctor Signature: _____

Patient Signature: _____

HSHealthSource®
Chiropractic & Progressive Wellness®

Financial Agreement

Please remember that insurance is considered a method of reimbursing the patient for fees put to the doctor and is NOT A SUBSTITUTE FOR PAYMENT. Some companies pay fixed allowances for certain procedures, and others pay a percentage of the charge. It is your responsibility to pay any deductible amount, co-insurance, or any other balance not paid by your insurance.

IN ORDER TO CONTROL YOUR OUTSTANDING BALANCE, IT IS OUR POLICY TO COLLECT CO-PAYS, CO-INSURANCE AND DEDUCTIBLE AT TIME OF SERVICE.

If this account is assigned to an attorney/outside agency for collection and/or suit, HealthSource shall be entitled to reasonable attorney's fees and for cost of collection.

I authorize the release of any information necessary to determine liability for payment and to obtain reimbursement on any claim.

_____ _____
PATIENT SIGNATURE INSURED'S SIGNATURE

_____
DATE

LEGAL ASSIGNMENT OF BENEFITS AND RELEASE OF MEDICAL AND PLAN DOCUMENTS

In considering the amount of medical expenses to be incurred, I, the undersigned, have insurance and/or employee health care benefits coverage with the above captioned, and hereby assign and convey directly to HealthSource all medical benefits and/or insurance reimbursement, if any, otherwise payable to me for services rendered from such doctor and clinic. I understand that I am financially responsible for all charges regardless of any applicable insurance or benefit payments. I hereby authorize the doctor to release all medical information necessary to process this claim. I hereby authorize any plan administrator or fiduciary, insurer and my attorney to release to such doctor and clinic any and all plan documents, insurance policy and/or settlement information upon written request from such doctor and clinic in order to claim such medical benefits, reimbursement or any applicable remedies. I authorize the use of this signature on all my insurance and/or employee health benefits claim submissions.

I hereby convey to the above named doctor and clinic to the full extent permissible under the law and under the any applicable insurance policies and/or employee health care plan any claim, chose in action, or other right I may have to such insurance and/or employee health care benefits coverage under any applicable insurance policies and/or employee health care plan with respect to medical expenses incurred as a result of the medical services I received from the above named doctor and clinic and to the extent permissible under the law to claim such medical benefits, insurance reimbursement and any applicable remedies. Further, in response to any reasonable request for cooperation, I agree to cooperate with such doctor and clinic in any attempts by such doctor and clinic to pursue such claim, chose in action or right against my insurers and/or employee health care plan, including, if necessary, bring suit with such doctor and clinic against such insurers and/or employee health care plan in my name but at such doctor and clinic's expenses.

This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original. I have read and fully understand this agreement.

_____ _____
Signature of Insured/Guardian Date

HealthSource® Chiropractic
Progressive Rehab & Wellness®

HIPAA PATIENT CONSENT FORM

We are required by the Health Insurance Portability and Accountability Act of 1996 (HIPAA) to maintain the privacy of your protected health information (PHI) and to provide you with a Notice of Privacy Practices. Our Notice of Privacy Practices provides information about how we may use and disclose your PHI, and contains a describing your rights as a patient under the law. You have the right to review our Notice before signing this Consent and you are advised to do so.

By signing this form, you consent to our use and disclosure to third parties of your PHI for treatment, payment, and health care operations, and for certain marketing purposes, as described in our Notice of Privacy Practices. If you sign this Consent but later change your mind, you have the right to revoke this Consent by delivering to us a written, dated document signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior Consent.

The patient understands that:

The Clinic has a Notice of Privacy Practices. The patient has received, and had the opportunity to review, this Notice before signing this consent. The Clinic encourages all patients to review the Notice of Privacy Practices.

The Clinic reserves the right to modify the Notice of Privacy Practices to keep up with changes in the law or office practices. We will make all modifications available for review by patients.

Protected health information may be disclosed or used for treatment, payment, or health care operations, and for certain marketing purposes.

The Clinic or its business affiliates may use your PHI to contact you with educational and promotional items in the future via email, U.S. Mail, telephone, fax and/or prerecorded messages. We **WILL NOT** ever sell or "SPAM" your personal contact information.

The patient has the right to restrict the uses of his or her information, but the Clinic does not have to agree to all such restrictions.

The patient may revoke this Consent in writing at any time and all future disclosures that require the patient's prior written consent will then cease.

The Clinic may condition receipt of treatment upon the execution of this Consent.

The Consent was signed by: _____
Printed Name – Patient or Representative

_____
Signature Date

Relationship to Patient
(if other than patient) _____

Witness: _____
Printed Name – Clinic Representative

_____
Signature Date

☐ Patient Refused to Sign ☐ Patient unable to sign for the following reason: _____

HealthSource™
Chiropractic & Progressive Rehab™

HealthSource
Authorization for Release of Records

1. I authorize the professional staff of _____ to disclose the following patients' specified information to the professional staff of **HealthSource.**

Patient Name: _____
Address: _____
Date of Birth: _____/_____/_____
Phone Number: _____
Social Security #: _____

2. Information to be released: ☐ Please FAX ☐ Please mail hardcopy

_____Complete health record
_____History and Physical Exam
_____Progress Notes
_____Radiology Reports
_____Radiology Films
_____Laboratory Reports
_____Discharge Summary
_____MRI of _____
_____Consultation Reports
_____HIV Test Results
_____Psychiatric Records
_____Drug Screen, blood, alcohol
_____Other_____
_____

I understand that if complete health record is checked above all medical information will be releases including psychiatric records, alcohol or drug screening and HIV test results.

3. This information is to be disclosed to:

I understand that if the person or entity that receives the above information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be re-disclosed by such person or entity and will likely no longer be protected by the federal privacy regulations.

4. I understand this authorization may be revoked in writing at any time, except to the extent that action has been taken thereon. This authorization will expire 90 days from, the date of authorization.

Access to medical information is the right of every patient; duplication and distribution is a service. Releases are subject to copy and distribution cost. I understand the potentiality of charge for the service and release of medical information and accept financial responsibility.

X_____ **Date**_____/_____/_____
Signature of patient

_____ **Please Print Name**

Signature of Legal Guardian _____ Date_____/_____/_____
Please Print Name _____

HealthSource™
Chiropractic & Progressive Rehab™

Patient Information

Date _____

Patient Name: _____ File # _____

The Neck Disability Index

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 circle the number that most 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
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; I 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 weights off the floor, but I can manage if they are conveniently positioned, for example, 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 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 to, with no pain in my neck.
1. I can read as much as I want to, with slight pain in my neck.
2. I can read as much as I want to, with moderate pain in my neck.
3. I can't 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 that come infrequently.
2. I have moderate headaches that come infrequently.
3. I have moderate headaches that come frequently.
4. I have severe headaches that 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 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 can't do any work at all.

SECTION 8-DRIVING
0. I can drive my car without any neck pain.
1. I can drive my car as long as I want, with slight pain in my neck.
2. I can drive my car as long as I want, with moderate pain in my neck.
3. I can't drive my car 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 can't 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 neck pain at all.
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 few of my recreation activities, because of pain in my neck.
4. I can hardly do any recreation activities, because of pain in my neck.
5. 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.

Patient's Signature: _____ Date: _____

HealthSource™
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Patient Information

Date _____

First Name: _____ Last Name: _____ Initial _____

Revised Oswestry Low Back Pain Disability Questionnaire

Please rate the severity of your pain by circling a number: *No pain* 0 1 2 3 4 5 6 7 8 9 10 *Unbearable pain*

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. three-quarters.
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 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.

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 1/2 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 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 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 1/2 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 _____

Instructions: 1. To determine the patient's index, add up the total points from all sections and divide this total by 50 (total possible points). Multiply that number by 100. 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.

Patient's Signature: _____ Date: _____