

Finley Chiropractic Health Information and History

112 Wagner Street, Troutman, NC 28166, (704) 528-9119

Patient Data

Date _____

Title: (Check one) ☐ Mr. ☐ Mrs. ☐ Ms. ☐ Miss ☐ Dr. ☐ Other _____

First Name _____ Middle Initial _____ Last Name _____

Address Line 1 _____

Address Line 2 _____

City _____ State _____ Zip Code _____

Home Phone (____) _____ - _____ Work Phone (____) _____ - _____

Cell Phone (____) _____ - _____ Email _____

Date of Birth ____/____/____

Sex: ☐ Male ☐ Female

Social Security Number: _____ - _____ - _____ Marital Status: ☐ Single ☐ Married ☐ Other

Employment Status: ☐ Employed ☐ Unemployed ☐ FT Student ☐ PT Student ☐ Other _____

Spouse Data

First Name _____ Middle Initial _____ Last Name _____

Home Phone (____) _____ - _____ Work Phone (____) _____ - _____

Employer Data

Name _____

Your Occupation _____ Your Job Description _____

Address _____

City _____ State _____ Zip Code _____

Emergency Contact

Contact Name _____ Relationship to Patient _____

Contact Home Phone (____) _____ - _____ Cell Phone (____) _____ - _____

How did you hear about our office? _____

Patient Name

Date

Medical Conditions: (Check all that apply to you)

- | | | | |
|---------------------------------------|--|--|--|
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Cancer | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Heart Disease |
| <input type="checkbox"/> Hypertension | <input type="checkbox"/> Psychiatric Illness | <input type="checkbox"/> Skin Disorder | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Other _____ | | | |

Surgeries: (Check all that apply to you)

- | | | | |
|--|---|---|---------------------------------------|
| <input type="checkbox"/> Appendectomy | <input type="checkbox"/> Cardiovascular procedure | <input type="checkbox"/> Cervical spine | <input type="checkbox"/> Hysterectomy |
| <input type="checkbox"/> Joint Replacement | <input type="checkbox"/> Prostate | <input type="checkbox"/> Lumbar spine | <input type="checkbox"/> Gall Bladder |
| <input type="checkbox"/> Brain | <input type="checkbox"/> Shoulder | <input type="checkbox"/> Thoracic spine | <input type="checkbox"/> Knee |
| <input type="checkbox"/> Carpal Tunnel | <input type="checkbox"/> Gastro-intestinal | <input type="checkbox"/> Uro-genital | <input type="checkbox"/> Hernia |
| <input type="checkbox"/> Other _____ | | | |

Allergies: (Check all that apply to you)

- | | | | |
|-------------------------------|---|--|--------------------------------------|
| <input type="checkbox"/> Eggs | <input type="checkbox"/> Fish and Shellfish | <input type="checkbox"/> Milk or Lactose | <input type="checkbox"/> Peanuts |
| <input type="checkbox"/> Soy | <input type="checkbox"/> Sulfites | <input type="checkbox"/> Wheat/Glutens | <input type="checkbox"/> Other _____ |

Social History: (Check all that apply to you)

- | | | | |
|------------------|--------------------------------------|--------------------------------------|--------------------------------|
| Caffeine use: | <input type="checkbox"/> occasional | <input type="checkbox"/> often | <input type="checkbox"/> never |
| Drink Alcohol: | <input type="checkbox"/> occasional | <input type="checkbox"/> often | <input type="checkbox"/> never |
| Exercise: | <input type="checkbox"/> occasional | <input type="checkbox"/> often | <input type="checkbox"/> never |
| Chew Tobacco: | <input type="checkbox"/> occasional | <input type="checkbox"/> often | <input type="checkbox"/> never |
| Cigarettes: | <input type="checkbox"/> <1 pack/day | <input type="checkbox"/> >1 pack/day | <input type="checkbox"/> never |
| Wear Seat Belts: | <input type="checkbox"/> occasional | <input type="checkbox"/> always | <input type="checkbox"/> never |
| Other _____ | | | |

Family History: (Check all that apply)

- | | | |
|---------------|---------------------------------|----------------------------------|
| Arthritis: | <input type="checkbox"/> Parent | <input type="checkbox"/> Sibling |
| Cancer: | <input type="checkbox"/> Parent | <input type="checkbox"/> Sibling |
| Diabetes: | <input type="checkbox"/> Parent | <input type="checkbox"/> Sibling |
| Heart Disease | <input type="checkbox"/> Parent | <input type="checkbox"/> Sibling |
| Hypertension | <input type="checkbox"/> Parent | <input type="checkbox"/> Sibling |
| Stroke | <input type="checkbox"/> Parent | <input type="checkbox"/> Sibling |
| Thyroid | <input type="checkbox"/> Parent | <input type="checkbox"/> Sibling |
| Other _____ | | |

Occupational Activities: (Check one that best describes your job description)

- | | | | |
|---|--|---|--|
| <input type="checkbox"/> Administration | <input type="checkbox"/> Teacher/ Educator | <input type="checkbox"/> Clerical/Secretary | <input type="checkbox"/> Computer User |
| <input type="checkbox"/> Heavy Equipment operator | <input type="checkbox"/> Daycare/Childcare | <input type="checkbox"/> Construction | <input type="checkbox"/> Health Care |
| <input type="checkbox"/> Food Service Industry | <input type="checkbox"/> Medium Manual Labor | <input type="checkbox"/> Manufacturing | <input type="checkbox"/> Home Services |
| <input type="checkbox"/> Heavy Manual Labor | <input type="checkbox"/> Light Manual Labor | <input type="checkbox"/> Executive/Legal | <input type="checkbox"/> Housekeeper |
| <input type="checkbox"/> Other _____ | | | |

Doctor's Signature _____

Patient Name _____**Date** _____**Review of Systems** – (Check box if you have had trouble with any of the following, circle NO if none)

Cardiovascular			No	Respiratory			No	Allergic/Immunologic			No
	Past	Present			Past	Present			Past	Present	
Poor Circulation				Asthma				Hives			
Hypertension				Tuberculosis				Immune Disorder			
Aortic Aneurism				Short Breath				HIV/AIDS			
Heart Disease				Emphysema				Allergy Shots			
Heart Attack				Cold/Flu				Cortisone Use			
Chest Pain				Cough							
High Cholesterol				Wheezing							
Pace Maker								Ear, Nose and Throat			No
Jaw Pain				Eyes			No		Past	Present	
Irregular Heartbeat					Past	Present		Difficulty Swallowing			
Swelling of legs				Glaucoma				Dizziness			
				Double Vision				Hearing Loss			
Genitourinary			No	Blurred Vision				Sore Throat			
	Past	Present						Nosebleeds			
Kidney Disease				Psychiatric			No	Bleeding Gums			
Burning Urination					Past	Present		Sinus Infections			
Frequent Urination				Depression							
Blood in Urine				Anxiety				Gastrointestinal			No
Kidney Stones				Stress					Past	Present	
Lower Side Pain								Gall Bladder Problems			
				Endocrine			No	Bowel Problems			
Neurologic			No		Past	Present		Constipation			
	Past	Present		Thyroid				Liver Problems			
Stroke				Diabetes				Ulcers			
Seizures				Hair Loss				Diarrhea			
Head Injury				Menopausal				Nausea/Vomiting			
Brain Aneurysm				Menstrual				Bloody Stools			
Numbness								Poor Appetite			
Severe Headaches				Hematologic			No				
Pinched Nerves					Past	Present		Musculoskeletal			No
Parkinson's				Hepatitis					Past	Present	
Carpal Tunnel				Blood Clots				Gout			
Vertigo				Cancer				Arthritis			
				Bruising				Joint Stiffness			
Constitutional			No	Bleeding				Muscle Weakness			
	Past	Present		Fever, Chills				Osteoporosis			
				Sweating				Broken Bones			
Weight Loss/Gain								Joints Replaced			
Low Energy Level											
Difficulty Sleeping											

Please list all current medications being taken _____

Are you pregnant? Yes _____ No _____ N/A _____ If yes, Number of weeks: _____

Doctor's Signature _____

Patient Name _____

Date _____

Using the key below, indicate on the body diagram where you are experiencing the following:

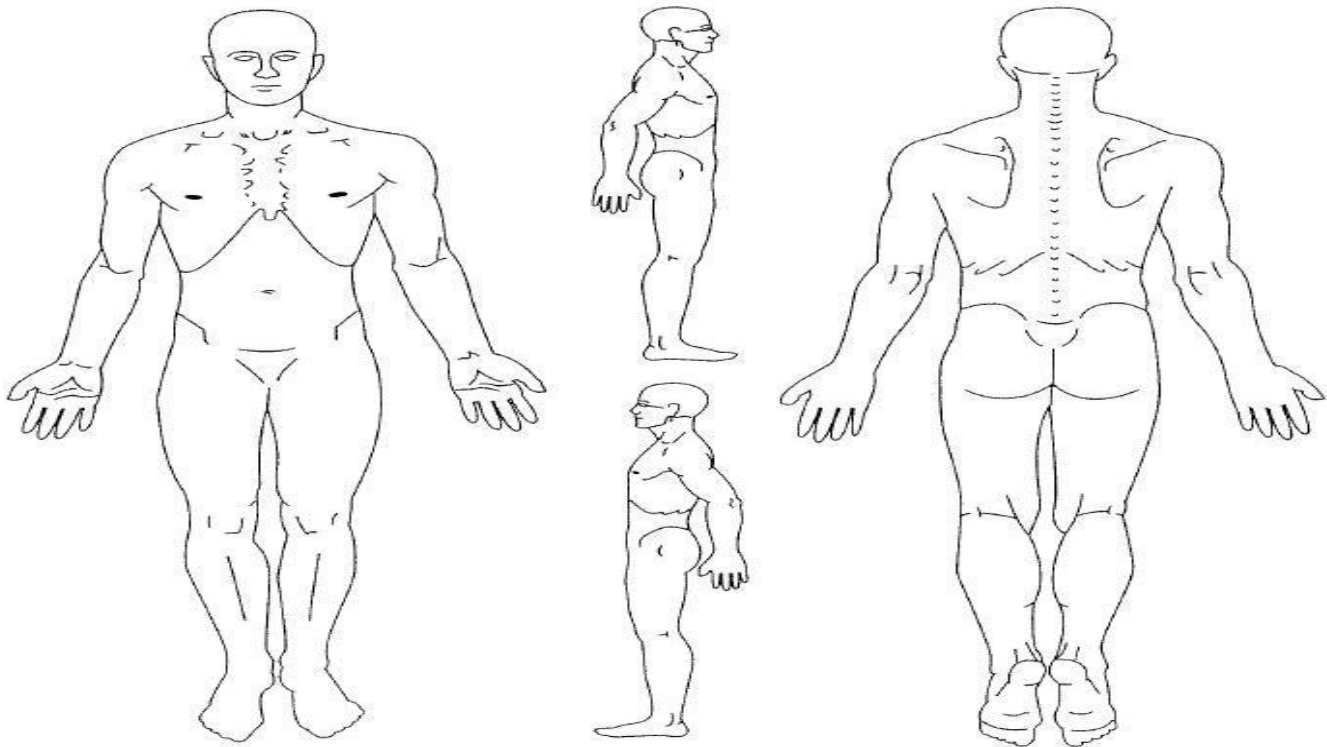
N=Numbness

B=Burning

S=Stabbing

T=Tingling

A=Dull Ache



Describe your symptoms in order of severity, with worse symptom being #1: _____

When did your symptoms begin? Month _____ Day _____ Year _____

Are your symptoms a result of: ☐ Motor Vehicle Accident ☐ Work related Accident ☐ Other _____

How did your symptoms begin? _____

How often do you experience your symptoms?

☐ Constantly
(76-100% of the day)

☐ Frequently
(51-75% of the day)

☐ Occasionally
(26-50% of the day)

☐ Intermittently
(0-25% of the day)

What describes the nature of your symptoms?

☐ Sharp
☐ Burning

☐ Dull ache
☐ Tingling

☐ Numb
☐ Stabbing

☐ Shooting
☐ Other _____

How are your symptoms changing?

☐ Getting better

☐ Not changing

☐ Getting worse

Doctor's Signature _____

Patient Name _____

Date _____

Employment, ADL, and Recreation Information

Outcomes Assessment Tool Used _____ Score _____

Description of Work: _____

Condition's Effect On Job Performance: ☐ **No Effect** ☐ **Mild** (painful can do) ☐ **Mod** (painful limited ability)
☐ **Mod/Sev** (limited duty) ☐ **Sev** (no limited duty) ☐ **Sev** (can't do limited duty)

Daily Activities: Effects of Current Condition on Performance

Bending:	<input type="checkbox"/> No Effect	<input type="checkbox"/> Mild Painful (Can do)	<input type="checkbox"/> Mod Painful (Limited)	<input type="checkbox"/> Sev Unable to Perform
Care –Infirm Family:	<input type="checkbox"/> No Effect	<input type="checkbox"/> Mild Painful (Can do)	<input type="checkbox"/> Mod Painful (Limited)	<input type="checkbox"/> Sev Unable to Perform
Carrying Groceries:	<input type="checkbox"/> No Effect	<input type="checkbox"/> Mild Painful (Can do)	<input type="checkbox"/> Mod Painful (Limited)	<input type="checkbox"/> Sev Unable to Perform
Change Posn–Sit–Stand:	<input type="checkbox"/> No Effect	<input type="checkbox"/> Mild Painful (Can do)	<input type="checkbox"/> Mod Painful (Limited)	<input type="checkbox"/> Sev Unable to Perform
Climb Stairs:	<input type="checkbox"/> No Effect	<input type="checkbox"/> Mild Painful (Can do)	<input type="checkbox"/> Mod Painful (Limited)	<input type="checkbox"/> Sev Unable to Perform
Driving:	<input type="checkbox"/> No Effect	<input type="checkbox"/> Mild Painful (Can do)	<input type="checkbox"/> Mod Painful (Limited)	<input type="checkbox"/> Sev Unable to Perform
Extended Computer Use:	<input type="checkbox"/> No Effect	<input type="checkbox"/> Mild Painful (Can do)	<input type="checkbox"/> Mod Painful (Limited)	<input type="checkbox"/> Sev Unable to Perform
Feeding:	<input type="checkbox"/> No Effect	<input type="checkbox"/> Mild Painful (Can do)	<input type="checkbox"/> Mod Painful (Limited)	<input type="checkbox"/> Sev Unable to Perform
Household Chores:	<input type="checkbox"/> No Effect	<input type="checkbox"/> Mild Painful (Can do)	<input type="checkbox"/> Mod Painful (Limited)	<input type="checkbox"/> Sev Unable to Perform
Kneeling:	<input type="checkbox"/> No Effect	<input type="checkbox"/> Mild Painful (Can do)	<input type="checkbox"/> Mod Painful (Limited)	<input type="checkbox"/> Sev Unable to Perform
Lift Children:	<input type="checkbox"/> No Effect	<input type="checkbox"/> Mild Painful (Can do)	<input type="checkbox"/> Mod Painful (Limited)	<input type="checkbox"/> Sev Unable to Perform
Lifting:	<input type="checkbox"/> No Effect	<input type="checkbox"/> Mild Painful (Can do)	<input type="checkbox"/> Mod Painful (Limited)	<input type="checkbox"/> Sev Unable to Perform
Pet Care:	<input type="checkbox"/> No Effect	<input type="checkbox"/> Mild Painful (Can do)	<input type="checkbox"/> Mod Painful (Limited)	<input type="checkbox"/> Sev Unable to Perform
Reading (Concentration):	<input type="checkbox"/> No Effect	<input type="checkbox"/> Mild Painful (Can do)	<input type="checkbox"/> Mod Painful (Limited)	<input type="checkbox"/> Sev Unable to Perform
Self Care–Bathing:	<input type="checkbox"/> No Effect	<input type="checkbox"/> Mild Painful (Can do)	<input type="checkbox"/> Mod Painful (Limited)	<input type="checkbox"/> Sev Unable to Perform
Self Care–Dressing:	<input type="checkbox"/> No Effect	<input type="checkbox"/> Mild Painful (Can do)	<input type="checkbox"/> Mod Painful (Limited)	<input type="checkbox"/> Sev Unable to Perform
Self Care–Shaving:	<input type="checkbox"/> No Effect	<input type="checkbox"/> Mild Painful (Can do)	<input type="checkbox"/> Mod Painful (Limited)	<input type="checkbox"/> Sev Unable to Perform
Sexual Activities:	<input type="checkbox"/> No Effect	<input type="checkbox"/> Mild Painful (Can do)	<input type="checkbox"/> Mod Painful (Limited)	<input type="checkbox"/> Sev Unable to Perform
Sleep:	<input type="checkbox"/> No Effect	<input type="checkbox"/> Mild Painful (Can do)	<input type="checkbox"/> Mod Painful (Limited)	<input type="checkbox"/> Sev Unable to Perform
Static Sitting:	<input type="checkbox"/> No Effect	<input type="checkbox"/> Mild Painful (Can do)	<input type="checkbox"/> Mod Painful (Limited)	<input type="checkbox"/> Sev Unable to Perform
Static Standing:	<input type="checkbox"/> No Effect	<input type="checkbox"/> Mild Painful (Can do)	<input type="checkbox"/> Mod Painful (Limited)	<input type="checkbox"/> Sev Unable to Perform
Walking:	<input type="checkbox"/> No Effect	<input type="checkbox"/> Mild Painful (Can do)	<input type="checkbox"/> Mod Painful (Limited)	<input type="checkbox"/> Sev Unable to Perform
Yard Work:	<input type="checkbox"/> No Effect	<input type="checkbox"/> Mild Painful (Can do)	<input type="checkbox"/> Mod Painful (Limited)	<input type="checkbox"/> Sev Unable to Perform

Recreational Activity: Effects of Current Condition on Performance

_____	<input type="checkbox"/> No Effect	<input type="checkbox"/> Mild Painful (Can do)	<input type="checkbox"/> Mod Painful (limited)	<input type="checkbox"/> Sev Unable to Perform
_____	<input type="checkbox"/> No Effect	<input type="checkbox"/> Mild Painful (Can do)	<input type="checkbox"/> Mod Painful (limited)	<input type="checkbox"/> Sev Unable to Perform
_____	<input type="checkbox"/> No Effect	<input type="checkbox"/> Mild Painful (Can do)	<input type="checkbox"/> Mod Painful (limited)	<input type="checkbox"/> Sev Unable to Perform

Doctor's Signature _____

Patient Name _____

Date _____

Payment/Insurance Information:

Who is responsible for your bill? ☐ Self ☐ Health Insurance ☐ Spouse ☐ Worker's Comp
☐ Auto Insur. ☐ Medicare ☐ Medicaid ☐ Other _____

Personal Health Insurance Carrier: _____ Insur. Card ID # _____

Policy Holder's Name: _____ Group # _____

Policy Holder's Date of Birth ____ / ____ / ____ Primary Care Physician _____

I authorize Finley Chiropractic Center to release medical information to my insurance company:

I understand and agree that health and accident policies are an arrangement between an insurance carrier and myself. I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment if my insurance carrier does not pay.

I also understand that payment of services is due at the time of service unless other financial arrangements have been made.

Signature: _____ Date: _____

Worker's Compensation Injury / Auto / Personal Injury:

Have you filed an injury report with your employer? ☐ Yes ☐ No Date: ____ / ____ / ____ Time: ____ am / pm

SIGNATURE OF PHYSICIAN: _____ **Date:** _____

PRIVACY PRACTICES ACKNOWLEDGMENT

I have received the Notice of Privacy Practices and I have been provided an opportunity to review it.

Print Name: _____ Birth date: _____

Signature _____ Date _____

OFFICE POLICIES

REFERRALS - The greatest honor a patient can give to their doctor is the referral of their family and friends. We promise to give your loved ones the same quality care and attention that you receive. Thank you in advance.

APPOINTMENT SCHEDULING - If it is necessary for you to miss a scheduled appointment with the Doctor, please call 24 hours in advance to reschedule, if at all possible. We reserve the right to charge \$30 for appointments cancelled or broken without 24 hours advance notice. Dr. Finley makes every effort to respect the value of your time; therefore he expects the same of you.

NEW PATIENTS – Your first appointment does not include time for paperwork. Please have it completed prior to your appointment. If you are more than 10 minutes late for your appointment, you will have to reschedule.

FINANCIAL AGREEMENTS - It is your payment that allows us to continue providing high levels of professional care, maintain our facility and pay our staff. If for any reason you can't keep your financial agreement, inform us immediately to eliminate any misunderstandings. If you have the desire to receive care in our office, we will make every attempt to make affordable arrangements. Additional paper work our office needs to fill out for you will be a \$20 fee each time; this is beyond the normal scope of filing insurances.

DISCOURAGEMENT - Please keep in mind that healing and spinal correction takes time. The problem you are having most likely did not develop in a day, therefore neither can the correction. However, if at any time during your care you do not feel that you're responding as well as you expected, please discuss it immediately with the Doctor. We want you to get the most from your chiropractic care!

PROTECTING YOUR PRIVACY - You have received a Notice of Privacy Practices for this office and every effort will be made to maintain patient privacy. Your signed consent must be given for any records to be released from this office. Any radiographs or x-rays taken at Finley Chiropractic Center are property of the office. However, you may check them out for 30 days if needed and we reserve the right to charge a refundable deposit until the films are returned.

Please list any individuals, family, primary physician, etc. whom we may discuss your care with: _____

May we leave general telephone messages? ☐ Yes ☐ No If so, where? ☐ home ☐ cell ☐ work

Neck Index

ACN Group, Inc. Form NI-100

ACN Group, Inc. Use Only 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

- ① 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

- ① 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

- ① 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

- ① 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

- ① 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

- ① 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

- ① 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

- ① 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

- ① 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

- ① 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

ACN Group, Inc. Form BI-100

ACN Group, Inc. Use Only 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

- ① The pain comes and goes and is very mild.
- ① The pain is mild and does not vary much.
- ② The pain comes and goes and is moderate.
- ③ The pain is moderate and does not vary much.
- ④ The pain comes and goes and is very severe.
- ⑤ The pain is very severe and does not vary much.

Sleeping

- ① I get no pain in bed.
- ① I get pain in bed but it does not prevent me from sleeping well.
- ② Because of pain my normal sleep is reduced by less than 25%.
- ③ Because of pain my normal sleep is reduced by less than 50%.
- ④ Because of pain my normal sleep is reduced by less than 75%.
- ⑤ Pain prevents me from sleeping at all.

Sitting

- ① I can sit in any chair as long as I like.
- ① I can only sit in my favorite chair as long as I like.
- ② Pain prevents me from sitting more than 1 hour.
- ③ Pain prevents me from sitting more than 1/2 hour.
- ④ Pain prevents me from sitting more than 10 minutes.
- ⑤ I avoid sitting because it increases pain immediately.

Standing

- ① I can stand as long as I want without pain.
- ① I have some pain while standing but it does not increase with time.
- ② I cannot stand for longer than 1 hour without increasing pain.
- ③ I cannot stand for longer than 1/2 hour without increasing pain.
- ④ I cannot stand for longer than 10 minutes without increasing pain.
- ⑤ I avoid standing because it increases pain immediately.

Walking

- ① I have no pain while walking.
- ① I have some pain while walking but it doesn't increase with distance.
- ② I cannot walk more than 1 mile without increasing pain.
- ③ I cannot walk more than 1/2 mile without increasing pain.
- ④ I cannot walk more than 1/4 mile without increasing pain.
- ⑤ I cannot walk at all without increasing pain.

Personal Care

- ① I do not have to change my way of washing or dressing in order to avoid pain.
- ① I do not normally change my way of washing or dressing even though it causes some pain.
- ② Washing and dressing increases the pain but I manage not to change my way of doing it.
- ③ Washing and dressing increases the pain and I find it necessary to change my way of doing it.
- ④ Because of the pain I am unable to do some washing and dressing without help.
- ⑤ Because of the pain I am unable to do any washing and dressing without help.

Lifting

- ① 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.
- ③ Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned (e.g., on a table).
- ④ Pain prevents me from lifting heavy weights off the floor, but I can manage light to medium weights if they are conveniently positioned.
- ⑤ I can only lift very light weights.

Traveling

- ① I get no pain while traveling.
- ① I get some pain while traveling but none of my usual forms of travel make it worse.
- ② I get extra pain while traveling but it does not cause me to seek alternate forms of travel.
- ③ I get extra pain while traveling which causes me to seek alternate forms of travel.
- ④ Pain restricts all forms of travel except that done while lying down.
- ⑤ Pain restricts all forms of travel.

Social Life

- ① My social life is normal and gives me no extra pain.
- ① My social life is normal but increases the degree of pain.
- ② Pain has no significant affect on my social life apart from limiting my more energetic interests (e.g., dancing, etc).
- ③ Pain has restricted my social life and I do not go out very often.
- ④ Pain has restricted my social life to my home.
- ⑤ I have hardly any social life because of the pain.

Changing degree of pain

- ① My pain is rapidly getting better.
- ① My pain fluctuates but overall is definitely getting better.
- ② My pain seems to be getting better but improvement is slow.
- ③ My pain is neither getting better or worse.
- ④ My pain is gradually worsening.
- ⑤ My pain is rapidly worsening.

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

Back
Index
Score

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