



PATIENT INTAKE FORM

WELCOME and THANK YOU for seeking out care at our office. We are a very unique team specializing in research based spinal and postural rehabilitation that helps our patients recover their optimal health; often where many other systems have failed. Because of this, we will only accept you as a patient if we are absolutely certain we know what is causing your condition, can perform the necessary tests to establish an optimal rehab program for you, and are completely confident we can help you recover your health. Please know if we do accept you as a patient, we will then make specific recommendations, as well as make certain your healing will be our TOP PRIORITY.

PATIENT'S PREFERRED NAME

DATE COMPLETED

Patient Information

Name: _____ Age: _____ Gender: M F
Home Address: _____ Home Phone: _____
City, State, Zip: _____ Work Phone: _____
Email Address: _____ Cell Phone: _____
Birth Date: ____/____/____ Social Security _____ Marital Status S M D W S
Occupation: _____ Employer Name: _____
Spouse's Name: _____ Children's Name(s): _____
How did you hear about this office? _____

Purpose For This Visit

Reason for this visit: _____

Is this related to an accident or specific injury*? Yes No If yes when? ____/____/____

***If your symptoms are the result of an auto accident or work related injury, please let the front desk staff know.**

Describe: _____

Please use the General Symptoms Chart on the next page to provide a detailed notation of your symptoms.

When did these symptoms begin? ____/____/____ Are they Constant Intermittent Activity related

Are they getting worse? Yes No Do they interfere with: Work Sleep Hobbies Daily routine

Explain _____

What activities aggravate your symptoms? _____

Is there anything that relieves your symptoms? Yes No If yes, explain: _____

Have you experienced these symptoms before (if not accident/injury related)? Yes No

If yes, explain: _____

Have you been treated for this? Yes No When were you last treated? _____

What treatment was performed? _____

How did you respond? _____

Experience with Chiropractic

Have you seen a chiropractor before? Yes No Who? _____

Reason for visit(s): _____

Did your previous chiropractor take "before" and "after" x-rays? Yes No

Did they recommend a specific course of treatment? Yes No Did they recommend a Home Care program? Yes No

If yes, what? _____ How long were you treated? _____ Last treatment: ____/____/____

How did you respond? _____

Are you aware of any poor posture habits? Yes No Is there a history of spinal problems in your family? Yes No

If yes, explain: _____

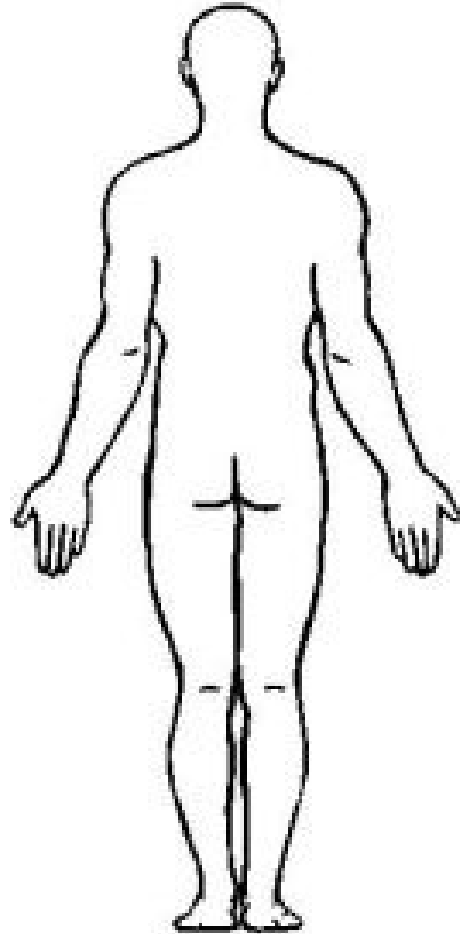
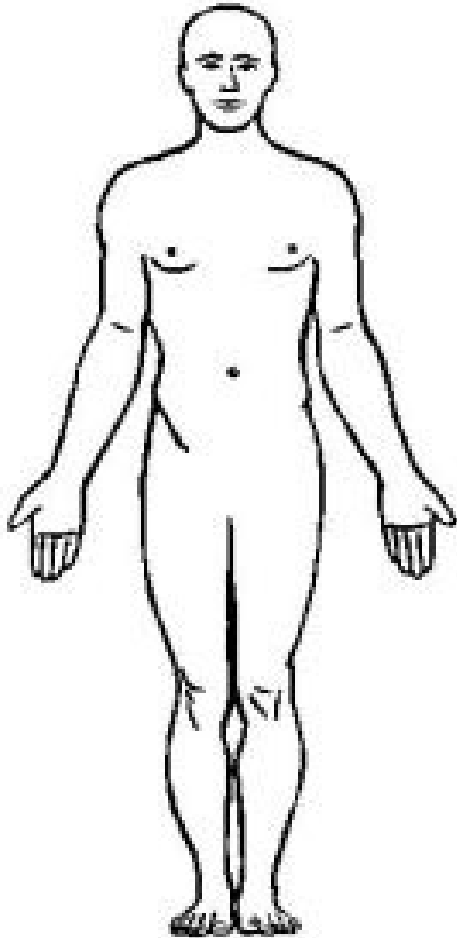
GENERAL SYMPTOMS CHART

Please use the following notations on the figures below to indicate the type and location of your symptoms, as it related to the purpose of your visit today/

A = Ache
B = Burning
P = Pins & Needles

G = Stabbing
M = Spasms
F = Stiffness

N = Numbness
T = Tingling
O = Other



If you marked "O" for Other on any part, please explain below:

Rate the severity of your complaint(s): (1 mild to 10 severe)

Primary Complaint: _____ 1 2 3 4 5 6 7 8 9 10

Secondary Complaint: _____ 1 2 3 4 5 6 7 8 9 10

Health & Lifestyle

Do you exercise? Yes No How often? _____ days per week; Other _____

What activities? Walking Running Weight Training Cycling Yoga Pilates Other _____

Do you smoke? Yes No How much/often? _____

Do you drink alcohol? Yes No How much/often? _____

Do you drink coffee? Yes No How much/often? _____

Do you take any supplements? (i.e. vitamins, minerals, herbs)? _____

Health Conditions

Your spine is the foundation of health and core strength in your body. Shifts in the vertebrae or sections of the spine will spread ultimately causing weakness and distortion to ALL The areas of the spine. These distortions are reflected in abnormal posture. Research shows abnormal posture leads to chronic pain, disease and possibly a shortened life span. Please answer the following questions accurately so we may determine the full extent of your condition.

CERVICAL SPINE (NECK)

Misalignment of the individual vertebrae or distortion of the complete cervical curve (neck) originating in the neck or a compensation from postural distortions in other areas of the spine may result in many health conditions. Have you experienced any of these symptoms presently or in the past?

Please indicate (N) = Now, (P) = Past next to all conditions you've experienced or both if applicable.

- | | | |
|--------------------------------------|-------------------------|-------------------------|
| ___ Neck Pain | ___ Headaches | ___ Sinusitis |
| ___ Pain in the shoulders/arms/hands | ___ Dizziness | ___ Allergies/Hay fever |
| ___ Numbness/tingling in arms/hands | ___ Visual disturbances | ___ Recurrent colds/flu |
| ___ Hearing disturbances | ___ Coldness in hands | ___ Low Energy/Fatigue |
| ___ Weakness in grip | ___ Thyroid conditions | ___ TMJ/Pain/Clicking |
| ___ Heaviness | | |

Please Explain: _____

THORACIC SPINE (UPPER BACK)

Misalignment of the individual vertebrae or distortion of the upper thoracic curve (upper back) originating in the upper back or a compensation from postural distortions in other areas of the spine may result in many health conditions. Have you experienced any of these symptoms presently or in the past?

Please indicate (N) = Now, (P) = Past, next to all conditions you've experienced or both if applicable.

- | | |
|--------------------------|------------------------------------------|
| ___ Heart Palpitations | ___ Recurrent Lung Infections/Bronchitis |
| ___ Heart Murmurs | ___ Asthma/Wheezing |
| ___ Tachycardia | ___ Shortness of breath |
| ___ Heart Attacks/Angina | ___ Pain on Deep Inspiration/Expiration |

Please Explain: _____

Health Conditions continued.....

THORACIC SPINE (MID BACK)

Misalignments of the individual vertebrae or distortion of the mid thoracic curve (mid back) originating in mid back or a compensation from postural distortions in other areas of the spine may result in many health conditions. Have you experienced any of these symptoms presently or in the past?

Please indicate (N) = Now, (P) = Past next to all conditions you've experienced or both if applicable.

- | | | |
|--------------------------------------------------------------------------------------------|---------------------------------|-----------------------------------------------------|
| <input type="checkbox"/> Mid Back Pain | <input type="checkbox"/> Nausea | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Pain in Ribs/Chest | <input type="checkbox"/> Ulcers | <input type="checkbox"/> Hypoglycemia/Hyperglycemia |
| <input type="checkbox"/> Indigestion/Heartburn | <input type="checkbox"/> Reflux | |
| <input type="checkbox"/> Tired Irritable after eating or when not having eaten for a while | | |

Please explain: _____

LUMBAR SPINE (LOW BACK)

Misalignment of the individual vertebrae or distortion of the lumbar curve (low back) originating in the low back or a compensation from postural distortions in other areas of the spine may result in many health conditions. Have you experienced any of these symptoms presently or in the past?

Please indicate (N) = Now, (P) = Past next to all conditions you've experienced or both if applicable.

- | | | |
|---------------------------------------------------------|----------------------------------------------------------------------|------------------------------------------------|
| <input type="checkbox"/> Pain in hips/legs/feet | <input type="checkbox"/> Weakness/injuries in hips/knees/ankles | <input type="checkbox"/> Low back pain |
| <input type="checkbox"/> Numbness/tingling in legs/feet | <input type="checkbox"/> Recurrent bladder infections | <input type="checkbox"/> Coldness in legs/feet |
| <input type="checkbox"/> Frequent/difficulty urinating | <input type="checkbox"/> Muscle cramps in legs/feet | <input type="checkbox"/> Sexual dysfunction |
| <input type="checkbox"/> Constipation/Diarrhea | <input type="checkbox"/> Menstrual irregularities/cramping (females) | |

Please Explain: _____

Other

Please list any health conditions not mentioned: _____

Please list any medications (include name, dose, for what condition, and how long you've been taking it):

Please list any surgeries (include type of surgery and date it was performed): _____

FAMILY HEALTH HISTORY

Have any of your family members ever been diagnosed with the following (please indicate Y for You, and O for Other than you, or both if applicable):

- | | | | |
|-----------------------------------------------|-----------------------------------------------|------------------------------------------------|---------------------------------------|
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Vertigo | <input type="checkbox"/> Neurological Problems | <input type="checkbox"/> Lung Disease |
| <input type="checkbox"/> Fibromyalgia | <input type="checkbox"/> Circulatory Problems | <input type="checkbox"/> Stroke | <input type="checkbox"/> Heart Murmur |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Cancer | <input type="checkbox"/> Osteoporosis |
| <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Paralysis | <input type="checkbox"/> Migraine Headaches | <input type="checkbox"/> Arthritis |
| <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Metal Implants | <input type="checkbox"/> Chronic Fatigue | <input type="checkbox"/> Gall Bladder |
| <input type="checkbox"/> Herniated Disc | <input type="checkbox"/> Appendectomy | <input type="checkbox"/> Asthma | <input type="checkbox"/> Hernia |
| <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Scoliosis | <input type="checkbox"/> Parkinson's Disease | <input type="checkbox"/> Anemia |
| <input type="checkbox"/> Digestive Disorders | <input type="checkbox"/> Multiple Sclerosis | <input type="checkbox"/> Influenza | <input type="checkbox"/> Tumors |
| <input type="checkbox"/> Thyroid Problems | <input type="checkbox"/> ADD/ADHD | <input type="checkbox"/> Eczema/Psoriasis | <input type="checkbox"/> Bronchitis |
| <input type="checkbox"/> Blood Sugar Problems | <input type="checkbox"/> Epilepsy/Seizures | <input type="checkbox"/> TMJ Dysfunction | <input type="checkbox"/> Depression |
| <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Other: _____ | | |
-

Women: Are you pregnant? Yes No Are you nursing? Yes No

Women: Are you taking birth control pills? Yes No Last Menstrual Period: ___/___/___

Authorization of Care:

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize and agree to allow the doctor and/or the designated staff to work with my spine or the spine of the child I represent through the use of spinal adjustments and rehabilitative exercises for the sole purpose of postural and structural restoration of normal bio-mechanical and neurological function. I also clearly understand that if I do not follow the doctors and/or staff's specific recommendations at this clinic that I will not receive the full benefit from these programs.

I understand that if I terminate my care prematurely that all fees incurred will be due and payable at that time. I agree to be responsible for payment of all services rendered on my behalf or on behalf of my dependents. Any balance past due 90 days will be sent to our collection agency and a \$30 collection fee is added on to the balance. Also there is a \$30 service fee for any returned checks.

I authorize the chiropractor to release any information including the diagnosis and the records of any treatment or examination rendered to my child or me during the period of such chiropractic care to third party payers and/or health practitioners. I further authorize him/her to disclose all or part of my patient record to any person or corporation which is or may be liable under a contract to the clinic or to the patient or to a family member or employer of the patient for all or part of the services rendered to me including and not limited to hospital or medical service companies, insurance companies, worker's compensation carriers, welfare funds or employers.

Patient's Signature (or parent of minor): _____ Date: ___/___/___

Patient's Name Printed: _____

Guardian or Spouse's Signature Authorizing Care: _____ Date: ___/___/___

I hereby authorize SpineCare Chiropractic to administer care as deemed necessary to my child, a minor under the age of 18 years old.

HEALTH CARE AUTHORIZATION FORM

Patient's Name _____ Date _____ DOB _____

THE PATIENT IDENTIFIED ABOVE AUTHORIZES **SpineCare Chiropractic Center** TO USE AND OR DISCLOSE PROTECTED HEALTH INFORMATION (PHI) IN ACCORDANCE WITH THE FOLLOWING:

SPECIFIC AUTHORIZATIONS

- I give permission to **SpineCare** to use my address, phone number and clinical records to contact me with appointment reminders, missed appointment notification, birthday cards, holiday related cards, information about treatment alternatives or other health related information.
- If **SpineCare** contacts me by phone, I give them permission to leave a phone message with a member of my household, on my answering machine or voice mail.
- By signing this form you are giving **SpineCare** permission to use and disclose your protected health information in accordance with the directives listed above, and in accordance with our Notice of Privacy Practices. A copy of this Notice is available per request.

SpineCare Chiropractic Center utilizes an open adjusting approach to treating patients, other patients may be in the room while you are being treated and they may be able to overhear some of your protected health information during the course of care. However if you need to speak with the doctor at any time in private, the doctor will provide a room for these conversations. If you have a problem with the open room treatments please notify the doctor immediately.

RIGHT TO REVOKE AUTHORIZATION

You have the right to revoke this Authorization, in writing, at any time. However, your written request to revoke this AUTHORIZATION is not effective to the extent that we have provided services or taken action in reliance on your authorization.

You may revoke this AUTHORIZATION by mailing or hand delivering a written notice to the Privacy Official of **SpineCare Chiropractic Center**. The written notice must contain the following information: Your name, Social Security number and date of birth; a clear statement of your intent to revoke this AUTHORIZATION; the date of your request, and your signature.

The revocation is not effective until it is received by the Privacy Official.

You have the right to refuse to sign this Authorization. If you refuse to sign this AUTHORIZATION, **SpineCare Chiropractic Center** will not refuse to provide treatment.

You have the right to inspect or copy the PHI to be used/disclosed.

A COPY OF THE SIGNED AUTHORIZATION WILL BE PROVIDED TO YOU PER REQUEST

Print Name of Patient _____

Date _____

Signature of Patient _____

Signature of Witness _____

INFORMED CONSENT FORM

PATIENT NAME: _____

To the patient: Please read this entire document prior to signing it. It is important that you understand the information contained in this document. In anything is unclear, please ask questions before you sign.

The nature of the chiropractic adjustment

The primary treatment I use as a Doctor of Chiropractic is spinal manipulative therapy. I will use that procedure to treat you. I may use my hands or a mechanical instrument upon your body in such a way as to move your joints. That may cause an audible “pop” or “click,” much as you have experienced when you “crack” your knuckles. You may feel a sense of movement.

Analysis / Examination / Treatment

As a part of the analysis, examination, and treatment, you are consenting to the following procedures:

- spinal manipulative therapy
 - range of motion testing
 - muscle strength testing
 - ultrasound
 - radiographic studies
 - Other (please explain)
 - palpation
 - orthopedic testing
 - postural analysis
 - hot/cold therapy
 - mechanical traction
 - vital signs
 - basic neurological testing
 - Electrical Stim
-

The material risks inherent in chiropractic adjustment.

As with any healthcare procedure, there are certain complications which may arise during chiropractic manipulation and therapy. These complications include but are not limited to: fractures, disc injuries, dislocations, muscle strain, cervical myelopathy, costovertebral strains and separations, and burns. Some types of manipulation of the neck have been associated with injuries to the arteries in the neck leading to or contributing to serious complications including stroke. Some patients will feel some stiffness and soreness following the first few days of treatment. I will make every reasonable effort during the examination to screen for contraindications to care; however, if you have a condition that would otherwise not come to my attention, it is your responsibility to inform me.

The probability of those risks occurring.

Fractures are rare occurrences and generally result from some underlying weakness of the bone which I check for during the taking of your history and during examination and X-ray. Stroke has been the subject of tremendous disagreement. The incidences of stroke are exceedingly rare and are estimated to occur between one in one million and one in five million cervical adjustments. The other complications are also generally described as rare.

The availability and nature of other treatment options

Other treatment options for your condition may include:

- Self-administered, over-the-counter analgesics and rest
- Medical care and prescription drugs such as anti-inflammatory, muscle relaxants and pain-killers
- Hospitalization
- Surgery

If you chose to use one of the above noted “other treatment” options, you should be aware that there are risks and benefits of such options and you may wish to discuss these with your primary medical physician.

The risks and dangers attendant to remaining untreated

Remaining untreated may allow the formation of adhesions and reduce mobility which may set up a pain reaction further reducing mobility. Over time this process may complicate treatment making it more difficult and less effective the longer it is postponed.

NUTRITIONAL INFORMED CONSENT

According to the Federal Food, Drug, and Cosmetic Act, as amended, Section 201 (g) (1), the term “DRUG” is defined to mean:

“Articles intended for use in the Diagnosis, Cure, Mitigation, Treatment or Prevention of disease.”

A Vitamin is not a drug, NEITHER is a Mineral, Trace Element, Amino Acid, Herb, or Homeopathic Remedy.

Although a Vitamin, a Mineral, Trace Element, Amino Acid, Herb or Homeopathic Remedy may have an effect on any disease process or symptoms, this does not mean that it can be misrepresented or be classified as a drug by anyone.

Therefore, please be advised that any suggested nutritional advice or dietary advice is not intended as a primary treatment and/or therapy for any disease or particular bodily symptom.

Nutritional counseling, vitamin recommendations, nutritional advice, and the adjunctive schedule of nutrition is provided solely to upgrade the quality of foods in the patient’s diet in order to supply good nutrition supporting the physiological and biomechanical processes of the human body.

Nutritional advice and nutritional intake may also enhance the stabilization of chiropractic adjustments and treatment.

DO NOT SIGN UNTIL YOU HAVE READ AND UNDERSTAND THE ABOVE.

I have read or have had read to me the above explanation of the chiropractic adjustment and related treatment. I have discussed it with *Dr. Creehan* and have had my questions answered to my satisfaction. By signing below I state that I have weighed the risks involved in undergoing treatment and have decided that it is in my best interest to undergo the treatment recommended. Having been informed of the risks, I hereby give my consent to that treatment.

Dated: _____

Dated: _____

Patient’s Name

Doctor’s Name

Signature or Signature of Parent
or Guardian (if a minor)

Signature

Neck Index

Form N1-100

rev 3/27/2003

Patient Name _____ Date _____

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

Pain Intensity

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

Sleeping

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

Reading

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

Concentration

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

Work

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

Personal Care

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

Lifting

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

Driving

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

Recreation

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

Headaches

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

Index Score = $\left[\frac{\text{Sum of all statements selected}}{\text{(# of sections with a statement selected} \times 5)} \right] \times 100$

Neck
Index
Score

Back Index

Form BI100

rev 3/27/2003

Patient Name _____ Date _____

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

Pain Intensity

- ⓪ The pain comes and goes and is very mild.
- ① The pain is mild and does not vary much.
- ② The pain comes and goes and is moderate.
- ③ The pain is moderate and does not vary much.
- ④ The pain comes and goes and is very severe.
- ⑤ The pain is very severe and does not vary much.

Sleeping

- ⓪ I get no pain in bed.
- ① I get pain in bed but it does not prevent me from sleeping well.
- ② Because of pain my normal sleep is reduced by less than 25%.
- ③ Because of pain my normal sleep is reduced by less than 50%.
- ④ Because of pain my normal sleep is reduced by less than 75%.
- ⑤ Pain prevents me from sleeping at all.

Sitting

- ⓪ I can sit in any chair as long as I like.
- ① I can only sit in my favorite chair as long as I like.
- ② Pain prevents me from sitting more than 1 hour.
- ③ Pain prevents me from sitting more than 1/2 hour.
- ④ Pain prevents me from sitting more than 10 minutes.
- ⑤ I avoid sitting because it increases pain immediately.

Standing

- ⓪ I can stand as long as I want without pain.
- ① I have some pain while standing but it does not increase with time.
- ② I cannot stand for longer than 1 hour without increasing pain.
- ③ I cannot stand for longer than 1/2 hour without increasing pain.
- ④ I cannot stand for longer than 10 minutes without increasing pain.
- ⑤ I avoid standing because it increases pain immediately.

Walking

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

Personal Care

- ⓪ I do not have to change my way of washing or dressing in order to avoid pain.
- ① I do not normally change my way of washing or dressing even though it causes some pain.
- ② Washing and dressing increases the pain but I manage not to change my way of doing it.
- ③ Washing and dressing increases the pain and I find it necessary to change my way of doing it.
- ④ Because of the pain I am unable to do some washing and dressing without help.
- ⑤ Because of the pain I am unable to do any washing and dressing without help.

Lifting

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

Traveling

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

Social Life

- ⓪ My social life is normal and gives me no extra pain.
- ① My social life is normal but increases the degree of pain.
- ② Pain has no significant affect on my social life apart from limiting my more energetic interests (e.g., dancing, etc).
- ③ Pain has restricted my social life and I do not go out very often.
- ④ Pain has restricted my social life to my home.
- ⑤ I have hardly any social life because of the pain.

Changing degree of pain

- ⓪ My pain is rapidly getting better.
- ① My pain fluctuates but overall is definitely getting better.
- ② My pain seems to be getting better but improvement is slow.
- ③ My pain is neither getting better or worse.
- ④ My pain is gradually worsening.
- ⑤ My pain is rapidly worsening.

Index Score = [Sum of all statements selected / (# of sections with a statement selected x 5)] x 100

Back
Index
Score