

# WELCOME

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

## PATIENT INFORMATION

Name: \_\_\_\_\_  
Last First MI What do you prefer to be called?

Email address: \_\_\_\_\_

Mailing Address: \_\_\_\_\_

CITY STATE ZIP

Phone # (H) \_\_\_\_\_ (W) \_\_\_\_\_ (Cell) \_\_\_\_\_

Can we call you at work?  Yes  No Can we send you text message reminders?  Yes  No

Date of Birth: \_\_\_\_\_ Sex:  Male  Female SS#: \_\_\_\_\_

Marital Status:  Single  Married  Divorced  Widowed  Separated  Minor

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

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

CITY STATE ZIP

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

How did you hear about our practice? \_\_\_\_\_

Emergency contact: Name: \_\_\_\_\_ Relation: \_\_\_\_\_ Phone #: \_\_\_\_\_

# HEALTH HISTORY

Who is your primary care physician? (Doctor and/or practice) \_\_\_\_\_

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

Have you been to a chiropractor in the past? If so, what was your experience? \_\_\_\_\_

What have you heard about chiropractic, positive or negative? \_\_\_\_\_

Will you use chiropractic as (please check one):  A temporary form of symptom relief **OR**  to maximize your health & avoid the problem from returning?

Are you interested in nutritional/supplemental counseling (please check one):  yes **OR**  no?

**Please check to indicate if you are currently experiencing any of the following conditions:**

- |  |  |   |  |  |
|--|--|---|--|--|
| <input type="checkbox"/> Neck Pain/Stiffness | <input type="checkbox"/> Pins/Needles in Arms  | <input type="checkbox"/> Light Bothers Eyes | <input type="checkbox"/> Sudden Weight Loss  | <input type="checkbox"/> Nausea                |
| <input type="checkbox"/> Back Pain/Stiffness | <input type="checkbox"/> Pins/Needles in Legs  | <input type="checkbox"/> Depression         | <input type="checkbox"/> Loss of Taste       | <input type="checkbox"/> Cold Feet             |
| <input type="checkbox"/> Arm/Hand Pain       | <input type="checkbox"/> Fatigue               | <input type="checkbox"/> Nervousness        | <input type="checkbox"/> Loss of Memory      | <input type="checkbox"/> Chest Pain            |
| <input type="checkbox"/> Leg/Knee Pain       | <input type="checkbox"/> Sleeping Difficulties | <input type="checkbox"/> Tension            | <input type="checkbox"/> Jaw Problems        | <input type="checkbox"/> Fever                 |
| <input type="checkbox"/> Shoulder Pain       | <input type="checkbox"/> Loss of Smell         | <input type="checkbox"/> Cold Sweats        | <input type="checkbox"/> Constipation        | <input type="checkbox"/> Fainting              |
| <input type="checkbox"/> Dizziness           | <input type="checkbox"/> Allergies             | <input type="checkbox"/> Stomach Problems   | <input type="checkbox"/> Shortness of Breath | <input type="checkbox"/> Bowel/Bladder Changes |
| <input type="checkbox"/> Headaches           | <input type="checkbox"/> Blurred Vision        | <input type="checkbox"/> Night Pain         | <input type="checkbox"/> Asthma              | <input type="checkbox"/> Abdominal Pain        |

**Please check to indicate if you have ever had any of the following:**

- |   |  |   |   |   |
|---|--|---|---|---|
| <input type="checkbox"/> Aids/HIV           | <input type="checkbox"/> Cancer              | <input type="checkbox"/> Hepatitis          | <input type="checkbox"/> Osteoporosis         | <input type="checkbox"/> Stroke             |
| <input type="checkbox"/> Alcoholism         | <input type="checkbox"/> Cataracts           | <input type="checkbox"/> Hernia             | <input type="checkbox"/> Pacemaker            | <input type="checkbox"/> Suicide Attempt    |
| <input type="checkbox"/> Allergy Shots      | <input type="checkbox"/> Chemical Dependency | <input type="checkbox"/> Herniated Disc(s)  | <input type="checkbox"/> Parkinson's Disease  | <input type="checkbox"/> Thyroid Problems   |
| <input type="checkbox"/> Anemia             | <input type="checkbox"/> Chicken Pox         | <input type="checkbox"/> Herpes             | <input type="checkbox"/> Pinched Nerve        | <input type="checkbox"/> Tonsillitis        |
| <input type="checkbox"/> Anorexia           | <input type="checkbox"/> Diabetes            | <input type="checkbox"/> High Cholesterol   | <input type="checkbox"/> Pneumonia            | <input type="checkbox"/> Tuberculosis       |
| <input type="checkbox"/> Appendicitis       | <input type="checkbox"/> Emphysema           | <input type="checkbox"/> Kidney disease     | <input type="checkbox"/> Polio                | <input type="checkbox"/> Tumors/Growths     |
| <input type="checkbox"/> Arthritis          | <input type="checkbox"/> Epilepsy            | <input type="checkbox"/> Liver Disease      | <input type="checkbox"/> Prostate Problems    | <input type="checkbox"/> Typhoid Fever      |
| <input type="checkbox"/> Asthma             | <input type="checkbox"/> Fracture(s)         | <input type="checkbox"/> Measles            | <input type="checkbox"/> Prosthesis           | <input type="checkbox"/> Ulcers             |
| <input type="checkbox"/> Bleeding Disorders | <input type="checkbox"/> Glaucoma            | <input type="checkbox"/> Migraines          | <input type="checkbox"/> Psychiatric Care     | <input type="checkbox"/> Vaginal Infections |
| <input type="checkbox"/> Breast Lump        | <input type="checkbox"/> Goiter              | <input type="checkbox"/> Miscarriage        | <input type="checkbox"/> Rheumatoid Arthritis | <input type="checkbox"/> Venereal Disease   |
| <input type="checkbox"/> Bronchitis         | <input type="checkbox"/> Gonorrhea           | <input type="checkbox"/> Mononucleosis      | <input type="checkbox"/> Rheumatic Fever      | <input type="checkbox"/> Whooping Cough     |
| <input type="checkbox"/> Bulimia            | <input type="checkbox"/> Gout                | <input type="checkbox"/> Multiple Sclerosis | <input type="checkbox"/> Scarlet Fever        | <input type="checkbox"/> Heart Disease      |
| <input type="checkbox"/> Mumps              | <input type="checkbox"/> Other _____         |   |   |   |

Are you currently under medical care?  Yes  No If yes, for what? \_\_\_\_\_

Please list any medications and/or birth control you are currently taking: \_\_\_\_\_

Please list any supplements you are currently taking (vitamins/herbs/minerals/protein powder): \_\_\_\_\_

Please list any surgeries and/or hospitalizations you have had (type & date): \_\_\_\_\_

Have you had COVID-19 in the past? Have you been vaccinated? How many boosters have you received? \_\_\_\_\_

Please list any allergies: \_\_\_\_\_

Is there a family history of any of the following conditions? (Indicate family member including parents, grandparents & siblings)

- |  |  |
|--|--|
| <input type="checkbox"/> Heart Disease _____ | <input type="checkbox"/> Diabetes _____  |
| <input type="checkbox"/> Cancer _____        | <input type="checkbox"/> Arthritis _____ |
|  | <input type="checkbox"/> Other _____     |

How often do you exercise:  Frequently  Moderately  Occasionally  None

How often do you utilize alcohol:  Frequently  Moderately  Occasionally  None

How often do you smoke cigarettes:  Frequently  Moderately  Occasionally  None

By signing, I certify that the above questions were answered accurately. I understand that providing incorrect information can be dangerous to my health.

**SIGNATURE (X)** \_\_\_\_\_ **DATE** \_\_\_\_\_

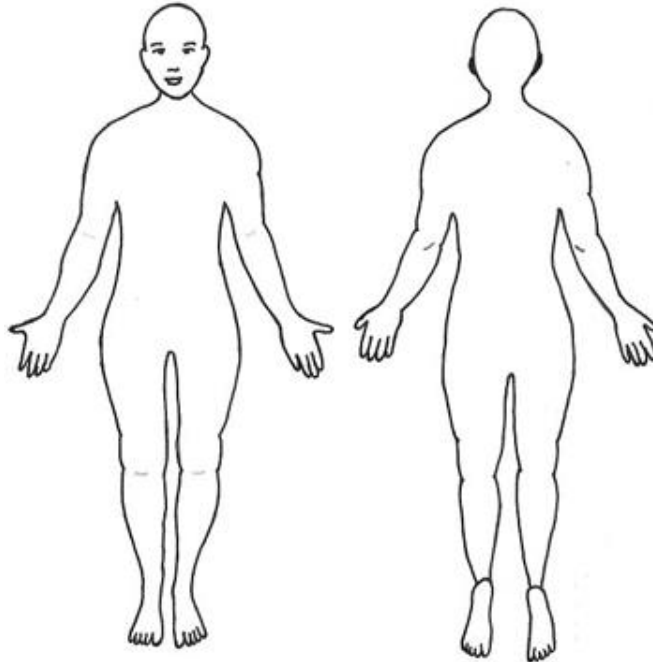
Doctor Initials/Date: \_\_\_\_\_

**PATIENT PAIN DIAGRAM**

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

Using the symbols given below, mark the areas on your body where you feel the described sensations. Include all affected areas.

- |        |          |                  |         |          |       |
|--------|----------|------------------|---------|----------|-------|
| Aching | Numbness | Pins and Needles | Burning | Stabbing | Other |
| +++++  | =====    | •••••            | XXXXX   | ΔΔΔΔΔ    | ooooo |



*Is your pain aggravated by any of the following?*

- |   |   |  |
|---|---|--|
| <input type="checkbox"/> Coughing or sneezing       | <input type="checkbox"/> Walking a distance         | <input type="checkbox"/> When you wake up  |
| <input type="checkbox"/> Lying flat on your back    | <input type="checkbox"/> Sitting in a chair         | <input type="checkbox"/> Bending forward   |
| <input type="checkbox"/> Lying flat on your stomach | <input type="checkbox"/> In the middle of the night | <input type="checkbox"/> Standing too long |
| Height: _____                                       | Weight: _____                                       | Right or Left-Handed: _____                |

Rate your symptoms on a scale of zero to ten, ten being the worst:

- |         |   |   |   |   |   |   |   |   |   |    |        |
|---------|---|---|---|---|---|---|---|---|---|----|--------|
| No Pain | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | SEVERE |
|---------|---|---|---|---|---|---|---|---|---|----|--------|

How often do you feel your symptoms:

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

If you didn't have these symptoms, what is the first thing you would do? \_\_\_\_\_

Have you had any recent imaging? (X-ray, MRI, etc.) Type: \_\_\_\_\_ Body Part: \_\_\_\_\_

Facility who performed imaging: \_\_\_\_\_

A patient coming to the doctor gives him/ her permission and authority to care for them in accordance with appropriate test, diagnosis, and analysis. The clinical procedures performed are usually beneficial and seldom cause any problem. In rare cases underlying physical defects, deformities, or pathologies, may render the patient susceptible for injury. The doctor, of course, will not provide specific healthcare, if he/ she is aware that such care may be contraindicated. It is the responsibility of the patient to make it known or to learn through health care procedures from whatever he/ she is suffering from: latent pathological defects, illnesses, or deformities, which would otherwise not come to the attention of the doctor.

I have read and understand the foregoing.

\_\_\_\_\_  
**Patients Signature**

Doctor Initials/Date: \_\_\_\_\_

## X-RAY QUESTIONNAIRE: FOR WOMEN ONLY

Our consultation and examination may indicate that x-rays are necessary to accurately diagnose and analyze your condition. Should x-rays be necessary we would like to confirm that you are not pregnant at this time.

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

There is a possibility that I am pregnant at this time.

Yes, I am definitely pregnant

No, I am definitely not pregnant at this time

I request that x-ray films not be taken because: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Date of last menstrual period: \_\_\_\_\_

## NOTICE OF PRIVACY PRACTICES

**This notice describes how medical information about you may be used and disclosed and how you can get access to this information.**

We care about our patients' privacy and strive to protect the confidentiality of your medical information at this practice. New federal legislation requires that we issue this official notice of our privacy practices. You have the right to the confidentiality of your medical information, and this practice is required by law to maintain the privacy of that information.

This practice is required to abide by the terms of the Notice of Privacy Practices currently in effect, and to provide notice of its legal duties and privacy practices with respect to protected health information. If you have any questions about this Notice, please contact the Privacy Officer at this practice.

### Who will follow this notice?

Any health care professional authorized to enter information into your medical record, all employees, staff, and other personnel at this practice who may need access to your information must abide by this Notice. All subsidiaries, business associates (e.g., a billing service), sites and location of this practice may share medical information with each other for treatment, payment purposes or health care operation as stated in this Notice. Except where treatment is involved, only the minimum necessary information needed to accomplish the task will be shared.

### How We May Use and Disclose Medical Information About You

*The following categories describe different ways that we may use and disclose medical information without your specific consent or authorization. Examples are provided for each category of uses or disclosures. Not all possible uses or disclosures are listed.*

**For Treatment.** We may use medical information about you to provide you with medical treatment or services. Example: In treating you for a specific condition, we may need to know if you have allergies or prior injuries or surgeries that could influence our treatment process.

**For Payment.** We may use and disclose medical information about you so that the treatment and services you receive from us may be billed and payment collected from you, an insurance company or a third party. Example: We may need to send your protected health information, such as your name, address, office visit date, and codes identifying your diagnosis and treatment to your insurance company for payment.

**For Health Care Operations.** We may use and disclose medical information about you for health care operations to assure that you receive quality care. Example: We may use medical information to review our treatment and services and evaluate the performance of our staff in caring for you.

### Other Uses or Disclosures That Can be Made Without Your Consent or Authorization

- As required during an investigation by law enforcement agencies
- To avert a serious threat to public health or safety
- As required by military command authorities for their medical records
- To worker's compensation or similar programs for processing of claims

- In response to a legal proceeding
- To a coroner or medical examiner for identification of a body
- If an inmate, to the correctional institution or law enforcement official
- As required by the US Food and Drug Administration (FDA)
- Other healthcare providers treatment activities
- Other covered entities' and providers' payment activities
- Other covered entities' healthcare operations activities (to the extent permitted under HIPAA)
- Uses and disclosures required by law
- Uses and disclosures in domestic violence or neglect situations
- Health oversight activities
- Other public health activities

We may contact you to provide appointment reminders or information about treatment and other health related benefits and services that may be of interest to you.

#### Uses and Disclosures of Protected Health Information Requiring Your Written Authorization

Other uses and disclosures of medical information not covered by this Notice or the laws that apply to us will be made only with your written authorization. If you give us authorization to use or disclose medical information about you, you may revoke that authorization, in writing, at any time. If you revoke your authorization, we will thereafter no longer use or disclose medical information about you for the reasons covered by your written authorization. We are unable to take back any disclosures we have already made with your authorization, and we are required to retain our records of the care we have provided you.

### YOUR INDIVIDUAL RIGHTS REGARDING:

#### Disclosures and Changes to Your Medical Information

**Right to Request Restrictions.** You have the right to request a restriction or limitation on the medical information we use or disclose about you for treatment, payment or health care operations or to someone who is involved in your care or the payment of your care. We are not required to agree to your request. If we do agree, we will comply with your request unless the information is needed to provide you with emergency treatment. To request restrictions, you must submit your request in writing to the Privacy Officer at this practice. In your request you must tell us what information you want to limit.

**Right to an Accounting of Non-Standard Disclosures.** You have the right to request a list of the disclosures we made of medical information about you. To request this list, you must submit your request in writing to the Privacy Officer at this practice. Your request must state the time period for which you want to receive a list of disclosures that is no longer than six years and may not include dates before April 14, 2003. Your request should indicate in what form you want the list (example: paper or electronically). The first list you request within a 12-month period will be free. For additional lists, we reserve the right to charge you for the cost of providing the list.

**Right to Amend.** If you feel that medical information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept. To request an amendment, your request must be made in writing and submitted to the Privacy Officer at this practice. In addition, you must provide a reason that supports your request. We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if the information was not created by us, is not part of the medical information kept at this practice, is not part of the information which you would be permitted to inspect and copy, or which we deem to be accurate and complete. If we deny your request for amendment, you have the right to file a statement of disagreement with us. We may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal. Statements of disagreement and any corresponding rebuttals will be kept on file and sent out with any future authorized requests for information pertaining to the appropriate portion of your record.

#### Your Access to Medical Information

**Right to Inspect and Copy.** You have the right to inspect and copy medical information that may be used to make decisions about your care. Usually this includes medical and billing records but does not include psychotherapy notes, information compiled for use in a civil, criminal, or administrative action or proceeding, and protected health information to which access is prohibited by law. To inspect and copy medical information that may be used to make decisions about you, you must submit your request in writing to the privacy officer at this practice. If you request a copy of the information, we reserve the right to charge a fee for the costs of copying, mailing or other supplies associated with your request. We may deny your request to inspect and copy in certain very limited circumstances. If you are denied access to medical information, you may request that the denial be reviewed. Another licensed health care professional chosen by this practice will review your request and the denial. The person conducting the review will not be that person who denied your request. We will comply with the outcome of the review.

**Right to a Paper Copy of This Notice.** You have the right to a paper copy of this Notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy. To obtain a paper copy of the current Notice, please request one in writing from the Privacy Office at this practice.

**Right to Request Confidential Communications.** You have the right to request how we should send communications to you about medical matters, and where you would like those communication sent. To request confidential communication, you must make your request in writing to the Privacy Officer at this practice. We will not ask you the reason for your request. We will accommodate all reasonable requests. Your request must specify how or where you wish to be contacted. We reserve the right to deny a request if it imposes an unreasonable burden on the practice.

**Complaints.** If you believe your privacy rights have been violated, you may file a complaint with the Privacy Officer at this practice or with the Secretary of the Department of Health and Human Services. All complaints must be submitted in writing. You will not be penalized or discriminated against for filing a complaint.

I have read and understand the Notice of Privacy Practices.

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

\_\_\_\_\_  
Date

PLEASE READ THOROUGHLY, INITIAL AT EACH SECTION AND SIGN AT THE BOTTOM. THANK YOU.

**Authorization to Release Information**

\_\_\_\_\_ I authorize Chiro One Wellness P.C. to release all information related to the care I receive to my HMO, insurance company, third party payor or their designee. I understand that this may be necessary for the payment of my bill, determining benefits or for utilization and quality review purposes.

**Information about Possible Risk of Chiropractic Treatment**

\_\_\_\_\_ You have the right, as a patient, to be informed about your condition and the recommended integrative and complementary procedure to be used so that you make an informed decision whether or not to undergo the procedure after knowing the risk and hazards involved. This disclosure is not meant to scare or alarm you; it is simply an effort to make you better informed so that you may give or withhold your consent to the procedure. Two different types of adjustment techniques are used in this office. Primarily, for a large majority of our patients, our office is currently utilizing state- of- the- art technology; therefore, safety is not a concern. In addition to spinal manipulation, treatment can also involve other forms of therapy including ultrasound, electrical stimulation, traction, hot and cold packs, hydrotherapy, infrared heat, low level laser, trigger point, massage, exercise, topical pain-relieving gel, nutritional supplement, and spinal decompression. As with any health procedure complication may arise during treatment. These complications include soreness, muscle or ligament strain, dislocation, fractures, stroke, disc injuries or physiotherapy burns. These are extremely rare occurrences.

**Spinal Decompression**

\_\_\_\_\_ You have the right, as a patient, to be informed about the recommended additive therapy spinal decompression. If treatment of spinal decompression is recommended, you understand, as with any healthcare procedure, there may be certain complications that arise. This may include: strains, muscle spasm, disc injury, or worsening pain. This list is not all inclusive. The complications are considered RARE. The most common risk is dull, achy soreness similar to having just worked out for the first time in a long time. This is usually due to stretching of tight muscles that haven't been stretched in this way. This will typically go away within the first week or two of treatments. We will warm the tissues up before treatment and will decompress your spine more conservative at first to prevent as much soreness as we can. It is recommended that you ice for 20 minutes up to 3 times daily for the first week to decrease pain and soreness.

**Assignment of Benefits**

\_\_\_\_\_ I assign all benefits payable to me for my care to Chiro One Wellness, PC. I understand that this health care facility will be paid directly by the insurance company or other payor. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is considered as valid as the original.

**Guarantee of Payment**

\_\_\_\_\_ I guarantee payment of all charges incurred for treatment in accordance with the rates and terms of this health care.

**Consent for Treatment**

\_\_\_\_\_ I authorize the performance of diagnostic tests, procedure and treatment deemed necessary by personnel involved in my care.

**Authorization to Treat a Minor**

\_\_\_\_\_ I hereby request my doctor at this clinic to perform diagnostic test and render chiropractic adjustment and other treatment to my minor son/daughter. This authorization also extends to all other doctors in this clinic and is intended to include radiographic examination at the doctor's discretion. As of this date, I have legal right to select and authorize health care services for the minor child named above. Under the terms and condition of my divorce (if applicable), separation or other authorization, the consent of a spouse/former spouse or other parent is not required. If my authority to so select and authorize this care should be revoked or modified in any way, I will immediately notify Disc Doctor.

**Signature of Patients or responsible party:** \_\_\_\_\_ **Date:** \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_

**Doctor Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

# Workers Compensation Injury Report

\*all information required\*

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

Social Security #: \_\_\_\_\_

Date of Injury: \_\_\_\_\_ Time of Incident: \_\_\_\_\_:\_\_\_\_\_ AM/PM

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

Employer's Address: \_\_\_\_\_  
Street City State Zip

Employer's Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Worker's Compensation Insurance Company: \_\_\_\_\_

Workers' Comp Board Case #: \_\_\_\_\_

Carrier Case #: \_\_\_\_\_

Adjuster's Name: \_\_\_\_\_

Adjuster's Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Body part affected by incident: \_\_\_\_\_

Is this case open?  YES  NO

Are you currently working?  YES  NO

If not, what was your last date of work? \_\_\_\_\_

Do you have a lawyer? If yes what is their contact information:

\_\_\_\_\_

Describe in detail how this injury happened: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Describe your job responsibilities: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**REQUEST FOR RELEASE OF MEDICAL RECORDS**

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

Patient DOB: \_\_\_\_\_

Patient Phone Number: \_\_\_\_\_

**TO:** \_\_\_\_\_

Physician's Name/Office

\_\_\_\_\_

Street

City

State

Zip

***TO BE RELEASED TO:***

**Dr. Mohamed Munassar**

Chiro First Wellness Center

4214 Clinton St.

West Seneca NY 14224

Phone: 716-675-2225

Fax: 716-675-2222

Email: [info@chirofirstwellnesscenter.com](mailto:info@chirofirstwellnesscenter.com)

\_\_\_\_\_  
*Patient's Name (Printed)*

\_\_\_\_\_  
*Date*

\_\_\_\_\_  
*Patient's Name (Signature)*

**Additional Comments:**





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

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

Check which applies:     Worker's Comp                       No Fault                       Personal Injury

According to the NF/WC fee schedule patients with no fault, worker's comp, or personal injury are only allotted 3 units of service per billing day. This letter states that I, the patient, am in agreeance that I will not receive any other treatments on the same day as another service.

Example: I will not receive chiropractic care on the same day as physical therapy.

If I, the patient, schedule 2 services within the same day and my service provider does not receive payment; I understand that I will be responsible for the payment of the service for that date.

#### **INDEPENDENT MEDICAL EXAMS (IME) ACKNOWLEDGEMENT**

New York state requires what is called and Independent Medical Exam (IME) for patient with workers compensation and no fault injuries. These exams are scheduled at any point at a different providers office. They are to determine your eligibility for care by the insurance carrier.

**You must attend your scheduled IME or it will result in denial of care to your provider. Any result of non-payment due to a missed IME will be your financial responsibility.**

I understand and acknowledge the terms of this agreement.

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

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

## NECK DISABILITY INDEX

This questionnaire has been designed to give the doctor information as to how your neck pain has affected your ability to manage in everyday life. Please answer every section and mark in each section only ONE box which applies to you. We realize you may consider that two of the statements in any one section relate to you, but please just mark the box which **MOST CLOSELY** describes your problem.

### Section 1 - Pain Intensity

- I have no pain at the moment.
- The pain is very mild at the moment.
- The pain is moderate at the moment.
- The pain is fairly severe at the moment.
- The pain is very severe at the moment.
- The pain is the worst imaginable at the moment.

### Section 2 - Personal Care (Washing, Dressing, etc.)

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

### Section 3 - Lifting

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

### Section 4 - Reading

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

### Section 5 - Headaches

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

Scoring: Questions are scored on a vertical scale of 0-5. Total scores and multiply by 2. Divide by number of sections answered multiplied by 10. A score of 22% or more is considered significant activities of daily living disability.

(Score \_\_\_ x 2) / (\_\_\_ Sections x 10) = \_\_\_\_\_ %ADL

### Section 6 - Concentration

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

### Section 7 - Work

- I can do as much work as I want to.
- I can 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.

### Section 8 - Driving

- I 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 my car at all because of severe pain in my neck.
- I can't drive my car at all.

### Section 9 - Sleeping

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

### Section 10 - Recreation

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

Comments \_\_\_\_\_ %ADL

## LOW BACK DISABILITY QUESTIONNAIRE (REVISED OSWESTRY)

This questionnaire has been designed to give the doctor information as to how your neck pain has affected your ability to manage in everyday life. Please answer every section and mark in each section only ONE box which applies to you. We realize you may consider that two of the statements in any one section relate to you, but please just mark the box which **MOST CLOSELY** describes your problem.

### Section 1 - Pain Intensity

- I can tolerate the pain without having to use painkillers.
- The pain is bad but I can manage without taking painkillers.
- Painkillers give complete relief from pain.
- Painkillers give moderate relief from pain.
- Painkillers give very little relief from pain.
- Painkillers have no effect on the pain and I do not use them.

### Section 2 - Personal Care (Washing, Dressing, etc.)

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

### Section 3 - Lifting

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

### Section 4 - 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 one-half mile.
- Pain prevents me from walking more than one-quarter mile.
- I can only walk using a stick 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.
- 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 30 minutes.
- Pain prevents me from sitting more than 10 minutes.
- Pain prevents me from sitting almost all the time.

Scoring: Questions are scored on a vertical scale of 0-5. Total scores and multiply by 2. Divide by number of sections answered multiplied by 10. A score of 22% or more is considered significant activities of daily living disability.

(Score \_\_\_ x 2) / ( \_\_\_ Sections x 10) = \_\_\_\_\_ %ADL

### 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 extra pain.
- Pain prevents me from standing more than 1 hour.
- Pain prevents me from standing more than 30 minutes.
- Pain prevents me from standing 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 - 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.
- 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 pain.

### Section 9 - 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 is bad but I manage journeys less than 1 hour.
- Pain restricts me to short necessary journeys under 30 minutes.
- Pain prevents me from traveling except to the doctor or hospital.

### Section 10 - 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 the present.
- My pain is neither getting better nor worse.
- My pain is gradually worsening.
- My pain is rapidly worsening.

Comments \_\_\_\_\_

%ADL