

Aliante Integrated Physical Medicine P.C. (IPM PC)

PATIENT APPLICATION FORM

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WELCOME TO OUR PHYSICAL MEDICINE & SPINAL REHABILITATION CENTER.

We specialize in helping our patients achieve a higher level of health through the use of a customized spinal, postural, and/or functional corrective care. Our approach is very unique and different from other physical medicine, traditional chiropractic or physical therapy offices. Our integrated approach allows our patients to achieve far superior results compared to most other systems. Please fill out the following information thoroughly so the doctor can let you know if you are a case we can accept. We do not accept all cases.

Please feel free to ask any questions if you need assistance. We look forward to serving you!

Patient Signature: _____ Date: _____

PATIENT APPLICATION SURVEY

Full Name: _____ Preferred Name: _____ Age _____ Gender: ☐ M ☐ F

Home Street Address: _____ Home Phone: (____) _____

City, State, Zip: _____ Work Phone: (____) _____

Email Address: _____ Cell Phone: (____) _____

Birth Date: ____/____/____ Social Security #: _____ - _____ - _____ Marital Status: S M D W

Height ____ Weight ____ Race/Ethnicity: ☐ African American ☐ Arabic ☐ Asian ☐ Caucasian ☐ Hispanic ☐ Native Am.

Occupation: _____ Employer Name: _____

Primary Spoken Language: _____ How were you referred to this office? _____

IN CASE OF EMERGENCY

Name _____ Relationship _____ Phone (____) _____

PURPOSE OF VISIT

(*please list in order of importance)

Major complaint/Reason for appointment:	Date conditions began:	Have you had this before?	Injury related?
1. _____	_____	☐ Yes ☐ No	☐ Yes ☐ No
2. _____	_____	☐ Yes ☐ No	☐ Yes ☐ No
3. _____	_____	☐ Yes ☐ No	☐ Yes ☐ No

EXPERIENCE WITH PHYSICAL MEDICINE

Have you been seen at a physical medicine center before? ☐ Yes ☐ No Who? _____

When? _____ Reason for visits? _____ How did you respond? _____

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

When? _____ Reason for visits? _____ How did you respond? _____

Have you seen a physical therapist before? ☐ Yes ☐ No Who? _____

When? _____ Reason for visits? _____ How did you respond? _____

GENERAL HEALTHCARE PROVIDERS

Primary Care Provider---Name: _____ Date of last visit: _____

Other Healthcare Providers---

Name: _____ Specialty: _____ Date of last visit: _____

Name: _____ Specialty: _____ Date of last visit: _____

Allergies(and reaction): _____

Previous major injuries or trauma and dates: _____

Previous surgeries and dates: _____

Previous hospitalizations or major and dates: _____

What other testing or treatments have you tried to date for **present condition**: _____

Current prescription medications: _____

Current over-the-counter medications & supplements (vitamins, herbs, etc.): _____

SOCIAL HISTORY AND LIFESTYLE

Do you exercise? ☐ Yes ☐ No How often? 1X 2X 3X 4X 5X per week other: _____
What activities? ☐ Running ☐ Jogging ☐ Weight Training ☐ Cycling ☐ Yoga ☐ Pilates ☐ Swimming ☐ Other _____
Do you consider yourself to be...? ☐ Underweight ☐ Normal weight ☐ Overweight ☐ Obese ☐ Severely obese
Smoking History? ☐ Never ☐ Former ☐ Current How many? _____ per ☐ day ☐ week ☐ month ☐ year
Do you use recreational drugs? ☐ Yes ☐ No Type: _____ How much? _____ per ☐ day ☐ week ☐ month ☐ year
Do you drink alcohol? ☐ Yes ☐ No How much? _____ per ☐ day ☐ week ☐ month ☐ year
Do you drink coffee? ☐ Yes ☐ No How much? _____ per ☐ day ☐ week ☐ month ☐ year

Functional Impact: Which activities in your life have been most affected by your **present condition**?

If you were to describe how this condition limits your ability to complete these activities (0% being completely unable to do, 100% being completely unaffected), what percentage would you describe your function? _____%

HEALTH CONDITIONS

Please check any problems you are currently experiencing:

GENERAL: ☐ Low energy/fatigue ☐ Muscle Spasm ☐ nausea ☐ dizziness ☐ headaches ☐ Jaw Pain
☐ sleep disturbance ☐ Depression ☐ Anxiety ☐ irritability ☐ snoring

Bladder & bowel Function: If you have had any change in your bowel or bladder function, do you:

☐ Urinate more often ☐ Have loss of control or accidents ☐ Have a sense of urgency
☐ Have problems with sexual function ☐ Have a loss of sensation around the groin or buttocks
☐ Constipation ☐ Diarrhea ☐ Recurrent bladder/urinary tract infections

NEUROLOGIC/ORTHOPEDIC:

☐ Neck pain ☐ Upper back pain ☐ Shoulder pain ☐ Mid-back pain ☐ Low back pain
☐ Pain into ribs/chest ☐ Scoliosis ☐ Muscle cramps/spasms
☐ Pain into shoulders/arms/hands ☐ Weakness into arms/hands ☐ Numbness/tingling into arms/hands
☐ Pain into hips/legs/feet ☐ Weakness into legs ☐ Numbness/tingling into legs/feet
☐ Osteoporosis ☐ *Arthritis ☐ *Seizures

OTHER:

☐ *Immune problems	☐ *Hearing disturbances	☐ *Heart murmurs	☐ Hypoglycemia
☐ *Infectious disease	☐ *Thyroid conditions	☐ Asthma	☐ Gallbladder problems
(e.g, HIV/AIDS, Hep C)	☐ Pain with breathing	☐ High cholesterol	☐ Acid reflux
☐ Dizziness/fainting	☐ Sinusitis	☐ *Kidney disease	☐ *Liver disease
☐ Cold hands/feet	☐ Heart palpitations	☐ Diabetes	☐ *Bleeding Disorder
☐ *Arthritis	☐ Shortness of breath	☐ Ulcers/gastritis	☐ Sleep apnea
☐ *Visual disturbances	☐ High blood pressure	☐ Indigestion/Heartburn	☐ *Lung disease

*Please explain any health conditions mentioned above as necessary: _____

Please list any health conditions not mentioned: _____

Have you ever been diagnosed with cancer? ☐ Yes ☐ No If yes, explain: _____

PERSONAL & FAMILY HEALTH HISTORY

Please indicate if **YOU** or any of your **immediate family members** ever had the following:

☐ Mental Health Disease	☐ Neurological Problems	☐ Lung Disease	☐ Thyroid	☐ Arthritis
☐ Circulatory Problems	☐ Immune System Problems	☐ Back Pain	☐ Cancer	☐ Scoliosis
☐ Heart Disease	☐ Stroke	☐ Kidney Disease	☐ Diabetes	☐ Osteoporosis
☐ Migraine Headaches	☐ Digestive Disorders	☐ Infectious Disease	☐ Seizures	☐ Liver Disease
☐ Other: _____				

HISTORY OF PRIMARY COMPLAINTS

Is this the first time you have had these symptoms? ☐ Yes ☐ No If No, when was the FIRST time you had these same symptoms? _____

How did the CURRENT episode of pain/discomfort occur? _____

How did the FIRST episode of pain/discomfort occur? _____

How would you describe your pain? Please describe your pain over the last 2 weeks in each painful area:

Pain Location: _____ ☐ Constant ☐ Frequent ☐ Occasional ☐ Seldom

RIGHT NOW: _____ / 10 (Pain severity: If 10 is the worst pain imaginable, and 0 is no pain)

Pain Quality: ☐ Dull ☐ Achy ☐ Stiff ☐ Intense ☐ Throbbing ☐ Sharp ☐ Stabbing ☐ Sharp with movement ☐ Burning
☐ Constricting ☐ Pressure ☐ Annoying ☐ Tight ☐ Unbearable ☐ Other: _____

Pain Location: _____ ☐ Constant ☐ Frequent ☐ Occasional ☐ Seldom

RIGHT NOW: _____ / 10 (Pain severity: If 10 is the worst pain imaginable, and 0 is no pain)

Pain Quality: ☐ Dull ☐ Achy ☐ Stiff ☐ Intense ☐ Throbbing ☐ Sharp ☐ Stabbing ☐ Sharp with movement ☐ Burning
☐ Constricting ☐ Pressure ☐ Annoying ☐ Tight ☐ Unbearable ☐ Other: _____

Pain Location: _____ ☐ Constant ☐ Frequent ☐ Occasional ☐ Seldom

RIGHT NOW: _____ / 10 (Pain severity: If 10 is the worst pain imaginable, and 0 is no pain)

Pain Quality: ☐ Dull ☐ Achy ☐ Stiff ☐ Intense ☐ Throbbing ☐ Sharp ☐ Stabbing ☐ Sharp with movement ☐ Burning
☐ Constricting ☐ Pressure ☐ Annoying ☐ Tight ☐ Unbearable ☐ Other: _____

Radiating: Does your pain seem to radiate from the primary area: ☐ Yes ☐ No If Yes, where does the pain radiate to? _____

Numbness/Tingling (pins and needles): Do you currently experience numbness and or tingling anywhere? ☐ No ☐ Yes:

Please describe where and when you feel these symptoms: _____

When is your pain/discomfort WORSE:

☐ It does not seem to be affected by the time of day
☐ In the morning ☐ In the afternoon
☐ In the afternoon ☐ In the evening
☐ While sleeping ☐ While awake

When your pain/discomfort BETTER:

☐ It does not seem to be affected by the time of day
☐ In the morning ☐ In the afternoon
☐ In the afternoon ☐ In the evening
☐ While sleeping ☐ While awake

What DECREASES your pain/symptoms? (check all that apply):

☐ Nothing	☐ Traction	☐ Electrical stimulation	☐ Ice	☐ Heat	☐ Massage/Rubbing
☐ Exercise/Activity	☐ Sitting	☐ "Popping" the joints	☐ Standing	☐ Rest	☐ Stretching
☐ "Popping" the joints	☐ Laying	☐ Bracing/taping	☐ Other: _____		
☐ Medications: _____					

What INCREASES your pain/symptoms? (check all that apply):

☐ Coughing	☐ Sneezing	☐ Bearing Down	☐ Sexual Intercourse	☐ Running	☐ Standing
☐ Lifting	☐ Bending	☐ Pushing	☐ Pulling	☐ Driving	☐ Sitting
☐ Walking	☐ Laying down	☐ Head movement	☐ Low back movement	☐ Other: _____	

INSURANCE AND FINANCIAL OBLIGATION INFORMATION

Do you have insurance? ☐ Yes ☐ No Policy# _____ Group # _____
Insurance Co. Name _____ Phone # _____
Address _____
Insured's Name _____ Birth date: ____ / ____ / ____ Relationship _____
Do you have secondary insurance? ☐ Yes ☐ No Policy# _____ Group # _____
Insurance Co. Name _____ Phone # _____
Address _____
Insured's Name _____ Birth date: ____ / ____ / ____ Relationship _____
For Automobile Accidents, what is the name of your Insurance Carrier? _____
Phone # _____ Policy Claim Number: _____
For Work Injury, what is your Employer Contact Name _____ Phone # _____
Claim No _____ If known, Insurance Carrier? _____

Other than yourself, who else should receive charges on your account? (CHECK ALL THAT APPLY)

☐ Spouse ☐ Parent/Guardian ☐ Workers Comp ☐ Auto Insurance ☐ Medicare ☐ Personal Health Insurance

By signing below, I verify that, I clearly understand that all insurance coverage, whether accident, auto, work related, or general coverage is an arrangement between my insurance carrier and myself. If this office **chooses** to bill any services to my insurance carrier this is done strictly as a **convenience** and **courtesy** for me. This office may provide any necessary reports subject to reasonable service fees to aid in insurance reimbursement of services, but I understand that insurance carriers may deny my claims and that I am ultimately responsible for any unpaid balances. Any monies received will be credited to my account. I understand there could be some services that my insurance company does not cover, if this is the case I am willing to pay for these services.

I also understand that I will be charged \$25 for any and all scheduled appointments that are missed without contacting the office in advance. This missed visit fee WILL NOT be covered by insurance and must be paid prior to the next scheduled visit.

Signature of Patient/or Guardian: _____ Date: _____

HEALTHCARE AUTHORIZATION FORM (HIPAA)

THE FOLLOWING AUTHORIZES Aliante IPM PC TO USE AND/OR DISCLOSE PROTECTED HEALTH CARE INFORMATION IN ACCORDANCE WITH THE FOLLOWING SPECIFIC AUTHORIZATIONS:

I give permission to Aliante IPM PC to use my name, address, phone numbers and clinical records to contact me with birthday cards, holiday related cards, health related e-mails messages and information about treatment alternatives or other health related information as well as any advertisements, newsletters or patient of the week/month postings.

I give permission to Aliante IPM PC to treat me in an open room where other patients are also being treated. I am aware that other persons in the office may overhear some of my protective health care information during the course of my treatment. Should I need to speak with a doctor or assistant in private, the doctor or assistant will provide a private room for these conversations BY APPOINTMENT ONLY.

By signing the following you are giving Aliante IPM PC permission to use and disclose your protected health information in accordance with the directives listed above.

Signature of Patient/or Guardian: _____ Date: _____

ACKNOWLEDGEMENT OF RECEIPT & NOTICE OF PRIVACY PRACTICES

I understand and have been provided with a notice of information practices that provides me a more complete description of information uses and disclosures; I understand that I have the following rights and privileges:

- * The right to review the notice prior to signing this consent.
- * The right to object to the use of my health care information for directory purpose.
- * The right to request restrictions as to how my health care information may be used or disclosed in this office to carry out treatment, payment, or health care operations.

Signature of Patient/or Guardian: _____ Date: _____

INFORMED CONSENT FORM Aliante IPM PC

Please read this entire document and discuss any questions or concerns prior to signing it. It is important that you understand the information contained in this document.

AUTHORIZATION OF CARE

I authorize and agree to allow the physician, nurse practitioner, physicians assistant, physical therapist, chiropractic intern, and/or assistants(s) to the use of physical examination, x-ray & MRI, structural and/or functional physiotherapy, spinal adjustments, rehabilitative exercises (in office & at home), traction, injections and other methods for the sole purpose of postural and structural improvement in biomechanical and related neurological function. I understand that I am responsible for all fees incurred for the services provided, and agree to ensure full payment of all charges. The healthcare providers and/or assistants will not be held responsible for any health conditions or diagnoses which are pre-existing, given by another health care practitioner, or are not related to the spinal structural conditions diagnosed at this clinic. I also clearly understand that if I do not follow the healthcare providers and/or assistants specific recommendations at this clinic that I will not receive the full benefit from this program, and that if I terminate my care prematurely that all fees incurred will be due and payable at that time. Any discounts are at the discretion of Aliante IPM PC and failure to keep your treatment plan agreement may result in full fees being applied. I authorize the assignment of all insurance benefits be directed to Aliante IPM PC for all services rendered.

Patient's Name Printed

Date

Patient's Signature

Guardian/Spouse's Signature Authorizing Care for Minor

Date

RADIOGRAPH CONSENT

In order to best determine the cause and extent of my underlying spinal problems, I hereby give my consent to Aliante IPM PC and assistants to take spine or other relevant radiographs as deemed clinically necessary through a medical and chiropractic history/examination and in accordance with clinical usage indications as published in the PCCRP Clinical Practice (2009).

Signature of Patient/or Guardian: _____ Date: _____

ALL FEMALES: I also hereby declare to my knowledge that I am not pregnant _____ (Initial).

ANALYSIS, EXAMINATION AND TREATMENT

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

Please initial each area below:

- | | |
|--|---|
| • Spinal Adjustment/Manipulative Therapy _____ | • Postural Analysis _____ |
| • Range of motion testing _____ | • Cryotherapy (ice) _____ |
| • Muscle strength testing _____ | • Physical examination _____ |
| • Radiographic Study/ X-ray _____ | • Vital signs _____ |
| • Palpation (examining the body using touch) _____ | • Neurological Examination _____ |
| • Orthopedic examination _____ | • Electrical Stimulation, muscle and/or joint _____ |

The Nature of the Chiropractic Adjustment: One of the primary treatments used by a Doctor of Chiropractic is the spinal adjustment or spinal manipulative therapy. We will use this type of procedure with you. We may use our hands or a mechanical instrument upon your body in such a way as to move your joints. This may cause an audible “pop” or “click” much like one experiences from “popping” knuckles. You may feel a sense of movement.

The material risks inherent in spinal and/or joint adjustment:

As with any healthcare procedure, there are certain complications which may arise with adjustment/ manipulation and therapy. These complications include but are not limited to: fracture, disc injury, dislocation, muscle strain, cervical myelopathy, costovertebral strains and separations, and burns. Some types of adjustment/manipulation of the neck have been associated with injuries to the arteries of 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. This is similar to the soreness associated with working out and the “lactic acid “response. We will make every reasonable effort during the examination to screen for contradictions to care; however, if you have a condition that would otherwise not come to our attention, it is your responsibility to inform us.

The probability of those risks occurring:

Fractures are rare occurrences and generally the result of an underlying weakness of the bone which will be checked for during your history, examination and on 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 to one in five million cervical adjustments. The other complications are also described as generally rare.

The availability and nature of other treatment options:

Other treatment options for your condition may include:

- Self administered, OTC treatments/medications
- Medications & prescription drugs
- Hospitalization
- Surgical procedures

The risks and dangers attendant to remaining untreated:

Remaining untreated may allow the formation of joint adhesions, and reduced mobility which may lead to a pain reaction and further reduced mobility. Over time this process may complicated treatment making it more difficult and less effective the longer care is postponed.

DO NOT SIGN UNTIL YOU HAVE READ AND UNDERSTAND THE ABOVE. PLEASE CHECK THE APPROPRIATE BLOCK AND SIGN BELOW.

I have read or have had read to me the aforementioned explanation of the adjustment/manipulation and related treatment. I have discussed any questions with the examining provider (MD, nurse practitioner, chiropractor, or chiropractic intern) 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 is in my best interest to undergo the treatment recommended. Having been informed of the risks, I hereby give my consent for treatment.

Dated: _____

Dated:_____

Patients Name

Providers Name

Patient Signature

Provider Signature

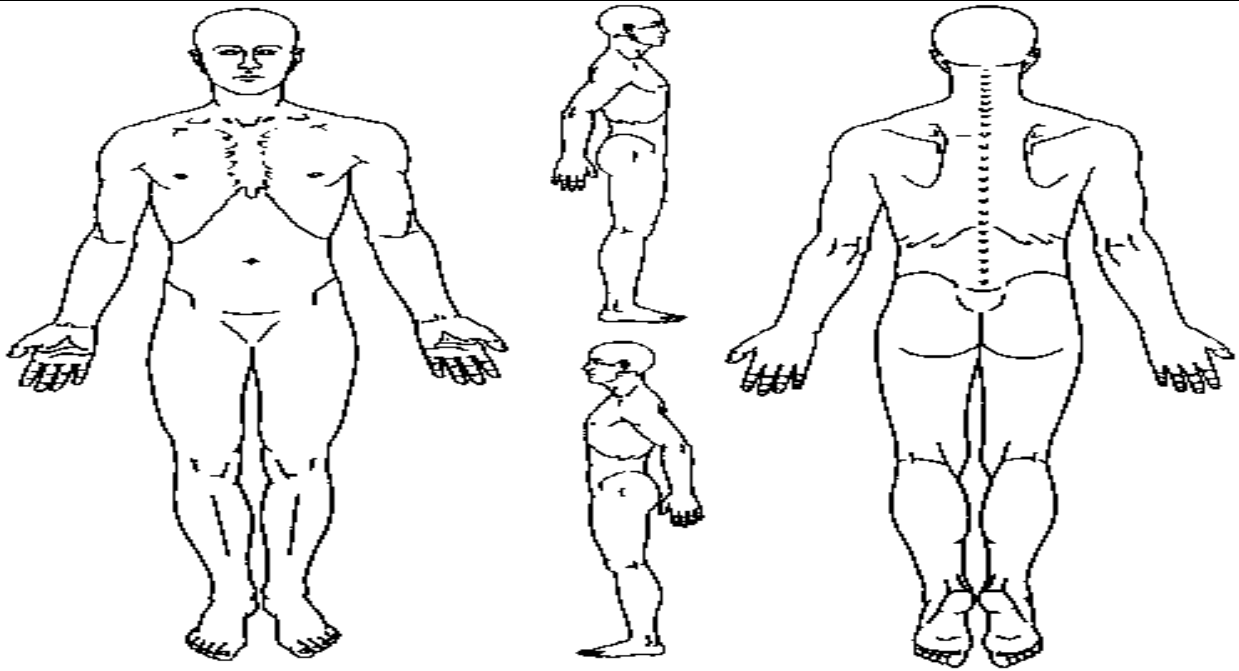
Signature of parent or guardian (if a minor)

THE DISABILITY INDEX QUESTIONNAIRE

NAME DATE

How long have you had spine or extremity pain yearsmonthsweeks_____

On the diagram below, please indicate where you are experiencing pain or other symptoms.



A = ACHE
S = STABBING

P = PINS & NEEDLES
N = NUMBNESS

B = BURNING
O = OTHER

Next Page: OVER PLEASE ☐

GENERAL PAIN DISABILITY INDEX QUESTIONNAIRE

The rating scales below are designed to measure the degree to which several aspects of your life are presently disrupted by chronic pain. In other words, we would like to know how much your pain is preventing you from doing what you would normally do, or from doing it as well as you normally would. Respond to each category by indicating the *overall* impact of pain in your life, not just when the pain is at its worst.

For each of the six categories of daily living listed, PLEASE CIRCLE THE NUMBER WHICH BEST DESCRIBES YOUR TYPICAL LEVEL OF ACTIVITIES. A score of 0 means no disability at all, and a score of 10 signifies that all of the activities in which you would normally be involved have been totally disrupted or prevented by your pain.

Revised March 15, 1993

1. **Family/Home Responsibilities.** This category refers to activities related to the home or family. It includes chores and duties performed around the house (e.g., yard work) and errands or favors for other family members (e.g., driving the children to school).

0	1	2	3	4	5	6	7	8	9	10
Completely able to function					Totally unable to function					

2. **Recreation.** This category includes hobbies, sports, and other similar leisure time activities.

0	1	2	3	4	5	6	7	8	9	10
Completely able to function					Totally unable to function					

3. **Social Activity.** This category refers to activities which involve participation with friends and acquaintances other than family members. It includes parties, theater, concerts, dining out, and other social functions.

0	1	2	3	4	5	6	7	8	9	10
Completely able to function					Totally unable to function					

4. **Occupation.** This category refers to activities that are a part of or directly related to one's job. This includes nonpaying jobs as well, such as that of a homemaker or volunteer worker.

0	1	2	3	4	5	6	7	8	9	10
Completely able to function					Totally unable to function					

5. **Self Care.** This category includes activities which involve personal maintenance and independent daily living (eg, taking a shower, driving, getting dressed, etc.).

0	1	2	3	4	5	6	7	8	9	10
Completely able to function					Totally unable to function					

6. **Life-Support Activity.** This category refers to basic life-supporting behaviors such as eating, sleeping, and breathing.

0	1	2	3	4	5	6	7	8	9	10
Completely able to function					Totally unable to function					

TOTAL SCORE: _____

SIGNATURE: _____

DATE: _____

Neck Disability Questionnaire

Please Read: This questionnaire is designed to enable us to understand how much your neck pain has affected your ability to manage everyday activities. Please answer each Section by circling the **ONE CHOICE** that most applies to you. We realize that you may feel that more than one statement may relate to you, but Please just circle the one choice which closely describes your problem *right now*.

SECTION 1--Pain Intensity

- A. I have no pain at the moment
- B. The pain is mild at the moment.
- C. The pain comes and goes and is moderate.
- D. The pain is moderate and does not vary much.
- E. The pain is severe but comes and goes.
- F. The pain is severe and does not vary much.

SECTION 2--Personal Care (Washing, Dressing etc.)

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

SECTION 3--Lifting

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

SECTION 4 --Reading

- A. I can read as much as I want to with no pain in my neck.
- B. I can read as much as I want with slight pain in my neck.
- C. I can read as much as I want with moderate pain in my neck.
- D. I cannot read as much as I want because of moderate pain in my neck.
- E. I cannot read as much as I want because of severe pain in my neck.
- F. I cannot read at all.

SECTION 5--Headache

- A. I have no headaches at all.
- B. I have slight headaches which come infrequently.
- C. I have moderate headaches which come in-frequently.
- D. I have moderate headaches which come frequently.
- E. I have severe headaches which come frequently.
- F. I have headaches almost all the time.

SECTION 6 -- Concentration

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

SECTION 7--Work

- A. I can do as much work as I want to.
- B. I can only do my usual work, but no more.
- C. I can do most of my usual work, but no more.
- D. I cannot do my usual work.
- E. I can hardly do any work at all.
- F. I cannot do any work at all.

SECTION 8--Driving

- A. I can drive my car without neck pain.
- B. I can drive my car as long as I want with slight pain in my neck.
- C. I can drive my car as long as I want with moderate pain in my neck.
- D. I cannot drive my car as long as I want because of moderate pain in my neck.
- E. I can hardly drive my car at all because of severe pain in my neck.
- F. I cannot drive my car at all.

SECTION 9--Sleeping

- A. I have no trouble sleeping
- B. My sleep is slightly disturbed (less than 1 hour sleepless).
- C. My sleep is mildly disturbed (1-2 hours sleepless).
- D. My sleep is moderately disturbed (2-3 hours sleepless).
- E. My sleep is greatly disturbed (3-5 hours sleepless).
- F. My sleep is completely disturbed (5-7 hours sleepless).

SECTION 10--Recreation

- A. I am able engage in all recreational activities with no pain in my neck at all.
- B. I am able engage in all recreational activities with some pain in my neck.
- C. I am able engage in most, but not all recreational activities because of pain in my neck.
- D. I am able engage in a few of my usual recreational activities because of pain in my neck.
- E. I can hardly do any recreational activities because of pain in my neck.
- F. I cannot do any recreational activities at all.

SIGNATURE: _____ DATE: _____

Name: _____

Dr. Signature: _____

DISABILITY INDEX SCORE: _____

0-4-no disability
5-14-mild disability
15-24-moderate disability
25-34-severe disability
above 34-complete disability

Low Back Disability Questionnaire

Please Read: This questionnaire is designed to enable us to understand how much your **low back** has affected your ability to manage everyday activities. Please answer each Section by circling the **ONE CHOICE** that most applies to you. We realize that you may feel that more than one statement may relate to you, but please **just circle the one choice which closely describes your problem RIGHT NOW.**

SECTION 1--Pain Intensity

- A. I have no pain at the moment
- B. The pain is mild at the moment.
- C. The pain comes and goes and is moderate.
- D. The pain is moderate and does not vary much.
- E. The pain is severe but comes and goes.
- F. The pain is severe and does not vary much.

SECTION 2--Personal Care (Washing, Dressing etc.)

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

SECTION 3--Lifting

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

SECTION 4 --Walking

- A. Pain does not prevent me from walking any distance.
- B. Pain prevents me from walking more than one mile.
- C. Pain prevents me from walking more than one mile.
- D. Pain prevents me from walking more than 1/2 mile.
- E. I can only walk while using a cane or on crutches.
- F. I am in bed most of the time and have to crawl to the toilet.

SECTION 5--Sitting

- A. I can sit in any chair as long as I like without pain.
- B. I can only sit in my favorite chair as long as I like.
- C. Pain prevents me from sitting more than one hour.
- D. Pain prevents me from sitting more than 1/2 hour.
- E. Pain prevents me from sitting more than ten minutes.
- F. Pain prevents me from sitting at all.

SECTION 6 -- Standing

- A. I can stand as long as I want without pain.
- B. I have some pain while standing, but it does not increase with time.
- C. I cannot stand for longer than one hour without increasing pain.
- D. I cannot stand for longer than 1/2 hour without increasing pain.
- E. I can't stand for more than 10 minutes without increasing pain.
- F. avoid standing because it increases pain right away.

SECTION 8--Social Life

- A. My social life is normal and gives me no pain.
- B. My social life is normal, but increases the degree of my pain.
- C. Pain has no significant effect on my social life apart from limiting my more energetic interests, e.g., dancing, etc.
- D. Pain has restricted my social life and I do not go out very often.
- E. Pain has restricted my social life to my home.
- F. Pain prevents me from sleeping at all.

SECTION 8--Traveling

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

SECTION 9--Sleeping

- A. I have no trouble sleeping
- B. My sleep is slightly disturbed (less than 1 hour sleepless).
- C. My sleep is mildly disturbed (1-2 hours sleepless).
- D. My sleep is moderately disturbed (2-3 hours sleepless).
- E. My sleep is greatly disturbed (3-5 hours sleepless).
- F. My sleep is completely disturbed (5-7 hours sleepless).

SECTION 10--Changing Degree of Pain

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

0-4-no disability
5-14-mild disability
15-24-moderate disability
25-34-severe disability
above 34-complete disability

SIGNATURE: _____ DATE: _____

Name: _____

Dr. Signature: _____

DISABILITY INDEX SCORE: _____