PATIENT APPLICATION FORM

WELCOME TO OUR CLINIC. We specialize in assisting our patients to achieve their highest level of health through our spinal and postural corrective programs. Our approach is very unique and advanced from other rehabilitative programs. This 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. Please feel free to ask any questions if you need assistance. We look forward to serving you.

Patient Signature: ____

Date: ___________________

PATIENT APPLICATION SURVEY

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

Names of Children: ____ Ages: ____________________

Occupation: ____ Employer Name: ______________________________

Spouse's Name: _________________________ Work Phone: ( ) _________________ Cell Phone: ( ) _______________________

Spouse's Employer: _______________________________________ Occupation: ____

How were you referred to this office? ____

PURPOSE OF THIS VISIT

Reason for this visit: ____

Is this purpose related to an auto accident / work injury? □ Yes □ No If so, when: _______________________________________

Describe: ____

Please describe the pain & its location: ____

When did this condition begin? __________/_____/________ When did you first notice it? ___________________________________

Is this condition getting worse? □ Yes □ No Is this condition: □ Constant □ Comes & goes □ Activity related

Does complaint(s) interfere with: __Work __Sleep __Hobbies __Daily Routine Explain: _____________________________________

What activities aggravate your symptoms? ____

Is there anything, which has relieved your symptoms? □ Yes □ No Describe:____

Have you experienced this condition before? □ Yes □ No If so, please explain: ____

Who have you seen for this? ____________________________________ What did they do? ________________________________

How did you respond? ____

EXPERIENCE WITH CHIROPRACTIC

Have you seen a Chiropractor before? □ Yes □ No Who? ________________________________ When? ____________________

Reason for visits: ____

How did you respond? ____

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

Did you know posture determines your health? □ Yes □ No

Are you aware of any of your poor posture habits? □ Yes □ No

Explain: ____

Are you aware of any poor posture habits in your spouse or children? □ Yes □ No

Explain: ____

The most common postural weakness is Forward Head Syndrome (head and neck starting to bend forward and progressively moving downward weakening your whole body). Even less severe forms of this posture can cause many adverse affects on your overall health. Have you ever been told or fell like you carry your head forward, noticed a rounding of your shoulders or a developing "hump" at the base of your neck? Yes No

Date: _______________

HEALTH 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 _______________

Do you smoke? Yes No How much? ____

Do you drink alcohol? Yes No How much / week? ____

Do you drink coffee? Yes No How many cups / day? ____

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

HEALTH CONDITIONS

Abnormal postural habits or distortions are the result of trauma or stress to the body that have misaligned the vertebrae in your spine. When these vertebrae are twisted from their normal position, they will cause stress to the spinal cord and the delicate nerves that pass between the vertebrae. These misalignments are called subluxations (sub-lux-a-shuns). It has been extensively documented that subluxations, causing stress to your nerves, will weaken and distort the overall structure of your spine. This results in a weakened and distorted POSTURE. Postural distortions have many serious and adverse affects on your overall health. The most common and detrimental postural distortion is called Forward Head Syndrome (a "hunched forward" posture starting in the neck and progressively moving down your spine weakening the entire body). Please check any health condition you may be experiencing, now or in the past.

CERVICAL SPINE (NECK):

Postural distortions from subluxations, (causing Forward Head Syndrome), in your neck will weaken the nerves into your arms, hands and head affecting these parts of your body. Do you experience…?

- ☐ Neck Pain
- ☐ Pain into your shoulders/arms/hands
- ☐ Numbness/tingling in arms/hands
- ☐ Hearing disturbances
- ☐ Weakness in grip
- ☐ Headaches
- ☐ Dizziness
- ☐ Visual disturbances
- ☐ Coldness in hands
- ☐ Thyroid conditions
- ☐ Sinusitis
- ☐ Allergies/Hay fever
- ☐ Recurrent colds/Flue
- ☐ Low Energy/Fatigue
- ☐ TMJ/Pain/Clicking

Explain: ____

THORACIC SPINE (UPPER BACK):

Postural distortions from subluxations (resulting from Forward Head Syndrome) in the upper back will weaken the nerves to the heart and lungs and affect these parts of your body. Do you experience…?

- ☐ Heart Palpitations
- ☐ Heart Murmurs
- ☐ Tachycardia
- ☐ Heart Attacks/Angina
- ☐ Recurrent Lung Infections/Bronchitis
- ☐ Asthma/Wheezing
- ☐ Shortness Of Breath
- ☐ Pain On Deep Inspiration/Expiration

THOPRACIC SPINE (MID BACK):

Postural distortions from subluxations (resulting from Forward Head Syndrome) in the mid back will weaken the nerves into your ribs/chest and upper digestive tract, and affect these parts of your body. Do you experience…?

- ☐ Mid Back Pain
- ☐ Pain Into Your Ribs/Chest
- ☐ Indigestion/Heartburn
- ☐ Reflux
- ☐ Nausea
- ☐ Ulcers/Gastritis
- ☐ Hypoglycemia
- ☐ Tired/Irritable after eating or when you haven't eaten for a while

LUMBAR SPINE (LOW BACK):

Postural distortions from subluxations in the low back (resulting from Forward Head Syndrome) will weaken the nerves into your legs/feet and pelvic organs and affect these parts of your body. Do you experience…?

- ☐ Pain into your hips/legs/feet
- ☐ Numbness/tingling in your legs/feet
- ☐ Coldness in your legs/feet
- ☐ Muscle cramps in your legs/feet
- ☐ Constipation / Diarrhea
- ☐ Weakness/injuries in your hips/knees/ankles
- ☐ Recurrent bladder infections
- ☐ Frequent/difficulty urinating
- ☐ Menstrual irregularities/cramping (females)
- ☐ Sexual dysfunction
- ☐ Low back pain

Please list any health conditions not mentioned: ____

Please list any medications / surgeries: ____

FAMILY HEALTH HISTORY

Have any of your family members ever been diagnosed with the following:

[] Diabetes
[] Rheumatic fever
[] High blood pressure
[] Kidney disease
[] Liver disease
[] Broken bones/fractures
[] Pneumonia
[] Whooping Cough
[] Thyroid
[] Arthritis
[] Varicose veins
[] Circulatory problems
[] Heart Disease
[] Epilepsy/seizures
[] Metal Implants
[] Appendectomy
[] Polio
[] Chicken Pox
[] Small Pox
[] epilepsy
[] Neurological problems
[] Stroke
[] Cancer
[] Migraine Headaches
[] Infectious disease
[] Tonsillectomy
[] Tuberculosis
[] Mumps
[] Influenza
[] Lumbago
[] Lung Disease
[] Heart murmur
[] Osteoporosis
[] Arthritis
[] Gall bladder
[] Hernia
[] Anemia
[] Meals
[] Pleurisy
[] Eczema
[] Other: ____

AUTHORIZATION CARE

I authorize and agree to allow the doctor and/or chiropractic assistant to work with my spine through the use spinal adjustments and rehabilitative exercises for the sole purpose of postural and structural restoration of normal biomechanical and 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 Doctor and/or chiropractic assistant 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 doctors and/or chiropractic assistant specific recommendations at this clinic that I will not receive the full benefit from these programs, and that if I terminate my care prematurely that all fees incurred will be due and payable at that time. I authorize the assignment of all insurance benefits be directed to the doctor and/or chiropractic assistant for all services rendered.

______________________	____________	____________________	__________
Patient's Name Printed	Date	Patient's signature	Date

______________________	____________________________________	__________
Minors Name	Guardian/Spouse's Signature of Authorizing care for minor	Date

IN CASE OF EMERGENCY

Name______________________________________

Relationship__________________________________

Work Phone__________________________________

Home Phone_________________________________

Cell Phone___________________________________

INSURANCE INFORMATION

I clearly understand that all insurance coverage, whether accident, 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 that they are performing these services are strictly as a convenience to me. The doctors office will provide any necessary reports or required information 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 are you willing to pay for these services [ ] YES [ ] NO

Patients Signature____ Date_________________________

Guardian or Spouse's Signature Authorizing Care_________________________ Date_________________________
I hereby authorize Active Family Chiropractic to administer care as deemed necessary to my child, a minor under the age of 18 years old.

Name of Insurance Co. ____ Policy#______________________

Address____ Phone # ______________________

Insured's Name____ Insured's SS# ____________________________

Relationship to Insured ____ Birthdate ______/_______/______

Employer____

Who should receive charges on your account?

❑ Patient ❑ Spouse ❑ Parent/Guardian ❑ Workers Comp ❑ Auto Insurance

❑ Medicare ❑ Personal Health Insurance

RADIOGRAPH CONSENT

I _______________________________ do hereby give my consent to allow Active Family Chiropractic and it's representatives, as deemed by the examining physician to take radiographs of my spine and/or extremities.

I also hereby declare that to my knowledge that I am not pregnant _______ (Initial)

Signature of Patient/or Guardian of said Minor ________________________________ Date ___________

HEALTHCARE AUTHORIZATION FORM

THE FOLLOWING AUTHORIZES ACTIVE FAMILY CHIROPRACTIC TO USE AND/OR DISCLOSE PROTECTED HEALTH CARE INFORMATION IN ACCORDANCE WITH THE FOLLOWING SPECIFIC AUTHORIZATIONS:

I give permission to Active Family Chiropractic 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 Active Family Chiropractic 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 chiropractic assistant in private, the doctor or therapist will provide a private room for these conversations.

By signing the following you are giving Active Family Chiropractic permission to use and disclose your protected health information in accordance with the directives listed above

ACKNOWLEDGEMENT OF RECIEPT & 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

Analysis: Pettibon

Diagnosis: (1) ________ (2) ________ (3) ________ (4) ________ (5) ________ (6) ________

Patient Accepted for Postural Corrective Care [ ] YES [ ] NO [ ] Referred out ______________________

Doctor's Signature __________________________________ Date ______________________________

Mode of Injury

Name: ____________ **Chart #:** ________ **Today's Date:** ________ **Date of Onset:** ________

Complete This Section if Injuries are a Result of a Work Related Accident.

My injury occurred while I was…

- O Carrying an object and lost my balance.
- O Driving
- O Lifting an object.
- O Engaged in a repetitive motion activity.
  Please describe: ____________
- O Struck by a falling object.
  Please describe: ____________
- O Other:
  Please describe: ____________

Did you report this incident in writing at work?

- O Yes
- O No

Did you see another health care provider for treatment related to this injury?

- O Yes
- O No

If you were injured by lifting, please complete all of the items which apply in the box below.

I was lifting the object:

- O from the floor
- O from a surface over my head
- O from a surface about waist high

The object I was lifting was about:

- O 2 - 5 pounds
- O 5 - 10 pounds
- O 10 - 15 pounds
- O 15 - 20 pounds
- O 20 - 25 pounds
- O 25 - 50 pounds
- O More than 50 pounds
- O ____________

While I was lifting, I:

- O had my back straight
- O had my waist bent
- O was twisted to the side

The pain I felt immediately after the injury was:

- O a dull ache
- O a grabbing feeling
- O a popping feeling
- O a sharp pain in one spot
- O a sharp pain with radiation of symptoms
- O ____________
- O ____________

If you were injured by falling, please complete the items in the box below.

I fell:

- O from a surface 2-4 feet high
- O from a surface 4-6 feet high
- O from a surface 6-8 feet high
- O from a surface higher than 8 feet
- O onto surface I was walking on

When I fell I hit my:

- O Back
- O Left elbow
- O Right elbow
- O Face
- O Left hand/wrist
- O Right hand/wrist
- O Head
- O Left knee
- O Right knee
- O Tail bone
- O ____________
- O ____________

I landed on:

- O Outstretched arms
- O Back
- O Knees
- O Rear end
- O Left side
- O Right side
- O Stomach
- O ____________
- O ____________
- O ____________

The surface I fell on can be described as:

- O Containing an object that caused the fall
- O Icy
- O Slick due to liquid
- O Uneven carpet
- O Wet
- O ____________
- O ____________

Complete this section if your injuries were NOT work related or auto accident related.

My injury occurred when I:

- O coughed or sneezed
- O looked over my shoulder
- O slipped and fell
- O straightened from bending
- O twisted at the waist

Injury occurred at:

- O Home
- O Mall
- O Retail store
- O Supermarket
- O Work
- O ____________
- O ____________
- O ____________

Office Use Only

The family history has been reviewed and found to:

- O be non-contributory to current conditions
- O further evaluation needed
- O Underlying Condition
- O Previous Injury - Resolved
- O Exacerbation
- O Chronic
- O Long Interim Time
- O Previous Care Ineffective

I understand that the information I have provided above is current and complete to the best of my knowledge.

Signature: ____________

REV. 10/01/97

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Neck Pain and Disability Index

Name: ______________________ **Chart #:** ______________ **Date:** __________

Please Read Instructions:

This questionnaire has been designed to give the doctor information as to how your neck pain has affected your ability to manage in everyday life. In each section, please fill in ONE circle only which most closely describes your problem.

Section 1 - Pain Intensity

- ○ **A.** I have no pain at the moment.
- ○ **B.** The pain is very mild at the moment.
- ○ **C.** The pain is moderate at the moment.
- ○ **D.** The pain is fairly severe at the moment.
- ○ **E.** The pain is very severe at the moment.
- ○ **F.** The pain is the worst imaginable at the moment.

Section 2 - Personal Care

- ○ **A.** I can look after myself normally 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 weight without extra pain.
- ○ **B.** I can lift heavy weight but it gives extra pain.
- ○ **C.** Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned.
- ○ **D.** Pain prevents me from lifting heavy weights, but I can manage light-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 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 can't read as much as I want because of moderate pain in my neck.
- ○ **E.** I can hardly read at all because of severe pain in my neck.
- ○ **F.** I cannot read at all.

Section 5 - Headaches

- ○ **A.** I have no headaches at all.
- ○ **B.** I have slight headaches which come infrequently.
- ○ **C.** I have moderate headaches which come infrequently.
- ○ **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 with no difficulty
- ○ **B.** I can concentrate fully when I want with slight difficulty.
- ○ **C.** I have a fair degree of difficulty in concentrating when I want.
- ○ **D.** I have a lot of difficulty in concentrating when I want.
- ○ **E.** I have a great degree of difficulty in concentrating when I want.
- ○ **F.** I cannot concentrate at all.

Section 7 - Work

- ○ **A.** I can do as much work as I want.
- ○ **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 can hardly do any work at all.
- ○ **E.** I cannot do my usual work.
- ○ **F.** I can't do any work at all.

Section 8 - Driving

- ○ **A.** I can drive my car without any 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.
- ○ **D.** I can't drive my car as long as I want because of moderate pain.
- ○ **E.** I can hardly drive at all because of severe pain in my neck.
- ○ **F.** I can't drive my car at all.

Section 9 - Sleeping

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

Section 10 - Recreation

- ○ **A.** I am able to engage in all recreational activities with no neck pain.
- ○ **B.** I am able to engage in all my recreational activities, with some pain in my neck.
- ○ **C.** I am able to engage in most, but not all of my usual recreational activities because of pain in my neck.
- ○ **D.** I am able to 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.
- ○ **F.** I can't do any recreational activities at all.

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Score: __________

I understand that the information I have provided above is current and complete to the best of my knowledge.

Signature: ______________________________

REV. 10/01/97

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Occupational History

Name: ______________________ **Chart #:** __________ **Today's Date:** ________ **Accident Date:** ______

Current Employer: ____

Current Occupation: ____

What limitations have you experienced as a result of your injury? (choose all that apply)

- O Cannot use left arm
- O Cannot use right arm
- O Cannot use left leg
- O Cannot use right leg
- O Cannot drive due to condition
- O Increased fatigability
- O Lifting exacerbates condition
- O Pain limits amount of movement
- O Cannot sit due to condition
- O Unable to lift more than 10 pounds
- O Unable to lift more than 15 pounds
- O Unable to lift more than 20 pounds
- O Unable to lift more than 25 pounds
- O Unable to lift more than 50 pounds
- O Cannot walk due to condition
- O ______________________
- O ______________________
- O ______________________

Your present job involves:

O Standing for:	O 30 minutes	O 2 hours	O 4 hours	O 8 hours
	O 1 hour	O 3 hours	O 6 hours	O More than 8 hours
O Driving for:	O 30 minutes	O 2 hours	O 4 hours	O 8 hours
	O 1 hour	O 3 hours	O 6 hours	O More than 8 hours
O Walking for:	O 30 minutes	O 2 hours	O 4 hours	O 8 hours
	O 1 hour	O 3 hours	O 6 hours	O More than 8 hours
O Sitting for:	O 30 minutes	O 2 hours	O 4 hours	O 8 hours
	O 1 hour	O 3 hours	O 6 hours	O More than 8 hours
O Lifting	O Less than 5 lbs.	O 10 - 15 lbs.	O 20 - 25 lbs.	O 40 - 50 lbs.
	O 05 - 10 lbs.	O 15 - 20 lbs.	O 25 - 40 lbs.	O More than 50 lbs.

O Repetitive Motion

Have you missed any work as a result of your condition? O Yes O No

If yes, how many days did you miss?

	[ ]	[ ]	[ ]	
0	O	O	O	0
1	O	O	O	1
2	O	O	O	2
3	O	O	O	3
4	O	O	O	4
5	O	O	O	5
6	O	O	O	6
7	O	O	O	7
8	O	O	O	8
9	O	O	O	9

Your last full day of work was:

	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	
0	O	O	O	O	O	O	O	O	0
1	O	O	O	O	O	O	O	O	1
2	O	O	O	O	O	O	O	O	2
3	O	O	O	O	O	O	O	O	3
4	O	O	O	O	O	O	O	O	4
5	O	O	O	O	O	O	O	O	5
6	O	O	O	O	O	O	O	O	6
7	O	O	O	O	O	O	O	O	7
8	O	O	O	O	O	O	O	O	8
9	O	O	O	O	O	O	O	O	9

Are you currently receiving worker's compensation? O Yes O No

I understand that the information I have provided above is current and complete to the best of my knowledge.

Signature: ______________________________

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Revised Oswestry Low Back Pain and Disability

Name: ______________________ **Chart #:** ______________ **Date:** __________

Please Read Instructions:
This questionnaire has been designed to give the doctor information as to how your low back pain has affected your ability to manage in everyday life. In each section, please fill in ONE circle which most closely describes your problem.

Section 1 - Pain Intensity

○ **A.** The pain comes and goes and is very mild.
○ **B.** The pain is mild and does not vary much.
○ **C.** The pain comes and goes and is moderate.
○ **D.** The pain is moderate and does not vary much.
○ **E.** The pain comes and goes and is very severe.
○ **F.** The pain is severe and doesn't vary much.

Section 2 - Personal Care

○ **A.** I can look after myself normally 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 can 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 weight without extra pain.
○ **B.** I can lift heavy weight but it gives extra pain.
○ **C.** Pain prevents me from lifting heavy weights off the floor.
○ **D.** Pain prevents me from lifting heavy weights, but I can manage if they are conveniently positioned.
○ **E.** Pain prevents me from lifting heavy weights, but I can manage light-medium weights if they are conveniently positioned.
○ **F.** I can only lift very light weights at the most.

Section 4 - Walking

○ **A.** I have no pain walking.
○ **B.** I cannot walk more than one mile without increasing pain.
○ **C.** I cannot walk more than 1/2 mile without increasing pain.
○ **D.** I cannot walk more than 1/4 mile without increasing pain.
○ **E.** I can walk with crutches.
○ **F.** I cannot walk at all without increasing pain.

Section 5 - Sitting

○ **A.** I can sit in any chair as long as I like.
○ **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 a half hour.
○ **E.** Pain prevents me from sitting more than 10 minutes.
○ **F.** I avoid sitting because it increases pain straight away.

Section 6 - Standing

○ **A.** I can stand as long as I want without pain.
○ **B.** I have some pain on 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 thanf 1/2 hour without increasing pain.
○ **E.** I can't stand for longer than 10 minutes without increasing pain.
○ **F.** I avoid standing because it increases the pain straight away.

Section 7 - Sleeping

○ **A.** I get no pain in bed.
○ **B.** I get pain in bed but it doesn't prevent me from sleeping well.
○ **C.** Because of pain my normal night's sleep is reduced by < 1/4.
○ **D.** Because of pain my normal night's sleep is reduced by < 1/2.
○ **E.** Because of pain my normal night's sleep is reduced by < 3/4.
○ **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 - Social Life

○ **A.** My social life is normal and gives me no pain.
○ **B.** My social life is normal but increases the degree of pain.
○ **C.** Pain limits 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.** I have hardly any social life because of the pain.

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.
○ **D.** My pain is neither getting better nor worse.
○ **E.** My pain is gradually worsening.
○ **F.** My pain is rapidly worsening.

Office Use Only

Score: __________

I understand that the information I have provided above is current and complete to the best of my knowledge.

Signature: ______________________________

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REV. 10/01/97

Roland-Morris Low Back Pain and Disability

Name: ____________________ **Chart #:** __________ **Date:** ________

Please Read Instructions:

This list contains some sentences that people have used to describe themselves when they have back pain. When you read them, you may find that some stand out because they describe you today. As you read the list, think of yourself today. Fill in the circle next to any sentence that describes you today. If the sentence does not describe you, then leave the space blank and go on to the next one. Remember, only check the sentences that describe you today.

- O **1)** I stay at home most of the time because of my back.
- O **2)** I change position frequently to try and get my back comfortable.
- O **3)** I walk more slowly than usual because of my back.
- O **4)** Because of my back, I am not doing any of the jobs that I usually do around the house.
- O **5)** Because of my back, I use a handrail to get upstairs.
- O **6)** Because of my back, I lie down to rest more often.
- O **7)** Because of my back, I have to hold on to something to get out of an easy chair.
- O **8)** Because of my back, I try to get other people to do things for me.
- O **9)** I get dressed more slowly than usual because of my back.
- O **10)** I only stand up for short periods of time because of my back.
- O **11)** Because of my back, I try not to bend or kneel down.
- O **12)** I find it difficult to get out of a chair because of my back.
- O **13)** My back is painful almost all the time.
- O **14)** I find it difficult to turn over in bed because of my back.
- O **15)** My appetite is not very good because of my back pain.
- O **16)** I have trouble putting on my socks (stockings) because of the pain in my back.
- O **17)** I only walk short distances because of my back pain.
- O **18)** I sleep less well because of my back.
- O **19)** Because of my back pain, I get dressed with help from someone else.
- O **20)** I sit down for most of the day because of my back.
- O **21)** I avoid heavy jobs around the house because of my back.
- O **22)** Because of my back pain, I am more irritable and bad tempered with people than usual.
- O **23)** Because of my back, I go upstairs more slowly than usual.
- O **24)** I stay in bed most of the time because of my back.

Office Use Only

Score: ________

I understand that the information I have provided above is current and complete to the best of my knowledge.

Signature: ____________________

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