Optimal Health
Chiropractic & Wellness Care

Adjuster Name:_____

Adjuster Phone #:_____

Adjuster Fax:_____

Claim #:_____

Personal Injury Checklist

____ Lien to Med Pay Lien to Liable
____ Lien to Attorney

The following items are mandatory:

____ Accident sheet completed
____ Declaration page
____ Police Report
____ Visible copy of identification
____ Health Insurance card
____ Original Lien
____ Letter of Representation (If they have an attorney)
____ Copies of all letters, HCFAS, and information patient may have brought in
____ Copy of billing package sent out

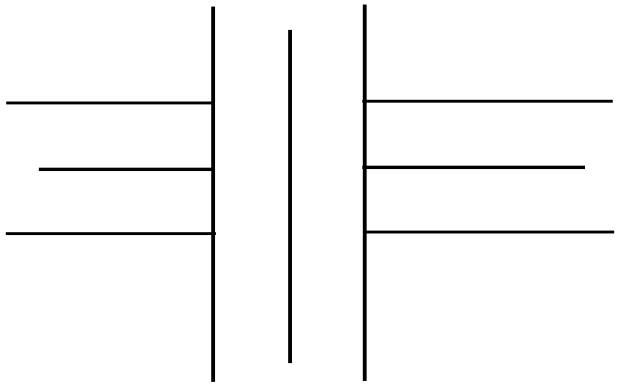
Optimal Health
Chiropractic & Wellness Care

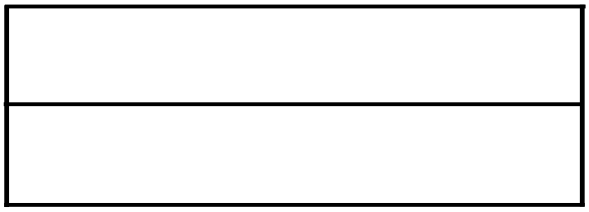
CONFIDENTIAL VEHICLE ACCIDENT REPORT

Name:_____ DOB:_____ Age:_____ Gender_____
Address:_____ City:_____ State:_____ Zip:_____
Home phone:_____ Cell Phone:_____ Work Phone:_____
Driver's license #:_____ Marital Status:_____
Occupation:_____ Email:_____
Nearest Relative Name & Telephone:_____
Height: _____ Weight:_____ lbs Race:_____
Date of accident:_____ Time of accident:_____
Were you: a) driver: b) passenger- front: c) passenger- rear: d) number of passengers:____
e) pedestrian:
Were you wearing shoulder harness: **Y / N** Were you wearing a seatbelt: **Y / N**
Your vehicle: a) auto b) truck c) van d) motorcycle e) motorhome t) bicycle g) other_____
Year and model of your vehicle:_____
Owner of vehicle:_____ Approx. damage to the vehicle:$_____Was it drivable: Y I N
Other vehicle: a) car b) truck c) van d) motorcycle e) motorhome f) bicycle g) other
Year and model of other vehicle:_____
Owner of vehicle:_____
Visibility at time of accident: _____Poor _____Fair _____Good
Road conditions at time of accident: ____ Dry ____Wet ____Rainy ____Snow ____ Ice ____Fog ____Clear____Dark
How accident occurred: a) struck BY another vehicle b) struck another vehicle c) struck stationary object
d) Other:_____
Where was your vehicle hit: a) front b) rear c) front right side d) front left side e) rear right side
f) rear left side g) other_____
Other vehicle contact: a) front b) rear c) front right side d) front left side e) rear right side
rear left side g) other
In your own words, please describe the accident:

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

INDICATE ON APPROPRIATE DIAGRAM HOW THE ACCIDENT HAPPENED:





Did you see the accident coming? **Y / N** Were you pre-warned that the accident was about to happen? **Y / N**
Did you brace for impact? **Y / N** Does your car have headrests? **Y / N**
If yes, what was the position of those headrests compared to your head before the accident a) top of headrest even with bott of head b) top of headrest even with top of head c) top of headrest even with middle of neck
Was the car you were in braking: **Y / N** Your approximate speed:_____MPH
What was occurring at the moment of impact: (circle as many as apply)

a) tensed body for impact b) neck whipped forward and back c) spine torqued and twisted
d) thrown over seat e) thrown from vehicle f) pinned vehicle
g) thrown from side to side h) cut and bruised i)other:_____

What was your head position at the time of impact:
Head turned: ____right ____left ____looking back
Body rotated: ____right ____left

Did you strike your: (circle as many as apply)
a) **Head** against: Dashboard Windshield Steering Wheel Right Door Left Door Headrest Unknown object
b) **Shoulder** against: Dashboard Windshield Steering Wheel Right Door Left Door Headrest Unknown object
c) **Arm** against: Dashboard Windshield Steering Wheel Right Door Left Door Headrest Unknown object
d) **Elbow** against: Dashboard Windshield Steering Wheel Right Door Left Door Headrest Unknown object
e) **Wrist** against: Dashboard Windshield Steering Wheel Right Door Left Door Headrest Unknown object
f) **Hip** against: Dashboard Windshield Steering Wheel Right Door Left Door Headrest Unknown object
g) **Knee** against: Dashboard Windshield Steering Wheel Right Door Left Door Headrest Unknown object
h) **Ankle** against: Dashboard Windshield Steering Wheel Right Door Left Door Headrest Unknown object

Were you rendered unconscious? **Y / N**
Were you able to move all your body parts? **Y / N** If no, explain:_____
Were you able to get out of the car? **Y / N** If no, explain:_____

Did you bleed or get cuts and bruises? **Y / N** If yes, bleeding:_____ Cuts/bruises: _____
Were there any flying objects in the car? **Y / N** Were you hit?_____ Where:_____
Please describe how you felt:

During the accident: _____
Immediately after the accident: _____
Later that day: _____
The next day: _____

Circle symptoms you have noticed since the accident:

Headache	Dizziness	Light bothers eyes	Cold sweats
Neck pain	Head heavy	Loss of memory	Feet cold
Neck stiffness	Pins/Needles in arm	Ears ring	Hands cold
Sleeping problems	Pins/Needles in leg	Face Flush	Stomach upset
Numbness in fingers	Buzzing in ears	Constipation	Loss of taste
Mid-back pain	Nervousness	Loss of balance	Diarrhea
Low-back pain	Numbness in toes	Tension	Shortness of breath
Fainting	Fever	Loss of smell	Vomit
Irritability	Fatigue	Chest pain	Depression

Symptoms other than above:_____

Pain level: on a scale of 0-10, with 0 being pain free and fully functional, and I0 being constant agony and totally inability to function, where would you rate yourself? **0 – 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10**

Indicate ability to perform the following activities:

U -Unable P -Painful D- Difficult L -Limited N -Normal

___ Coughing or sneezing	___ Lying on side	___ Gripping	___ Climbing stairs
___ Getting in/out of car	___ Bending forward	___ Pushing	___ Bending to brush teeth
___ Pulling	___Turning over in bed	___ Kneeling	___ Reaching
___ Walking short distance	___ Balancing	___ Sexual activity	___ Standing more than 1 hour
___ Dressing self	___ Stooping	___ Lying on back	___ Sleeping
___ Lying on stomach	___ Sitting at table	___Other: _____	

Have you lost any time from work as a result of this accident? **Y / N** If yes, please complete below:

a) Last day worked: _____
b) Type of employment : _____
c) Are you being compensated for time from lost work? **Y / N**

Was a police report filed? **Y / N**
Did you receive medical attention at the time of the accident? **Y / N**
If yes, what was done: _____
Were you taken by ambulance to the hospital: **Y / N** If yes, where? _____
What was done? _____
What was the diagnosis given? _____

Where did you go immediately after the accident? a) resume activities b) home c) this office

d) Medical attention: **Y / N** If yes, where? _____ Were you examined? **Y / N**

e) Were you x-rayed: **Y / N** If yes, where? _____

f) Date of treatment: _____ What treatment was given? _____

Second doctor/clinic seen: _____ Date of visit: _____

a) Were you examined: **Y / N** b) Were you x-rayed: **Y / N**

c) Were you given treatment **Y / N** If yes, explain: _____

d) What benefits did you receive from treatment? _____

e) Date of last treatment: _____

Did you have any physical complaints before the accident? **Y / N** If yes, please describe: _____

_____

_____

Have you ever been involved in an accident before: **Y / N** If yes, please describe and indicate date: _____

_____

_____

List surgical operation(s) and year(s): _____

_____

_____

_____

Medications you take now (circle all that apply):

None Nerve pills Pain killers Muscle Relaxers

Stimulant(s) Tranquilizers Insulin Birth Control

Other: _____

Do you smoke? **Y / N** Packs per day: _____ For how long: _____

Drink alcohol? **Y / N** Drinks per day: _____

Caffeine? **Y / N** Cups per day: _____

Exercise regularly? **Y / N** What exercises? _____

During the day (at work or home) do you: a) sit b) computer c) desk d) stand in one position

Lift more/less than 25 lbs. Explain: _____

Have you ever suffered from (circle all that apply):

Dizziness Backaches Heart trouble Diabetes Arthritis

Headaches Asthma Digestive Disorders Nervousness Sinus trouble

Neck Pain

FAMILY MEDICAL HISTORY

Has any family member (parents, brothers, sisters, grandparents) bad any of the following disorders? Please list family member next to disorder:

High blood pressure:_____ Heart disease:_____
Cancer:_____ Diabetes:_____
Thyroid:_____ Kidney:_____
Arthritis:_____ Tuberculosis:_____
Stroke:_____ Lung disease:_____

Patient Name:_____ Date:_____
Height:_____ Weight:_____ Date of Birth:_____

Please list any medication(s) you are presently taking (including vitamins)

Medication	Dose	Reason

When treatment is concluded, Patient agrees to have Optimal Health Chiropractic paid directly from the insurance company or Attorney. IF patient is paid directly or no payment is received, patient is responsible for any billing incurred. _____

Your Auto Insurance Information

Company:_____
Address:_____
City:_____State:_____ Zip:_____
Contact Name:_____
Phone number:_____
Policy Holder:_____
Policy number:_____
Claim number:_____

Other Vehicle Insurance Information

Company:_____
Address:_____
City:_____State:_____ Zip:_____
Contact Name:_____
Phone number:_____
Policy Holder:_____
Policy number:_____
Claim number:_____

Your Health Insurance Information

Policy Holder:_____
Company Name:_____
Policy number:_____
Relationship to Patient: **self / spouse / child / other**
Policy holder DOB:_____
Emergency contact:_____

Election To Not File Health Insurance Claim

To Whom It May Concern:

Upon my inquiry, the staff of Optimal Health Chiropractic has advised me that the cost of my treatment may be covered in whole or in part by my own health insurance. The staff has informed me that if I file on my own health insurance, I will be responsible for paying deductibles and co-payments, and these payments will be due as treatment is received. The staff has provided me with factual information regarding the various forms of reimbursement available to me and has answered my questions.

After giving due consideration to my options, I have decided that **I do not wish to file any claims on my health insurance.** I hereby instruct the staff to refrain from sending bills and treatment records to my health insurance carrier or health benefit plan. I authorize the staff to send bills and treatment records only to potential sources of payment other than my health insurance.

I understand that the clinic will rely on my decision and render treatment based on the assumption that payment will be received from sources other than my health insurance. I will not be expected to pay deductibles and co-payments. I understand that if third-party payors are billed, they will be billed at the clinic's usual rates rather than at discounted rates that may apply to in-network providers.

I understand that contractual and statutory deadlines may prevent me from filing on my health insurance at a later date. **The decision I am making today not to file on my health insurance is irrevocable.**

I understand that I remain personally liable for the reasonable value of the treatment rendered to me by the clinic.

Today's Date: _____

_____
Patient

_____
Witness

ASSIGNMENT OF BENEFITS

IN CONSIDERATION of the Willingness of (Optimal Health Chiropractic) to treat me on a credit without demand for payment at the time of services rendered, I do hereby agree and stipulate as follows:

Irrevocably assign to (Optimal Health Chiropractic) any proceeds or compensation that I am or may become entitled to receive as result of injuries that occurred on _____ to the extent of the chiropractic services rendered. I make this agreement without prejudice to any rights I may have to prosecute the legal claims against any party who may be liable for my injuries, but I hereby authorize and instruct you to pay directly to (Optimal Health Chiropractic), from any of my disability benefits, medical payments benefits, liability benefits, health and accident benefits, workers' compensation benefits, judgments, settlements, or proceeds of any kind that would be otherwise payable to me, such sums as are due or may become due to (Optimal Health Chiropractic) for its services rendered.

I appoint Optimal Health Chiropractic) as my attorney in tact to affix my name as an endorsement upon the reverse of any check or draft upon which I am named a payee and to deposit said check or draft and apply the proceeds to any unpaid balance that I have with (Optimal Health Chiropractic).

I authorize (Optimal Health Chiropractic) to release to any insurer with applicable coverage or to my attorney or successor attorney any information regarding my injuries, prior medical history, or treatment as may be necessary to facilitate collection of proceeds under this assignment

I acknowledge that I remain personally liable for the total amount due to (Optimal Health Chiropractic) for services rendered, including any balance remaining after the application of insurance payments and settlement or judgment proceeds. If (Optimal Health Chiropractic) is required to take legal action against me to recover any unpaid balance on my account, I agree to reimburse (Optimal Health Chiropractic) for its costs of recovery, including reasonable attorney's fees.

_____
Patient

_____
Date

_____
Witness

NOTICE OF LIEN

Pursuant to N.C.G.S. 44-49 and 44-50,(Optimal Health Chiropractic) hereby asserts and gives notice of lien upon any sums recovered in damages for personal injury in any civil action and also upon all funds paid to the above-named patient in compensation for or settlement of injuries sustained, whether in litigation or otherwise.
(Optimal Health Chiropractic) hereby requests that if its claim is not paid in full from the foregoing proceeds, a full disclosure and accounting of proceeds be provided in conformity with N.C.G.S. 44-50.1. (Optimal Health Chiropractic) agrees to be bound by any confidentiality agreements regarding the contents of the accounting.

(Optimal Health Chiropractic)

By:_____

X-Ray Assignment Agreement and Consent Form

I understand that my doctor is submitting my X-Rays for radiological interpretation and report by John R. Henry, DC DACBR, a radiologist certified by the American Chiropractic Board of Radiology.

I give my consent to Brookside Radiology Consultants, Inc. for use and disclosure of my Protected Health Information for the purpose of treatment, payment or healthcare operations of the Practice. I acknowledge that I have received or reviewed and understand the Notice of Privacy Practice of Brookside Radiology Consultants, Inc. which describes the Practice's policies and procedures regarding the use and disclosure of any of my Protected Health Information created, received, or maintained by the Practice. **My signature authorizes the release of medical information.**

_____ _____

Patient Name Today's Date

_____ _____

Patient Signature Parent/Guardian Signature (if applicable)

TO BE MAINTAINED BY REFERRING DOCTOR

Optimal Health
Chiropractic & Wellness Care

INFORMED CONSENT FORM

PATIENT NAME:_____ DATE: _____

To the patient: Please read this entire document prior to signing it. It is Important that you understand the information contained in this document. If 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
- pressure wave medical wave
- radiographic studies
- whole body vibration
- palpation
- orthopedic testing
- postural analysis testing
- hot/cold therapy
- mechanical traction
- extremity manipulative therapy
- vital signs
- basic neurological
- myofascial release
- electrical stim
- cold laser therapy
- TENS units

Other:_____

The material risks inherent in chiropractic adjustment:

As with any healthcare procedure, there an, certain complications which may arise during chiropractic manipulation and therapy. These complications, though ***extremely rare,*** include but are not limited to fractures, there have been reports of disc injuries although no clinical scientific study has ever demonstrated chiropractic care to be the cause, dislocations, muscle strain, cervical myelopathy, costovertebral strains and separations and bums. Some manipulations of the upper spine have been associated with Injury to the arteries in the neck which could cause or contribute to stroke. However, documented cases are exceedingly rare, and it has been estimated by researchers that the probability of a spinal adjustment causing a stroke Is one in several million. Stroke has been the subject of tremendous disagreement and cause is yet to be determined. 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.
Overall, compared to other forms of health care, chiropractic is extremely safe, and complications are generally rare.

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.

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

I have read the above explanation of the chiropractic adjustment and related treatment. By signing below, I state that Ihave 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 and extend this consent to Include all Doctors of Optimal Health Chiropractic, PLLC.

Dated:_____ **Printed Name:** _____

Patient Signature (Or Signature of Parent or Guardian): _____

PATIENT NAME:_____ **DATE:**_____

Financial Responsibility:

The privilege of insurance assignment begins when our office has qualified your insurance coverage. For your convenience, Optimal Health Chiropractic will bill your insurance company directly and accept assignment. Your insurance is not a guarantee of payment for services rendered in this office. It is your responsibility to pay any remaining balance with our office and seek reimbursement from your insurance company. Your fees are due and payable at this time of examination, x-rays and treatments are received, unless other arrangements have been made in advance. X-Rays remain property of this clinic.

- All co-payments and deductibles must be paid when services are rendered.
- There will be a $35 fee for all returned checks.
- Balances over 30 days may be subject to additional collection fees.
- All accounts not paid within 90 days will receive final notification and be turned over to a collection agency for further action.
- If the schedule of care is suspended or terminated, all outstanding fees for professional services will be immediately due and payable.

Patient Name: _____ **Signature:** _____

HIPAA Privacy Practices:

I acknowledge that I have received and/or have been given the opportunity to review Optimal Health Chiropractic's Notice of HIPAA Privacy Practices for protected health information.

Patient Name: _____ **Signature:** _____

Consent to treat minor: (Minor's name): _____

Parent/Guardian Signature Authorizing Care: _____

NOTICE OF PRIVACY PRACTICES AVAILABLE UPON REQUEST

I understand and consent to the following appointment reminders that will be used by the Practice: a) postcards or letters mailed to the address I provided; b) phone calls made to the number I have provided and/or voicemails left on an answering machine or with the individual answering the phone; c) emails sent to the email address I have provided.

AUTHORIZATION FOR RELEASE OF IDENTIFYING HEALTH INFORMATION

You may release my health information to the following:

- ☐ **DO NOT RELEASE MY INFORMATION TO ANYONE**
- ☐ **ANYONE WHO REQUESTS IT**
- ☐ **SPOUSE**_____
- ☐ **CHILDREN** _____
- ☐ **FAMILY MEMBER**_____
- ☐ **FRIEND**_____

ATTENTION PATIENT: If no one is checked on this form, we cannot give any information to anyone. If you sign this authorization, you can revoke it later. The exception to this is if we have already acted in accordance with the authorization. If you want to revoke your authorization later, simply send a written note to the office.

Signature:_____ **DATE:**_____

History of Present and Past Illness

Name: _____ Date: _____

Date of Birth: _____

How often are you feeling the pain?
Constantly (76%-100% of the day) Frequently (51%-75%) Occasionally (26%-50%) Intermittently (0%-25%)

What makes your symptoms worse?
Bending Exercising Lifting Sitting Sleeping Standing Travelling Walking

What relieves your symptoms?
Ice Heat Exercise Massage Chiropractic Medication

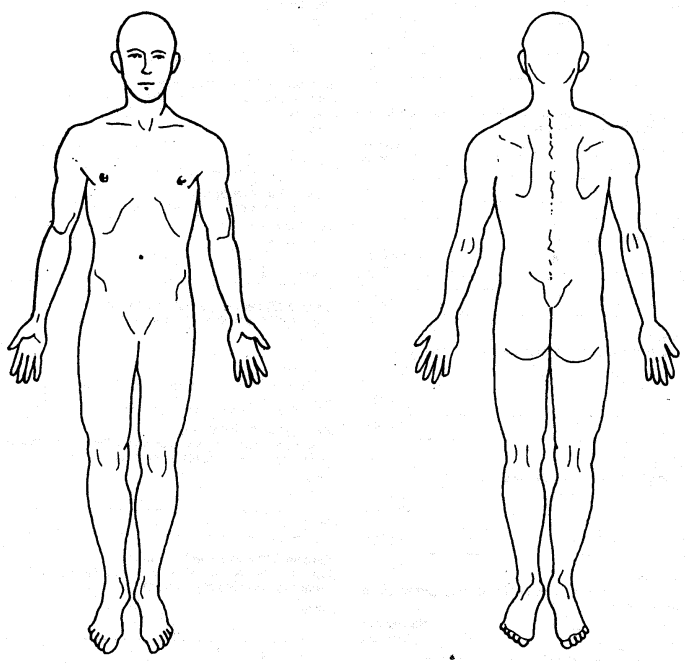
Is the problem affecting any of the following?
Employment Personal Care Social Life Exercise

On a scale of 1-10 (1 is least amount, 10 is most), what is your level of pain? _____

TELL US WHERE YOU HURT.

Please read carefully:
Mark the areas on your body where you feel your pain. Include all affected areas. Mark areas of radiation. If your pain radiates, draw an arrow from where it start to where it stops. Please extend the arrow as far as the pain travels. Use the appropriate symbol(s) listed below.

Ache > > > > >	Numbness = = = = = =	Pins & Needles o o o o
Burning x x x x	Stabbing / / / / /	Throbbing ~ ~ ~ ~ ~ ~ ~



Chief Complaint (Purpose of this appointment):_____

Date symptoms appeared or accident happened:_____

Is this due to : Auto ___ Work ____ Other _____

How did this happen?_____

Have you ever had the same or a similar condition? YES NO

If yes, when and describe:_____

Do you have a history of stroke or hypertension? YES NO If YES, Date of stroke:_____

Date of last physical examination:_____ Are you pregnant? YES NO UNCERTAIN

List any major illnesses, injuries, falls, auto accidents or surgeries?

_____

_____

Women, please include information about childbirth/dates:

_____

_____

What medications and/or drugs are you currently taking?_____

Do you have allergies of any kind? YES NO

If yes, describe:_____

Do you have a congenital condition? YES NO

If yes, describe:_____

Social History

Please indicate beside each activity whether you engage in it:

OFTEN=O SOMETIMES= S NEVER=N

___Exercise	___High stress activity
___Alcohol use	___Family pressures
___Drug use	___Other mental stresses
___Tobacco use	___Other (specify)
___Caffeine	_____

Chiropractic Case History/Patient Information

Patient Name:_____ Date:_____

Home Address:_____ City:_____State:____Zip:_____

Email:_____ Phone number:_____

Age:_____ Date of Birth:_____ Race:_____ Marital Status: M S W D

Occupation:_____ Employer:_____

Employer's Phone: _____ EXT:_____

Emergency Contact: _____ Relationship:_____ Phone:_____

Family Medical Doctor:_____ Phone:_____ Fax:_____

Address:_____ City:_____ State:___ Zip:_____

When doctors work together, it benefits you. May we have your permission to update your medical doctor regarding your care at this office? YES NO

Family and Personal Health History

Do you or any family member have/had any of the following? Please put an "X" for you, and "F" for family.

_____Depression	____Hypoglycemia	____Osteoporosis
_____Heart Attack	____Anemia	____Arthritis
_____Diabetes	____Cancer	____Carpal Tunnel
_____Thyroid Disease	____Heart Trouble	____Neuropathy
_____Liver/Gallbladder Disease	____Intestinal Problems	____Weight Gain
_____Kidney Disease	____Shortness of Breath	____Back Pain
_____Stroke	____High Cholesterol	____Neck Pain
_____Fatigue	____Headaches/Migraines	____Shoulder Pain
_____Brain Fog	____High Blood Pressure	____Knee Pain
_____Dizziness	____Poor Sleep	

☐ **I am interested in the practitioner presenting solutions for ALL checked ailments.**

I certify the information provided is accurate to the best of my knowledge.

Name:_____ Signature of Patient/Legal Guardian:_____

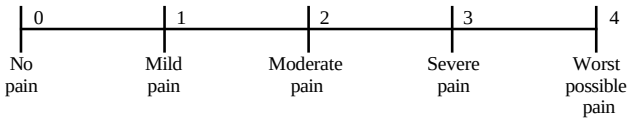
Patient Name:_____ Date of Birth:_____

Functional Rating Index

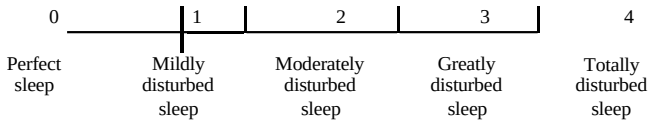
For use with **Neck and/or Back Problems** only.

In order to properly assess your condition, we must understand how much your **neck and/or back problems** has affected your ability to manage everyday activities. For each item below, **please circle the number which most closely describes your condition right now**.

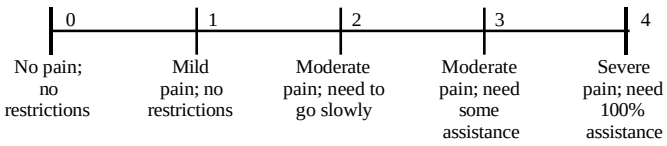
1. Pain Intensity



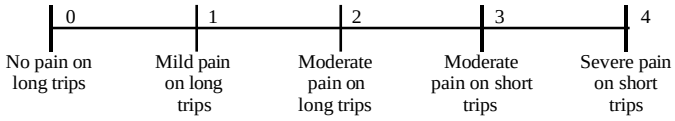
2. Sleeping



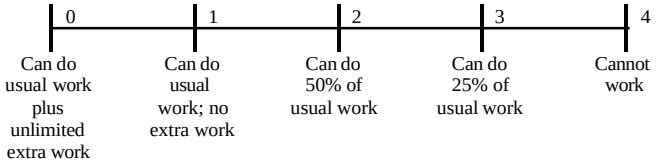
3. Personal Care (washing, dressing, etc.)



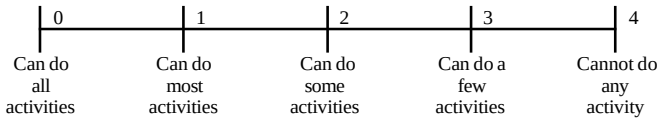
4. Travelling (driving, etc.)



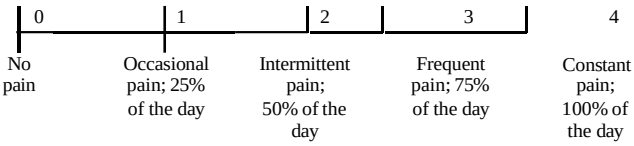
5. Work



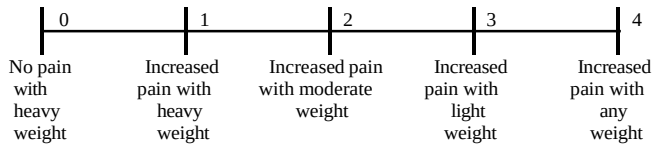
6. Recreation



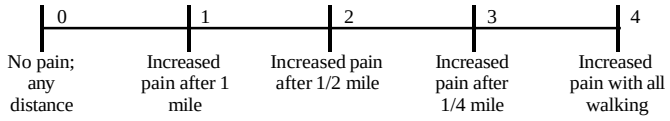
7. Frequency of Pain



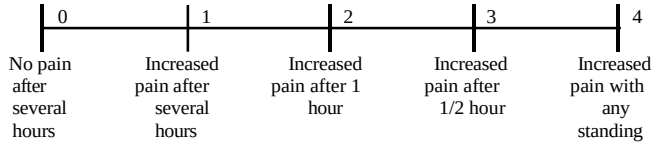
8. Lifting



9. Walking



10. Standing



Patient's Signature _____

Date _____

For Office Use Only:

Practitioner ID#: _____

Total Score _____ **/ 40**

Clinical Diagnosis Codes:

Patient ID#: _____

The Rivermead Post-Concussion Symptoms Questionnaire*

Patient name_____Date of Injury_____Today's Date_____

After a head injury or accident some people experience symptoms which can cause worry or nuisance. We would like to know if you now suffer any of the symptoms given below. As many of these symptoms occur normally, we would like you to compare yourself now with before the accident. For each one please circle the number closest to your answer.

0 = Not experienced at all
1= no more of aproblem now than before the accident
2 = amildproblem now
3 = a moderate problem now
4 = a severe problem now

Compared with before the accident, do you now (i.e. over the last 24 hours) suffer from:

Headaches	0	1	2	3	4
Feelings of dizziness	0	1	2	3	4
Nausea and/or vomiting	0	1	2	3	4
Noise sensitivity, or easily upset by loud noise	0	1	2	3	4
Sleep disturbance	0	1	2	3	4
Fatigue trying more easily	0	1	2	3	4
Being irritable, easily angered	0	1	2	3	4
Feeling depressed or tearful	0	1	2	3	4
Feeling frustrated or impatient	0	1	2	3	4
Forgetfulness, poor memory	0	1	2	3	4
Poor Concentration	0	1	2	3	4
Taking longer to think	0	1	2	3	4
Blurred Vision	0	1	2	3	4
Light sensitivity, or easily upset or irritated by bright light	0	1	2	3	4
Double vision	0	1	2	3	4
Restlessness	0	1	2	3	4

Are you experiencing any other difficulties? Please specify, and rate as above.

1._____	0	1	2	3	4
2._____	0	1	2	3	4

*King, N, Crawford S., Wenden F., Moss,N., and Wade, D. (1995) J. Neurology 242: 587-592

Lumbar Questionnaire

Name: _____
Date: _____

Please circle the number that most closely corresponds with each question

1. Over the past week, how would you rate your back pain?

No Pain — Worst Possible Pain

0 1 2 3 4 5 6 7 8 9 10

2. Over the past week, how much has your back pain interfered with your daily activities (housework, washing, dressing, walking, climbing stairs, getting in/out of bed/chair)?

No Interference — Unable to Carry Out Activity

0 1 2 3 4 5 6 7 8 9 10

3. Over the past week, how much has your back pain interfered with your ability to take part in recreational, social, and family activities?

No Interference — Unable to Carry Out Activity

0 1 2 3 4 5 6 7 8 9 10

4. Over the past week, how anxious (tense, uptight, irritable, difficulty in concentrating/relaxing) have you been feeling?

Not At All Anxious — Extremely Anxious

0 1 2 3 4 5 6 7 8 9 10

5. Over the past week, how depressed (down-in-the-dumps, sad, low in spirits, pessimistic, unhappy) have you been feeling?

Not At All Depressed — Extremely Depressed

0 1 2 3 4 5 6 7 8 9 10

6. Over the past week, how have you felt your work (both inside and outside of the home) has affected (or would affect) your back pain?

Have Made It No Worse — Have Made It Much Worse

0 1 2 3 4 5 6 7 8 9 10

7. Over the past week, how much have you been able to control(reduce/help) your back pain on your own?

Completely Control It — No Control Whatsoever

0 1 2 3 4 5 6 7 8 9 10

Cervical Questionnaire

Name: _____
Date: _____

Please circle the number that most closely corresponds with each question.

1. Over the past week, how would you rate your neck pain?

No Pain — Worst Possible Pain

0 1 2 3 4 5 6 7 8 9 10

2. Over the past week, how much has your neck pain interfered with your daily activities (housework, washing, dressing, walking ,climbing stairs, getting in/out of bed/chair)?

No Interference — Unable to Carry Out Activity

0 1 2 3 4 5 6 7 8 9 10

3. Over the past week, how much has your neck pain interfered with your ability to take part in recreational, social, and family activities?

No Interference — Unable to Carry Out Activity

0 1 2 3 4 5 6 7 8 9 10

4. Over the past week, how anxious (tense, uptight, irritable, difficulty in concentrating/relaxing) have you been feeling?

Not At All Anxious — Extremely Anxious

0 1 2 3 4 5 6 7 8 9 10

5. Over the past week, how depressed (down-in-the-dumps, sad, low in spirits, pessimistic, unhappy) have you been feeling?

Not At All Depressed — Extremely Depressed

0 1 2 3 4 5 6 7 8 9 10

6. Over the past week, how have you felt your work (both inside and outside of the home) has affected (or would affect) your neck pain?

Have Made It No Worse — Have Made It Much Worse

0 1 2 3 4 5 6 7 8 9 10

7. Over the past week, how much have you been able to control(reduce/help) your neck pain on your own?

Completely Control It — No Control Whatsoever

0 1 2 3 4 5 6 7 8 9 10