SPORT & SPINAL
REHAB
Chiropractic | Physical Therapy | Massage

Please Print

Last Name _____ First Name _____ Birth Date _____

Address _____ City _____ State _____ Zip_____

Home Phone _____ Cell Phone _____ Email _____

What is your preferred method of contact? □ Home □ Cell □ E-mail

How do you prefer to receive appointment reminders? □ Phone □ Text □ E-mail

Employer _____ Occupation _____

Primary Physician _____ May we contact them? _____

Emergency Contact _____ Phone _____ Relation_____

Who may we thank for referring you to us? _____

Do you have any medication allergies?

□ No known medication allergies

□ Yes. What?

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

Are you currently taking any medications?

□ Not currently prescribed any medications

□ Yes. What?

1. _____ _____ mg / mcg / g / other ___
2. _____ _____ mg / mcg / g / other ___
3. _____ _____ mg / mcg / g / other ___
4. _____ _____ mg / mcg / g / other ___
5. _____ _____ mg / mcg / g / other ___
6. _____ _____ mg / mcg / g / other ___

Patient Name: _____ Signature: _____ Date: _____

Parent or Guardian: _____ Signature: _____ Date: _____

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Informed Consent to Care

You are the decision maker for your health care. Part of our role is to provide you with information to assist you in making informed choices. This process is often referred to as "informed consent" and involves your understanding and agreement regarding the care we recommend, the benefits and risks associated with the care, alternatives, and the potential effect on your health if you choose not to receive the care. We may conduct some diagnostic or examination procedures if indicated. Any examinations or tests conducted will be carefully performed but may be uncomfortable.

Chiropractic care centrally involves what is known as a chiropractic adjustment. There may be additional supportive procedures or recommendations as well. When providing an adjustment, we use our hands or an instrument to reposition anatomical structures, such as vertebrae. Potential benefits of an adjustment include restoring normal joint motion, reducing swelling and inflammation in a joint, reducing pain in the joint, and improving neurological functioning and overall well-being.

It is important that you understand, as with all health care approaches, results are not guaranteed, and there is no promise to cure. As with all types of health care interventions, there are some risks to care, including, but not limited to: muscle spasms, aggravating and/or temporary increase in symptoms, lack of improvement of symptoms, burns and/or scarring from electrical stimulation and from hot or cold therapies, including but not limited to hot packs and ice, fractures (broken bones), disc injuries, strokes, dislocations, strains, and sprains.

With respect to strokes, there is a rare but serious condition known as an "arterial dissection" that typically is caused by a tear in the inner layer of the artery that may cause the development of a thrombus (clot) with the potential to lead to a stroke. The best available scientific evidence supports the understanding that chiropractic adjustment does not cause a dissection in a normal, healthy artery. Disease processes, genetic disorders, medications, and vessel abnormalities may cause an artery to be more susceptible to dissection. Strokes caused by arterial dissections have been associated with over 72 everyday activities such as sneezing, driving, and playing tennis.

Arterial dissections occur in 3-4 of every 100,000 people whether they are receiving health care or not. Patients who experience this condition often, but not always, present to their medical doctor or chiropractor with neck pain and headache. Unfortunately, a percentage of these patients will experience a stroke.

The reported association between chiropractic visits and stroke is exceedingly rare and is estimated to be related in one in one million to one in two million cervical adjustments. For comparison, the incidence of hospital admission attributed to aspirin use from major GI events of the entire (upper and lower) GI tract was 1219 events/ per one million persons/year and risk of death has been estimated as 104 per one million users.

It is also important that you understand there are treatment options available for your condition other than chiropractic procedures. Likely, you have tried many of these approaches already. These options may include, but are not limited to self-administered care, over-the-counter pain relievers, physical measures and rest, medical care with prescription drugs, physical therapy, bracing, injections, and surgery. Lastly, you have the right to a second opinion and to secure other opinions about your circumstances and health care as you see fit.

I have read, or have had read to me, the above consent. I appreciate that it is not possible to consider every possible complication to care. I have also had an opportunity to ask questions about its content, and by signing below, I agree with the current or future recommendation to receive chiropractic care as is deemed appropriate for my circumstance. I intend this consent to cover the entire course of care from all providers, including doctors who are serving as coverage/back-up doctors in place of Dr. Brandon T. Nevel in this office for my present condition and for any future condition(s) for which I seek chiropractic care.

Patient Name: _____ Signature: _____ Date: _____

Parent or Guardian: _____ Signature: _____ Date: _____

Witness Name: _____ Signature: _____ Date: _____

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OFFICE POLICIES AND PROCEDURES / CANCELLATION AGREEMENT

Appointments / Urgent Need or Sudden Illness: Patients are normally seen by appointment only. Same day appointments and walk-ins are welcome but are usually only available for urgent or sudden cases. We have a limited number of same day or "work-in" appointments available every day. Please call ahead, as these spots fill up quickly.

Cancellations: Please call within 24 hours if you are unable to keep your scheduled appointment. This allows us to provide that time slot to another patient. ***If you are not able to do so, there will be a $25.00 cancellation fee.***

Treatment of Minors: Patients under the age of 18 must be accompanied by a responsible adult or have written permission for treatment from a parent or guardian.

No Insurance: Payment will be due at the time of service. If you are unable to pay your balance in full, you will need to make prior arrangements with our Office Manager.

Insurance: Although we are contracted with several insurance companies, it is your responsibility to make sure that our physician is on your plan. It is also your responsibility to know your insurance benefits.
At the time of service, you will be responsible for all fees that are not covered by your insurance, including co-pays, co-insurance, deductibles and non-covered services or items received. The co-pay cannot be waived by our practice, as it is a requirement placed on you by your insurance carrier. We strive to be as accurate as possible in calculating your responsibility but, with so many variations with policies and fee schedules, we are not always exact. You may receive a statement from our office for any balance due. For your convenience, we accept cash, checks, credit cards (Visa, MasterCard, Amex, and Discover). Payments are also accepted by phone.

Billing: If you receive a bill from us, it is because we believe that the balance is your responsibility. If you think it could be an error, please contact your insurance company first. If you have any questions about your bill or cannot pay the full balance, please call our office with any questions or to make payment arrangements. Accounts that are not paid within 60 days begin our in-house collection process.

Acknowledgement: I acknowledge that I have read and received a copy of the Sport & Spinal Rehab Office Policies and Procedures / Cancellation Agreement.

Patient Name: _____ Signature: _____ Date: _____

Parent or Guardian: _____ Signature: _____ Date: _____

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ASSIGNMENT OF INSURANCE BENEFITS, RELEASE, & DEMAND

I, the undersigned patient/insured knowingly, voluntarily, and intentionally assign the rights and benefits of my **Medical payments policy of insurance** to the above health care provider. I understand it is the intention of the provider to accept this assignment of benefits in lieu of demanding payment at the time services are rendered. I understand this document will allow the provider to file suit against an insurer for payment of the insurance benefits or an explanation of benefits and to seek §627.428 damages from the insurer. If the provider's bills are applied to a deductible, I agree this will serve as a benefit to me. This assignment of benefits includes the cost of transportation, medications, supplies, overdue interest and any potential claim for common law or statutory bad faith/unfair claims handling. If the insurer disputes the validity of this assignment of benefits, then the insurer is instructed to notify the provider in writing within five days of receipt of this document. Failure to inform the provider shall result in a waiver by the insurer to contest the validity of this document. The undersigned directs the insurer to pay the health care provider the maximum amount directly without any reductions & without including the patient's name on the check. To the extent, the PIP insurer contends there is a material misrepresentation on the application for insurance resulting in the policy of insurance is declared voided, rescinded, or canceled, I, as the named insured under said policy of insurance, hereby assign the right to receive the premiums paid for my PIP insurance to this provider and to file suit for recovery of the premiums. The insurer is directed to issue such a refund check payable to this provider only. Should the medical bills not exceed the premium refunded, then the provider is directed to mail the patient/named insured a check which represents the difference between the medical bills and the premiums paid. The patient agrees before the services are provided that the provider's charges for services are reasonable, usual and customary.

Disputes: The insurer is directed by the provider and the undersigned to not issue any checks or drafts in partial settlement of a claim that contain or are accompanied by language releasing the insurer or its insured/patient from liability unless there has been a prior written settlement agreed to by the health provider (specifically the office manager) and the insurer as to the amount payable under the insurance policy. The insured and the provider hereby contest and objects to any reductions or partial payments. Any partial or reduced payment, regardless of the accompanying language, issued by the insurer and deposited by the provider shall be done so under protest, at the risk of the insurer, and the deposit shall not be deemed a waiver, accord, satisfaction, discharge, settlement, or agreement by the provider to accept a reduced amount as payment in full. The insurer is hereby placed on notice that this provider reserves the right to seek the full amount of the bills submitted. If the PIP insurer states it can pay claims at 200% of Medicare, then the insurer is instructed & directed to provide this provider with a copy of the policy of insurance within 10 days**. Any effort by the insurer to pay a disputed debt as full satisfaction must be mailed to the address above, after speaking with the office manager, and mailed to the specific attention of the Office Manager. See Fla. Stat. §673.3111.**

EUOs and IMEs: If the insurer schedules a defense examination or examination under oath (hereinafter "EUO") the insurer is hereby INSTRUCTED to send a copy of said notification to this provider. The provider or the provider's attorney is expressly authorized to appear at any EUO or IME set by the insurer. The health care provider is not the agent of the insurer or the patient for any purpose. This assignment applies to both past and future medical expenses and is valid even if undated. A photocopy of this assignment is to be considered as valid as the original. I agree to pay any applicable deductible, co-payments, for services rendered after the policy of insurance exhausts and for any other services unrelated to the automobile accident. The health care provider is

given the power of attorney to: endorse my name on any check for services rendered by the above provider and to request a copy of any statements or examinations under oath given by patient.

Express Consent and Release of information: I authorize this provider to: furnish an insurer, an insurer's intermediary, the patient's other medical providers, and the patient's attorney and hired experts via mail, fax, or email, with any and all information that may be contained in the medical records; to obtain insurance coverage information (declaration sheet & policy of insurance) in writing and telephonically from the insurer; request from any insurer all explanation of benefits (EOBs) for all providers and non-redacted PIP payout sheets; obtain any written and verbal statements the patient or anyone else provided to the insurer; obtain copies of the entire claim file, the property damage file, and all medical records, including but not limited to, documents, reports, scans, notes, bills, opinions, X-rays, IMEs, and MRIs, from any other medical provider or any insurer. The provider is permitted to produce my medical records to its attorney and experts in connection with any pending lawsuits. The patient's other medical providers are authorized to sign affidavits and testify justifying the patient's care and treatment. The insurer is directed to keep the patient's medical records from this provider private and confidential. The insurer is not authorized to provide the patient's medical records to anyone without the patient's and the provider's prior express written permission.

Demand: Demand is hereby made for the insurer to pay all bills within 30 days without reductions and to mail the latest non-redacted PIP payout sheet and the insurance coverage declaration sheet to the above provider within 15 days. The insurer is directed to pay the bills in the order they are received. However, if a bill from this provider and a claim from anyone else is received by the insurer on the same day the insurer is directed to not apply this provider's bill to the deductible. If a bill from this provider and claim from anyone else is received by the insurer on the same day, then the insurer is directed to pay this provider first before the policy is exhausted. In the event the provider's medical bills are disputed or reduced by the insurer for any reason, or amount, the insurer is to: set aside the entire amount disputed or reduced; escrow the full amount at issue; and not pay the disputed amount to anyone or any entity, including myself, until the dispute is resolved by a Court. Do not exhaust the policy. The insurer is instructed to inform, in writing, the provider of any dispute and when the policy is exhausted.

Certification: I certify that: I have read and agree to the above; I have not been solicited or promised anything in exchange for receiving health care. I have not received any promises or guarantees from anyone as to the results that may be obtained by any treatment or service; and I agree the provider's prices for medical services, treatment and supplies are reasonable, usual and customary.

Caution: Please read before signing. **If you do not completely understand this document, please ask us to explain it to you.**

Patient Name: _____ Signature: _____ Date: _____

Parent or Guardian: _____ Signature: _____ Date: _____

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Release of Patient Records Authorization

I hereby authorize you to release confidential health information about me by releasing a copy of my medical records, or a summary or narrative of my protected health information to Sport & Spinal Rehab/Dr. Brandon Nevel, D.C. This authorization is a given pursuant to Florida Statue 456.057 and HIPAA Regulations. I understand that Florida Statue 456.057 (10) makes clear that any third party to whom records are disclosed is prohibited from further disclosing any information in this medical record without the expressed written consent of the patient or the patient's legal representative.

Patient Name: _____ Date of Birth: _____

Please release my protected health information to the following physician/person/facility/entity and/or those directly associated in my medical care:

Name: Sport & Spinal Rehab / Brandon T. Nevel, D.C.
Address: 103 S US HWY 1 Suite B-4, Jupiter FL, 33477
Phone: 561.406.6905
Fax: 561.406.6913

The information you may release subject to this signed release form is as follows:

□ Complete Records	□ History & Physical	□ Progress Notes
□ Care Plan	□ Lab Reports	□ Radiology Reports
□ Pathology Reports	□ Treatment Records	□ Operative Reports
□ Hospital Reports	□ Medication Records	□ Other: _____

Patient Name: _____ Signature: _____ Date: _____

Parent or Guardian: _____ Signature: _____ Date: _____

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INITIAL EVALUATION NON-ACCIDENT RELATED

LAST NAME: _____ FIRST NAME: _____ DATE: _____

Is your visit for wellness care or a specific injury? ☐ Wellness Care ☐ Specific Injury

If it is a specific injury, please answer below:

What is the date the injury began? _____

How did you injure yourself? _____

_____

_____

Do you feel your condition is:	☐ Improving	☐ Staying the same	☐ Getting worse	
Have you lost time from work?	☐ Yes	☐ No		
Can you perform physical work activities?	☐ Yes	☐ No		
If no, because of:	☐ Pain	☐ Weakness	☐ Stress	☐ Other

ACTIVITIES OF DAILY LIVING Please select all activities in which you are currently experiencing problems:

☐ Seeing	☐ Tasting	☐ Smelling	☐ Eating
☐ Hearing	☐ Bathing	☐ Grooming	☐ Dressing
☐ Reading	☐ Typing	☐ Writing	☐ Grasping
☐ Holding	☐ Pinching	☐ Standing	☐ Leaning
☐ Walking	☐ Stooping	☐ Squatting	☐ Climbing
☐ Kneeling	☐ Bending	☐ Twisting	☐ Carrying
☐ Lifting	☐ Pushing	☐ Pulling	☐ Reaching
☐ Sitting	☐ Driving	☐ Riding car	☐ Air travel
☐ Sports	☐ Exercising	☐ Loss of sexual drive	☐ Reclining
☐ Restful sleeping	☐ Insomnia	☐ Using the toilet	☐ Loss of concentration
☐ Nervous	☐ Irritable	☐ Change in personality	☐ Tactile feeling

Can you go to sleep without problems?	☐ Yes	☐ No
Do you awaken because of pain?	☐ Yes	☐ No
If yes, where? (body part)	_____	
Did you have sleep problems before?	☐ Yes	☐ No

PAST MEDICAL HISTORY **Please check all that apply:**

☐ None	☐ Abdominal Pain	☐ Angina	☐ Anorexia
☐ Anxiety	☐ Aortic aneurysm	☐ Arthritis	☐ Asthma
☐ Bladder Infection	☐ Blood Disorder	☐ Breast Lumps	☐ Breast Soreness
☐ Bronchitis	☐ Cancer/Tumors	☐ Cardiovascular	☐ Chest Pain
☐ Chronic Cough	☐ Chronic Sinusitis	☐ Colitis	☐ Constipation
☐ Convulsions	☐ COPD	☐ Depression	☐ Dermatitis/Eczema/Rash
☐ Diabetes	☐ Difficulty Swallowing	☐ Dizziness	☐ Emphysema
☐ Endometriosis	☐ Epilepsy	☐ Excessive Thirst	☐ Fainting
☐ Frequent Urination	☐ General Fatigue	☐ Gout	☐ Hand Pain
☐ Headache	☐ Heart Attack	☐ Heart Disease	☐ Heartburn
☐ Hepatitis	☐ High Blood Pressure	☐ High Cholesterol	☐ High PSA
☐ High Triglycerides	☐ HIV/AIDS/STD	☐ Irritable Colon	☐ Jaw Pain
☐ Kidney Disorders	☐ Kidney Stones	☐ Liver/Gallbladder	☐ Loss of appetite
☐ Low Back Pain	☐ Loss of bladder control	☐ Lung Disease	☐ Mental Disease
☐ Mid Back Pain	☐ Muscular incoordination	☐ Neck Pain	☐ Osteoarthritis
☐ Pain ankle/foot	☐ Pain lower leg/knee	☐ Pain upper arm/elbow	☐ Pain upper leg/hip
☐ Painful urination	☐ PMS	☐ Pneumonia	☐ Profuse/Irregular menstrual flow
☐ Prostate problems	☐ Rapid heartbeat	☐ Renal disease	☐ Rheumatoid arthritis
☐ Scoliosis	☐ Shoulder Pain	☐ Stroke	☐ Swelling/Stiffness Joints
☐ Thyroid Disease	☐ Tinnitus/Ear noises	☐ Tuberculosis	☐ Ulcer
☐ Visual Disturbances	☐ Weight gain/loss	☐ Wrist Pain	

FAMILY HISTORY **Please check all that apply:**

☐ None	☐ Abdominal Pain	☐ Angina	☐ Anorexia
☐ Anxiety	☐ Aortic aneurysm	☐ Arthritis	☐ Asthma
☐ Bladder Infection	☐ Blood Disorder	☐ Breast Lumps	☐ Breast Soreness
☐ Bronchitis	☐ Cancer/Tumors	☐ Cardiovascular	☐ Chest Pain
☐ Chronic Cough	☐ Chronic Sinusitis	☐ Colitis	☐ Constipation
☐ Convulsions	☐ COPD	☐ Depression	☐ Dermatitis/Eczema/Rash
☐ Diabetes	☐ Difficulty Swallowing	☐ Dizziness	☐ Emphysema
☐ Endometriosis	☐ Epilepsy	☐ Excessive Thirst	☐ Fainting
☐ Frequent Urination	☐ General Fatigue	☐ Gout	☐ Hand Pain
☐ Headache	☐ Heart Attack	☐ Heart Disease	☐ Heartburn
☐ Hepatitis	☐ High Blood Pressure	☐ High Cholesterol	☐ High PSA
☐ High Triglycerides	☐ HIV/AIDS/STD	☐ Irritable Colon	☐ Jaw Pain
☐ Kidney Disorders	☐ Kidney Stones	☐ Liver/Gallbladder	☐ Loss of appetite
☐ Low Back Pain	☐ Loss of bladder control	☐ Lung Disease	☐ Mental Disease
☐ Mid Back Pain	☐ Muscular incoordination	☐ Neck Pain	☐ Osteoarthritis
☐ Pain ankle/foot	☐ Pain lower leg/knee	☐ Pain upper arm/elbow	☐ Pain upper leg/hip
☐ Painful urination	☐ PMS	☐ Pneumonia	☐ Profuse/Irregular menstrual flow
☐ Prostate problems	☐ Rapid heartbeat	☐ Renal disease	☐ Rheumatoid arthritis
☐ Scoliosis	☐ Shoulder Pain	☐ Stroke	☐ Swelling/Stiffness Joints
☐ Thyroid Disease	☐ Tinnitus/Ear noises	☐ Tuberculosis	☐ Ulcer
☐ Visual Disturbances	☐ Weight gain/loss	☐ Wrist Pain	

SURGICAL HISTORY **Please check all that apply:**

☐ None	☐ Other	☐ Abdominal Exploration	☐ Abdominoplasty
☐ Abortion	☐ ACL Reconstruction	☐ Adenoid Removal	☐ Angioplasty
☐ Appendectomy	☐ Bone Fracture Repair	☐ Breast Lump Removal	☐ Bunion Removal
☐ Carotid Artery Surgery	☐ Cataract Surgery	☐ Cervical Spine Surgery	☐ Cholecystectomy
☐ Cosmetic Breast Surgery	☐ C-Section	☐ Facelift	☐ Gallbladder Removal
☐ Gastric Bypass Surgery	☐ Heart Bypass Surgery	☐ Heart Surgery	☐ Hemorrhoid Surgery
☐ Hernia Repair	☐ Hip Joint Replacement	☐ Hysterectomy	☐ Kidney Transplant
☐ Knee Arthroscopy	☐ Knee Joint Replacement	☐ Knee Surgery	☐ LASIK Eye Surgery
☐ Liposuction	☐ Lumbar Spine Surgery	☐ Mastectomy	☐ Prostate Removal
☐ Rotator Cuff Surgery	☐ TMJ Surgery	☐ Tonsillectomy	☐ Vasectomy

Surgical History was reviewed:

☐ Not contributory

MEDICATIONS **Please check all that apply:**

☐ None	☐ Other	☐ Analgesics	☐ Antacids	☐ Antibiotics
☐ Antihistamines	☐ Anti-Inflammatory	☐ Arthritis	☐ Aspirin	☐ Birth Control
☐ Blood Pressure	☐ Bone Density	☐ Cancer	☐ Cholesterol	☐ Daily Vitamins
☐ Diabetes	☐ Digestion	☐ Heart	☐ Muscle Relaxers	☐ OTC
☐ Pain	☐ Steroids	☐ Thyroid		

ALLERGIES **Please check all that apply:**

☐ None	☐ Other	☐ Chemical	☐ Environmental	☐ Food
☐ Medication	☐ Seasonal			

SOCIAL HISTORY **Please check all that apply:**

☐ Married	☐ Single	☐ Widowed	☐ Divorced	☐ Separated

Do you have any children? ☐ Yes ☐ No If yes, how many? _____

Are you pregnant? (FEMALES) ☐ Yes ☐ No If yes, how far along? _____ Due Date: _____

Do you use: ☐ Tobacco ☐ Alcohol ☐ Coffee

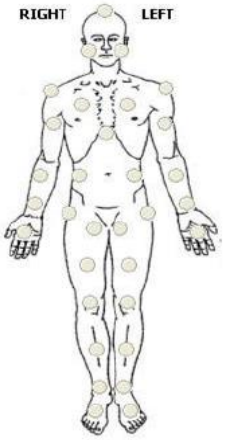
Smoking Status:

☐ Current every day smoker	☐ Current some day smoker	☐ Former smoker
☐ Never smoker	☐ Heavy tobacco smoker	☐ Light tobacco smoker

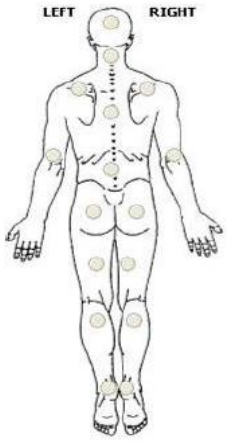
Complaint Form
(Initial Exam, Follow-Up/Final Exam, Daily Note)

Place an X the part(s) of the body where you are experiencing pain or discomfort and grade your pain level on a scale of 0-10 with 10 being the worst.

Please grade pain 0-10 (10 is the highest) ⓿ ❶ ❷ ❸ ❹ ❺ ❻ ❼ ❽ ❾ ❿



Other: _____



This complaint came on:	☐ Gradually	☐ Immediately		
It is getting:	☐ Better	☐ Same	☐ Worse	
The intensity is:	☐ Minimal	☐ Slight	☐ Moderate	☐ Severe
The frequency is:	☐ Occasional	☐ Frequent	☐ Constant	
The pain is:	☐ Dull	☐ Sharp	☐ Aching	☐ Shooting
	☐ Spasm	☐ Throbbing	☐ Burning	☐ Numb
	☐ Tingling	☐ Other: _____		
The pain is on the:	☐ Left side	☐ Right Side	☐ Bilateral	

Please mark the actions affecting your complaint(s): ***Other: _____***

Morning	☐ Brings on	☐ Aggravates	☐ Relieves
Afternoon	☐ Brings on	☐ Aggravates	☐ Relieves
Bending forward	☐ Brings on	☐ Aggravates	☐ Relieves
Bending back	☐ Brings on	☐ Aggravates	☐ Relieves
Bending left	☐ Brings on	☐ Aggravates	☐ Relieves
Bending right	☐ Brings on	☐ Aggravates	☐ Relieves
Twisting left	☐ Brings on	☐ Aggravates	☐ Relieves
Twisting right	☐ Brings on	☐ Aggravates	☐ Relieves
Coughing	☐ Brings on	☐ Aggravates	☐ Relieves
Sneezing	☐ Brings on	☐ Aggravates	☐ Relieves
Straining	☐ Brings on	☐ Aggravates	☐ Relieves
Standing	☐ Brings on	☐ Aggravates	☐ Relieves
Lifting	☐ Brings on	☐ Aggravates	☐ Relieves
Sitting	☐ Brings on	☐ Aggavates	☐ Relieves
Heat	☐ Brings on	☐ Aggravates	☐ Relieves
Cold	☐ Brings on	☐ Aggravates	☐ Relieves
Rest	☐ Brings on	☐ Aggravates	☐ Relieves
Laying down	☐ Brings on	☐ Aggravates	☐ Relieves
Medications	☐ Brings on	☐ Aggravates	☐ Relieves

PAIN DISABILITY QUESTIONNAIRE

LAST NAME: _____ FIRST NAME:_____ MI:_____ DATE:_____

Complete this questionnaire if you're experiencing any pain/discomfort. Rate the degree to which your symptoms over the past month have negatively affected your ability to perform the following functions. Rate each function as follows: 0 not at all, 1 – 3 slightly, 4 – 6 moderately, 7 – 10 severely.

1. Does your pain interfere with your normal work inside and outside the home?

Work Normally — Unable to work at all

0 1 2 3 4 5 6 7 8 9 10

2. Does your pain interfere with personal care (such as washing, dressing, etc.)?

Take care of myself completely — Need help with all my personal care

0 1 2 3 4 5 6 7 8 9 10

3. **Does your pain interfere with traveling**?

Travel anywhere I like — Only travel to see doctors

0 1 2 3 4 5 6 7 8 9 10

4. Does your pain affect your ability to sit or stand?

No problems — Not sit/stand at all

0 1 2 3 4 5 6 7 8 9 10

5. Does your pain affect your ability to lift overhead, grasp objects, or reach for things?

No problems — Cannot do at all

0 1 2 3 4 5 6 7 8 9 10

6. Does your pain affect your ability to lift objects off the floor, bend, stoop, or squat?

No problems — Cannot do at all

0 1 2 3 4 5 6 7 8 9 10

7. Does your pain affect your ability to walk or run?

No problems — Cannot walk/run at all

0 1 2 3 4 5 6 7 8 9 10

8. Has your income decreased since your pain began?

No decline — Lost all income

0 1 2 3 4 5 6 7 8 9 10

9. Do you have to take pain medication every day to control your pain?

No medication needed — On pain medication throughout the day

0 1 2 3 4 5 6 7 8 9 10

10. Does your pain force you to see doctors much more than before your pain began?

Never see doctors — See doctors weekly

0 1 2 3 4 5 6 7 8 9 10

11. Does your pain interfere with your ability to see people who are important to you as much as you would like?

No problems — Never see them

0 1 2 3 4 5 6 7 8 9 10

12. Does your pain interfere with recreational activities and hobbies that are important to you?

No interference — Total interference

0 1 2 3 4 5 6 7 8 9 10

13. Do you need help of your family and friends to complete everyday tasks (including both work outside home and housework) because of your pain?

Never need help — Need help all the time

0 1 2 3 4 5 6 7 8 9 10

14. Do you feel now more depressed, tense, or anxious than before your pain began?

No depression/tension — Severe depression/tension

0 1 2 3 4 5 6 7 8 9 10

15. Are there emotional problems caused by your pain that interfere with your family, social, and/or work activities?

No problems — Severe problems

0 1 2 3 4 5 6 7 8 9 10