



## PATIENT APPLICATION FORM: CHILD

WELCOME and THANK YOU for trusting us with your child/children applying as patient(s) in our clinic. We are a very unique team specializing in researched, evidence-based, spinal pediatric adjusting and postural rehabilitation that has helped infants, young children, and even teenagers with early onset to advanced spinal distortion and injuries known to cause developmental and lifelong health problems. Because of this specialized approach, we may not accept your child as a patient until we are absolutely certain we know the cause of their condition; perform the necessary tests to determine the optimal program of correction, and we are completely confident you and your child place their health as a TOP PRIORITY. At that time we will make specific recommendations. Thank you again for giving your child the opportunity to apply as a patient.

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***PATIENT NAME***

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***DATE COMPLETED***

## Patient Information

Name: \_\_\_\_\_ (Age) \_\_\_\_\_ Gender: M F  
Home Address: \_\_\_\_\_ Birth Date: \_\_\_\_/\_\_\_\_/\_\_\_\_  
City, State, Zip: \_\_\_\_\_ Cell Phone: ( ) \_\_\_\_\_  
Name of Mother/Guardian: \_\_\_\_\_ Home Phone: ( ) \_\_\_\_\_  
Birth Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ (Age) \_\_\_\_\_ Marital Status: S M D W Work Phone: ( ) \_\_\_\_\_  
Home Address (if different): \_\_\_\_\_ Cell Phone: ( ) \_\_\_\_\_  
City, State, Zip: \_\_\_\_\_ Email: \_\_\_\_\_  
Employer Name: \_\_\_\_\_ Occupation: \_\_\_\_\_  
Name of Father/Guardian: \_\_\_\_\_ Home Phone: ( ) \_\_\_\_\_  
Birth Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ (Age) \_\_\_\_\_ Marital Status: S M D W Work Phone: ( ) \_\_\_\_\_  
Home Address (if different): \_\_\_\_\_ Cell Phone: ( ) \_\_\_\_\_  
City, State, Zip: \_\_\_\_\_ Email: \_\_\_\_\_  
Employer Name: \_\_\_\_\_ Occupation: \_\_\_\_\_  
How were you referred to this office? \_\_\_\_\_

## Purpose For This Visit

Reason for this visit: \_\_\_\_\_  
Is this related to an accident or specific injury (other than auto or work-related)\*?  Yes  No If yes, when: \_\_\_\_/\_\_\_\_/\_\_\_\_  
*\*If your child's symptoms are the result of an auto accident or work-related injury, please ask the front-desk person for the corresponding application.*  
Describe incident or reason for onset of symptoms: \_\_\_\_\_  
\_\_\_\_\_

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

When did these symptoms begin? \_\_\_\_/\_\_\_\_/\_\_\_\_ Are they:  Constant  Intermittent  Activity-related  
Are they getting worse?  Yes  No Do they interfere with:  School  Sleep  Hobbies/Play  Daily Routine  
Explain: \_\_\_\_\_  
\_\_\_\_\_  
What activities aggravate these symptoms? \_\_\_\_\_  
Is there anything that relieves your symptoms?  Yes  No If yes, explain: \_\_\_\_\_  
Has your child experienced these symptoms before (if not accident/injury related)?  Yes  No  
If yes, explain: \_\_\_\_\_  
\_\_\_\_\_  
Has your child been treated for this?  Yes  No When was the last treatment? \_\_\_\_/\_\_\_\_/\_\_\_\_  
Name of treating practitioner/facility? \_\_\_\_\_  
What treatment(s) was performed? \_\_\_\_\_  
\_\_\_\_\_  
How did your child respond? \_\_\_\_\_  
\_\_\_\_\_

# GENERAL SYMPTOMS CHART

Please use the following notations on the figures below to indicate the type and location of your child's symptoms, as it relates to the purpose of your visit today.

A = ACHE

B = BURNING

P = PINS & NEEDLES

G = STABBING

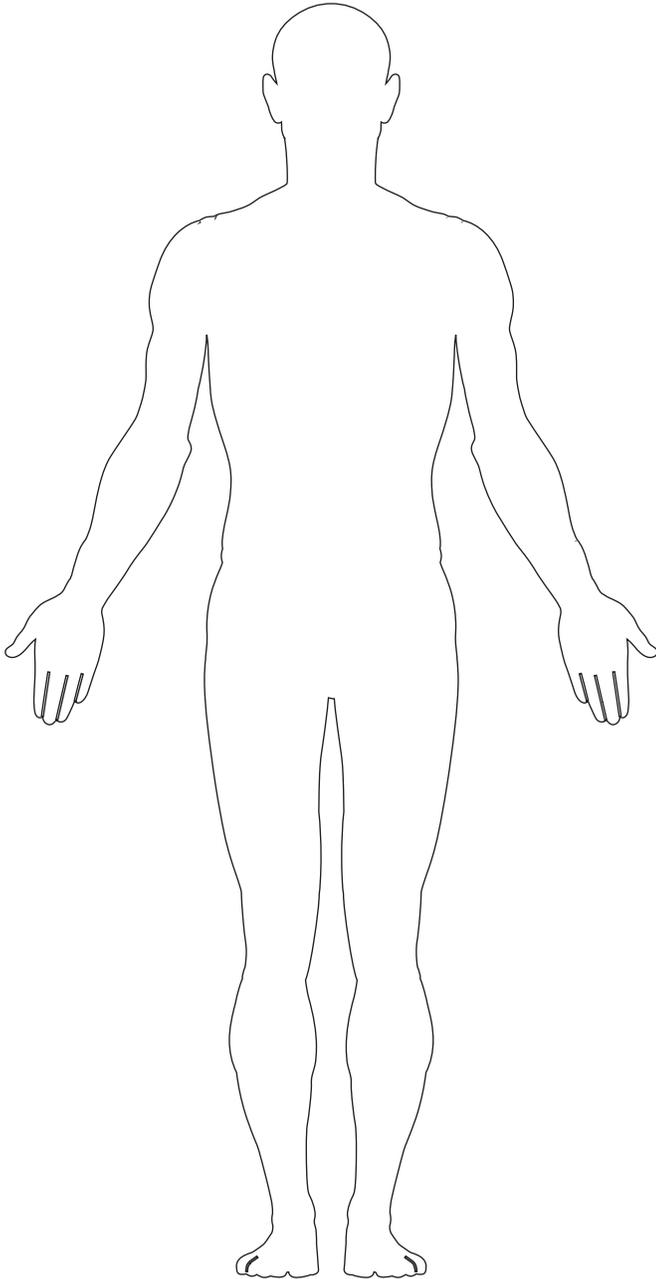
M = SPASMS

F = STIFFNESS

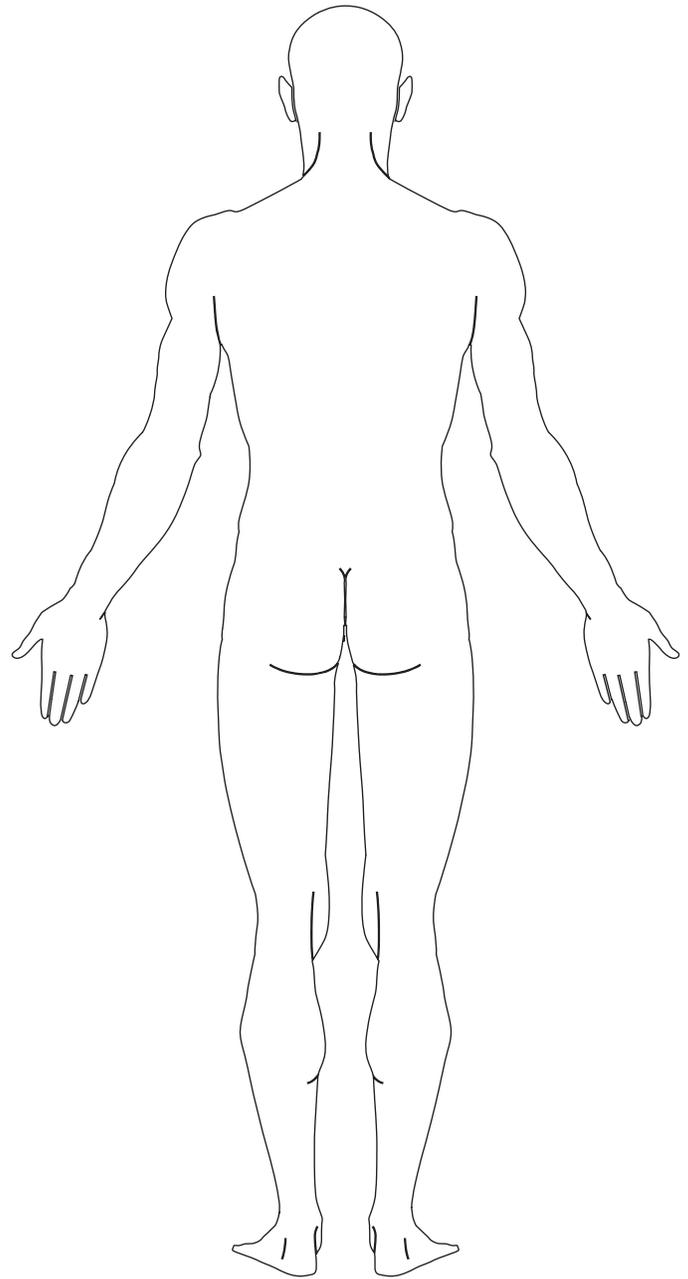
N = NUMBNESS

T = TINGLING

O = OTHER



**FRONT**



**BACK**

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

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## Health Conditions

Your spine is the foundation of health and core strength in your body. Shifts in the vertebrae or sections of the spine will spread ultimately causing weakness and distortion to ALL the areas of the spine. These distortions are reflected in abnormal posture. Research shows abnormal posture leads to chronic pain, disease and possibly a shortened life span.<sup>1</sup> Please answer the following questions accurately so we may determine the full extent of your child's condition.

### HISTORY OF TRAUMA

The below-listed traumas may lead to misalignment of the individual vertebrae, soft tissue injury to the supportive structures of the spine, as well as shifts and distortions in whole curves and sections of the spine. Please check any of the following if your child has experienced such (*if you check an item with an asterisk, please offer a detailed explanation*):

- Fell from a height of two (2) feet or more as an infant
- Experienced a fall that left a bruise or lump on their head or other resulting trauma\*
- Rough shaking as an infant
- Were involved in a car accident (*if you check this item, please ask the front desk person for the corresponding form*)
- Experience broken bones or debilitating injuries\*
- Difficult Birth (see below)

Explanation of (\*) item(s): \_\_\_\_\_

### BIRTH EXPERIENCE:

How long was labor? \_\_\_\_\_

Describe any complications: \_\_\_\_\_

Type of delivery:     Vaginal                       C-Section                       Vacuum Extraction                       Forceps Assistance

### VACCINATION HISTORY

What vaccinations has your child received (please note at what age and where each was received):

1. \_\_\_\_\_ Age: \_\_\_\_\_  Mos.  Yrs. Where received: \_\_\_\_\_
2. \_\_\_\_\_ Age: \_\_\_\_\_  Mos.  Yrs. Where received: \_\_\_\_\_
3. \_\_\_\_\_ Age: \_\_\_\_\_  Mos.  Yrs. Where received: \_\_\_\_\_
4. \_\_\_\_\_ Age: \_\_\_\_\_  Mos.  Yrs. Where received: \_\_\_\_\_
5. \_\_\_\_\_ Age: \_\_\_\_\_  Mos.  Yrs. Where received: \_\_\_\_\_

**Please check any of the following responses your child experienced as a result of a vaccination (please indicate which vaccination caused the condition by writing the corresponding number next to that condition).**

- |   |   |  |
|---|---|--|
| <input type="checkbox"/> Swelling, redness, heat/hardness of site   | <input type="checkbox"/> Body rash or hives                     | <input type="checkbox"/> High fever (over 103 degrees) |
| <input type="checkbox"/> High-pitched screaming                     | <input type="checkbox"/> Extreme sleepiness or unresponsiveness | <input type="checkbox"/> Body twitching or paralysis   |
| <input type="checkbox"/> Breathing problems (asthma, etc.)          | <input type="checkbox"/> Excessive bleeding or anemia           | <input type="checkbox"/> Head banging                  |
| <input type="checkbox"/> Excessive diarrhea or chronic constipation | <input type="checkbox"/> Loss of memory/foggy state             | <input type="checkbox"/> Muscle weakness               |
| <input type="checkbox"/> Chronic ear or respiratory Infections      | <input type="checkbox"/> Vision or hearing disturbances         | <input type="checkbox"/> Joint pain                    |
| <input type="checkbox"/> Crossing of eyes                           | <input type="checkbox"/> Seizures                               | <input type="checkbox"/> Other (please explain)        |

Explanation(s): \_\_\_\_\_

1. Postural and Degenerative Kyphosis: Freeman JT. Posture in the Aging and Aged body. JAMA 1957, Oct 19: 843-846.

## Health Conditions *continued...*

### CERVICAL SPINE (NECK)

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

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

- |  |   |  |
|--|---|--|
| <input type="checkbox"/> Neck Pain                       | <input type="checkbox"/> Headaches              | <input type="checkbox"/> Sinusitis             |
| <input type="checkbox"/> Pain in shoulders/arms/hands    | <input type="checkbox"/> Dizziness              | <input type="checkbox"/> Allergies/Hay fever   |
| <input type="checkbox"/> Numbness/tingling in arms/hands | <input type="checkbox"/> Visual disturbances    | <input type="checkbox"/> Recurrent colds/Flu   |
| <input type="checkbox"/> Hearing disturbances            | <input type="checkbox"/> Coldness in hands      | <input type="checkbox"/> Low Energy/Fatigue    |
| <input type="checkbox"/> Weakness in grip                | <input type="checkbox"/> Thyroid conditions     | <input type="checkbox"/> TMJ/Pain/Clicking     |
| <input type="checkbox"/> Colic                           | <input type="checkbox"/> Ear Infections         | <input type="checkbox"/> Flu/Stomach disorders |
| <input type="checkbox"/> Sore throats                    | <input type="checkbox"/> Learning disabilities  | <input type="checkbox"/> Hyperactivity/ADD     |
| <input type="checkbox"/> Auto-Immune Diseases            | <input type="checkbox"/> Other (please explain) |  |

Explanation(s): \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

### THORACIC SPINE (UPPER BACK)

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

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

- |   |  |  |
|---|--|--|
| <input type="checkbox"/> Heart Palpitations                             | <input type="checkbox"/> Heart Murmurs                       | <input type="checkbox"/> Asthma/Wheezing               |
| <input type="checkbox"/> Shingles                                       | <input type="checkbox"/> Shortness Of Breath                 | <input type="checkbox"/> Tachycardia (fast heart beat) |
| <input type="checkbox"/> Upper Back Pain                                | <input type="checkbox"/> Pain On Deep Inspiration/Expiration | <input type="checkbox"/> Other (please explain)        |
| <input type="checkbox"/> Recurrent Lung Infections/Bronchitis/Pneumonia |  |  |

Explanation(s): \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

### THORACIC SPINE (MID BACK)

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

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

- |  |   |   |
|--|---|---|
| <input type="checkbox"/> Mid Back Pain   | <input type="checkbox"/> Nausea           | <input type="checkbox"/> Diabetes               |
| <input type="checkbox"/> Pain in Ribs/Chest  | <input type="checkbox"/> Ulcers/Gastritis | <input type="checkbox"/> Hypoglycemia           |
| <input type="checkbox"/> Indigestion/Heartburn   | <input type="checkbox"/> Reflux           | <input type="checkbox"/> Diabetes               |
| <input type="checkbox"/> Liver problems  | <input type="checkbox"/> Spleen problems  | <input type="checkbox"/> Other (please explain) |
| <input type="checkbox"/> Tired/Irritable after eating or when not having eaten for a while |   |   |

Explanation(s): \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

## Health Conditions *continued...*

### LUMBAR SPINE (LOW BACK)

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

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

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

Explanation(s): \_\_\_\_\_

### OTHER

Please list any health conditions not mentioned: \_\_\_\_\_

Please list any medications (include name, dose, for what condition, and how long your child has been taking it): \_\_\_\_\_

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

## Family Health History

Have any of your family members ever been diagnosed with the following? **If so, please indicate "P" for your child (patient), and "O" for Other than your child, or both if applicable (Items marked with an asterisk, please offer a detailed list or explanation):**

- |   |   |   |   |
|---|---|---|---|
| <input type="checkbox"/> ADD                    | <input type="checkbox"/> Allergies/Hay fever* | <input type="checkbox"/> Anemia             | <input type="checkbox"/> Appendectomy         |
| <input type="checkbox"/> Arthritis              | <input type="checkbox"/> Asthma               | <input type="checkbox"/> Bed wetting        | <input type="checkbox"/> Blood sugar problems |
| <input type="checkbox"/> Broken bones/fractures | <input type="checkbox"/> Cancer               | <input type="checkbox"/> Cerebral Palsy     | <input type="checkbox"/> Chicken pox/shingles |
| <input type="checkbox"/> Circulatory problems   | <input type="checkbox"/> Crohn's/Colitis      | <input type="checkbox"/> Depression         | <input type="checkbox"/> Diabetes             |
| <input type="checkbox"/> Ear Infections         | <input type="checkbox"/> Eczema               | <input type="checkbox"/> Eczema/Psoriasis   | <input type="checkbox"/> Epilepsy/seizures    |
| <input type="checkbox"/> Fetal drug exposure    | <input type="checkbox"/> Food allergies*      | <input type="checkbox"/> Gall bladder       | <input type="checkbox"/> Headaches            |
| <input type="checkbox"/> Heart disease          | <input type="checkbox"/> Heart murmur         | <input type="checkbox"/> Hepatitis          | <input type="checkbox"/> Hernia               |
| <input type="checkbox"/> High blood pressure    | <input type="checkbox"/> HIV                  | <input type="checkbox"/> Infectious disease | <input type="checkbox"/> Influenza            |
| <input type="checkbox"/> Kidney Disease         | <input type="checkbox"/> Liver disease        | <input type="checkbox"/> Lumbago            | <input type="checkbox"/> Lung disease         |
| <input type="checkbox"/> Measles                | <input type="checkbox"/> Metal implants       | <input type="checkbox"/> Migraine headaches | <input type="checkbox"/> Mumps                |
| <input type="checkbox"/> Neurological problems  | <input type="checkbox"/> Osteoporosis         | <input type="checkbox"/> Paralysis          | <input type="checkbox"/> Pleurisy             |
| <input type="checkbox"/> Pneumonia/Bronchitis   | <input type="checkbox"/> Polio                | <input type="checkbox"/> Rash               | <input type="checkbox"/> Rheumatic fever      |
| <input type="checkbox"/> Scoliosis              | <input type="checkbox"/> Seizure disorder     | <input type="checkbox"/> Sickle cell anemia | <input type="checkbox"/> Small Pox            |
| <input type="checkbox"/> Spinal Bifida          | <input type="checkbox"/> Stroke               | <input type="checkbox"/> Thyroid problems   | <input type="checkbox"/> Tonsillectomy        |
| <input type="checkbox"/> Tuberculosis           | <input type="checkbox"/> Varicose veins       | <input type="checkbox"/> Whooping cough     | <input type="checkbox"/> Other*               |

Explanation of (\*) item(s): \_\_\_\_\_

## Experience with Chiropractic

Has your child seen a Chiropractor before?  Yes  No Who? \_\_\_\_\_

Reason for visit(s): \_\_\_\_\_

Did the previous chiropractor take 'before' and 'after' x-rays?  Yes  No What was the diagnosis? \_\_\_\_\_

Did he or she recommend a specific course of treatment?  Yes  No Did they recommend a Home Health Care program?  Yes  No

If yes, what? \_\_\_\_\_

How long was your child treated? \_\_\_\_\_ Last treatment: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

How did your child respond? \_\_\_\_\_

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

If yes, explain: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

## Pregnancy Release

This is to certify that to the best of my knowledge that my child is not pregnant and the above doctor and his/her associates have my permission to perform an x-ray evaluation. I have been advised that x-ray can be hazardous to an unborn child.

Date of last menstrual cycle: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

## Authorization of Care

I authorize and agree to allow the doctor and/or his/her designated staff to take x-rays and work with my spine or the spine of the charge I represent through the use of spinal adjustments and rehabilitative exercises for the sole purpose of postural and structural restoration of normal bio-mechanical and neurological function.

I 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 his/her staff will not be held responsible for any health conditions or diagnoses which are pre-existing, given by another healthcare 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 staff's 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.

Patient's Signature \_\_\_\_\_ Date \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

Patient's Name Printed \_\_\_\_\_

If patient is not your biological child, but a legal charge requiring guardianship for treatment, please complete the following:

Date Guardianship Awarded \_\_\_\_\_ County, State of Guardianship \_\_\_\_\_

I hereby authorize the doctor to administer care as deemed necessary to my charge as appointed to by the courts.

Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

## In Case of Emergency

Name \_\_\_\_\_ Relationship \_\_\_\_\_

Work Phone ( ) \_\_\_\_\_

Home Phone ( ) \_\_\_\_\_

Cell Phone ( ) \_\_\_\_\_

## Insurance

We may accept assignment of insurance benefits. By signing this policy, you agree to assign your insurance benefits to this clinic. In cases where benefits are not assignable or in any case where your benefit is processed directly to you regardless of assignment, you agree to submit any payments received along with the explanation of benefits to this clinic within 10 days of receipt unless you have paid for the services represented by said payment in full at the time of service. In no case will an assignment alleviate you of your obligation for payment of services received.

Your insurance plan is a contract between you and your insurance company. This clinic is not a party to that contract and therefore cannot modify the terms of that contract. Payment for treatment you receive from this clinic is your responsibility whether your insurance company pays or not. We cannot bill your insurance company unless you provide us with the necessary billing information, assign your benefits to this clinic and agree to permit us to release the necessary medical information required to secure payment. In the event we do accept assignment of benefits we require that you provide a credit card with authorization to bill that account any balance or make other payment arrangements. We will make every effort to ensure that your insurance carrier properly processes your services for payment. In some circumstances we may require your assistance. If your insurance company has not paid your account in full within 60 days and you refuse to assist us in dealing with your carrier, the balance will be automatically be transferred to your credit card or the extended payment plan.

NOTE: Please be aware that some, and perhaps all, of the services provided may be non-covered services and not considered reasonable and necessary under your insurance program. If you are unsure as to the nature of the service you are receiving, please ask your doctor. For coverage information, it is your responsibility to review your benefit contract.

## DECLARATION

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 doctor's 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

Signature of Person Authorizing Care:

\_\_\_\_\_ Date \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Relationship to Insured \_\_\_\_\_ Date of Birth \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Employer \_\_\_\_\_

**Primary Insurance Company** \_\_\_\_\_ Policy# \_\_\_\_\_

Address Phone # (     ) \_\_\_\_\_

Insured's Name \_\_\_\_\_ Insured's Social Security #: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

**Secondary Insurance Company** \_\_\_\_\_ Policy# \_\_\_\_\_

Address Phone # (     ) \_\_\_\_\_

Insured's Name \_\_\_\_\_ Insured's Social Security #: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

# Neck Index

Form N1-100

rev 3/27/2003

**Patient Name** \_\_\_\_\_ **Date** \_\_\_\_\_

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

## **Pain Intensity**

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

## **Sleeping**

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

## **Reading**

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

## **Concentration**

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

## **Work**

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

## **Personal Care**

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

## **Lifting**

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

## **Driving**

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

## **Recreation**

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

## **Headaches**

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

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

Neck  
Index  
Score

# Back Index

Form B1100

rev 3/27/2003

Patient Name \_\_\_\_\_ Date \_\_\_\_\_

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

## Pain Intensity

- Ⓐ The pain comes and goes and is very mild.
- Ⓛ The pain is mild and does not vary much.
- Ⓜ The pain comes and goes and is moderate.
- Ⓨ The pain is moderate and does not vary much.
- Ⓔ The pain comes and goes and is very severe.
- Ⓟ The pain is very severe and does not vary much.

## Sleeping

- Ⓐ I get no pain in bed.
- Ⓛ I get pain in bed but it does not prevent me from sleeping well.
- Ⓜ Because of pain my normal sleep is reduced by less than 25%.
- Ⓨ Because of pain my normal sleep is reduced by less than 50%.
- Ⓔ Because of pain my normal sleep is reduced by less than 75%.
- Ⓟ Pain prevents me from sleeping at all.

## Sitting

- Ⓐ I can sit in any chair as long as I like.
- Ⓛ I can only sit in my favorite chair as long as I like.
- Ⓜ Pain prevents me from sitting more than 1 hour.
- Ⓨ Pain prevents me from sitting more than 1/2 hour.
- Ⓔ Pain prevents me from sitting more than 10 minutes.
- Ⓟ I avoid sitting because it increases pain immediately.

## Standing

- Ⓐ I can stand as long as I want without pain.
- Ⓛ I have some pain while standing but it does not increase with time.
- Ⓜ I cannot stand for longer than 1 hour without increasing pain.
- Ⓨ I cannot stand for longer than 1/2 hour without increasing pain.
- Ⓔ I cannot stand for longer than 10 minutes without increasing pain.
- Ⓟ I avoid standing because it increases pain immediately.

## Walking

- Ⓐ I have no pain while walking.
- Ⓛ I have some pain while walking but it doesn't increase with distance.
- Ⓜ I cannot walk more than 1 mile without increasing pain.
- Ⓨ I cannot walk more than 1/2 mile without increasing pain.
- Ⓔ I cannot walk more than 1/4 mile without increasing pain.
- Ⓟ I cannot walk at all without increasing pain.

## Personal Care

- Ⓐ I do not have to change my way of washing or dressing in order to avoid pain.
- Ⓛ I do not normally change my way of washing or dressing even though it causes some pain.
- Ⓜ Washing and dressing increases the pain but I manage not to change my way of doing it.
- Ⓨ Washing and dressing increases the pain and I find it necessary to change my way of doing it.
- Ⓔ Because of the pain I am unable to do some washing and dressing without help.
- Ⓟ Because of the pain I am unable to do any washing and dressing without help.

## Lifting

- Ⓐ I can lift heavy weights without extra pain.
- Ⓛ I can lift heavy weights but it causes extra pain.
- Ⓜ Pain prevents me from lifting heavy weights off the floor.
- Ⓨ Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned (e.g., on a table).
- Ⓔ Pain prevents me from lifting heavy weights off the floor, but I can manage light to medium weights if they are conveniently positioned.
- Ⓟ I can only lift very light weights.

## Traveling

- Ⓐ I get no pain while traveling.
- Ⓛ I get some pain while traveling but none of my usual forms of travel make it worse.
- Ⓜ I get extra pain while traveling but it does not cause me to seek alternate forms of travel.
- Ⓨ I get extra pain while traveling which causes me to seek alternate forms of travel.
- Ⓔ Pain restricts all forms of travel except that done while lying down.
- Ⓟ Pain restricts all forms of travel.

## Social Life

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

## Changing degree of pain

- Ⓐ My pain is rapidly getting better.
- Ⓛ My pain fluctuates but overall is definitely getting better.
- Ⓜ My pain seems to be getting better but improvement is slow.
- Ⓨ My pain is neither getting better or worse.
- Ⓔ My pain is gradually worsening.
- Ⓟ My pain is rapidly worsening.

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

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