

# WELCOME

Date: \_\_\_\_\_

## Patient Information

Name: \_\_\_\_\_  
Last First MI

Mailing Address: \_\_\_\_\_  
\_\_\_\_\_

Phone # (H) \_\_\_\_\_ (W) \_\_\_\_\_ (CELL) \_\_\_\_\_

Email address: \_\_\_\_\_ Cell Phone Carrier \_\_\_\_\_

Would you like to receive reminders of your appointments? Text message: Yes  No  Email: Yes  No

Can we call you at work?  Yes  No

Date of Birth: \_\_\_\_\_ Sex:  Male  Female SS#: \_\_\_\_\_

Marital Status:  Single  Married  Divorced  Widowed  Separated  Minor

Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_

Employer Address: \_\_\_\_\_ Phone: \_\_\_\_\_

How did you hear about our practice? \_\_\_\_\_

Emergency contact: Name: \_\_\_\_\_ Relation: \_\_\_\_\_ Phone #: \_\_\_\_\_

Phone #: (H) \_\_\_\_\_ (W) \_\_\_\_\_

## Accident Information

Is this visit due to an accident?  Yes  No If yes, what type?  Auto  Work  Other \_\_\_\_\_

Has it been reported?  Yes  No If yes, to whom? \_\_\_\_\_

## Financial Information

Name of person responsible for this account: \_\_\_\_\_

Relationship to patient (if other than self): \_\_\_\_\_ Phone # \_\_\_\_\_

Date of birth of account holder \_\_\_\_\_

Do you have health insurance?  Yes  No Name of Carrier: \_\_\_\_\_

Do you have secondary insurance?  Yes  No Name of Carrier: \_\_\_\_\_

**PLEASE PROVIDE THIS OFFICE WITH A COPY OF YOUR INSURANCE CARD(S)**

## Assignment and Release (insured patients)

I certify that I (or my dependent) have insurance coverage with \_\_\_\_\_ and I AUTHORIZE, REQUEST AND ASSIGN MY INSURANCE COMPANY TO PAY DIRECTLY TO THE PHYSICIAN/MEDICAL PRACTICE, A&E Integrated Health, INSURANCE BENEFITS OTHERWISE PAYABLE TO ME. I hereby authorize the doctor to release all information necessary, including the diagnosis and the records of any exam or treatment rendered to me, in order to secure the payment of benefits. I authorize the use of this signature on all insurance claims, including electronic submissions.

SIGNATURE (X) \_\_\_\_\_ DATE \_\_\_\_\_

# Health History

Who is your primary care physician? (doctor and/or practice) \_\_\_\_\_

**Please check to indicate if you are currently experiencing any of the following conditions:**

- |  |  |   |  |                                     |
|--|--|---|--|-------------------------------------|
| <input type="checkbox"/> Neck Pain/Stiffness | <input type="checkbox"/> Pins/Needles in Arms  | <input type="checkbox"/> Light Bothers Eyes | <input type="checkbox"/> Sudden Weight Loss    | <input type="checkbox"/> Nausea     |
| <input type="checkbox"/> Back Pain/Stiffness | <input type="checkbox"/> Pins/Needles in Legs  | <input type="checkbox"/> Depression         | <input type="checkbox"/> Loss of Taste         | <input type="checkbox"/> Cold Feet  |
| <input type="checkbox"/> Arm/Hand Pain       | <input type="checkbox"/> Fatigue               | <input type="checkbox"/> Nervousness        | <input type="checkbox"/> Loss of Memory        | <input type="checkbox"/> Chest Pain |
| <input type="checkbox"/> Leg/Knee Pain       | <input type="checkbox"/> Sleeping Difficulties | <input type="checkbox"/> Tension            | <input type="checkbox"/> Jaw Problems          | <input type="checkbox"/> Fever      |
| <input type="checkbox"/> Headaches           | <input type="checkbox"/> Loss of Smell         | <input type="checkbox"/> Cold Sweats        | <input type="checkbox"/> Constipation          | <input type="checkbox"/> Fainting   |
| <input type="checkbox"/> Dizziness           | <input type="checkbox"/> Allergies             | <input type="checkbox"/> Stomach Problems   | <input type="checkbox"/> Shortness of Breath   |                                     |
| <input type="checkbox"/> Asthma              | <input type="checkbox"/> Blurred Vision        | <input type="checkbox"/> Night Pain         | <input type="checkbox"/> Bowel/Bladder Changes |                                     |

**Please check to indicate if you have ever had any of the following:**

- |   |  |   |   |   |
|---|--|---|---|---|
| <input type="checkbox"/> Aids/HIV           | <input type="checkbox"/> Cancer              | <input type="checkbox"/> Hepatitis          | <input type="checkbox"/> Osteoporosis         | <input type="checkbox"/> Stroke             |
| <input type="checkbox"/> Alcoholism         | <input type="checkbox"/> Cataracts           | <input type="checkbox"/> Hernia             | <input type="checkbox"/> Pacemaker            | <input type="checkbox"/> Suicide Attempt    |
| <input type="checkbox"/> Allergy Shots      | <input type="checkbox"/> Chemical Dependency | <input type="checkbox"/> Herniated Disc     | <input type="checkbox"/> Parkinson's Disease  | <input type="checkbox"/> Thyroid Problems   |
| <input type="checkbox"/> Anemia             | <input type="checkbox"/> Chicken Pox         | <input type="checkbox"/> Herpes             | <input type="checkbox"/> Pinched Nerve        | <input type="checkbox"/> Tonsillitis        |
| <input type="checkbox"/> Anorexia           | <input type="checkbox"/> Diabetes            | <input type="checkbox"/> High Cholesterol   | <input type="checkbox"/> Pneumonia            | <input type="checkbox"/> Tuberculosis       |
| <input type="checkbox"/> Appendicitis       | <input type="checkbox"/> Emphysema           | <input type="checkbox"/> Kidney Disease     | <input type="checkbox"/> Polio                | <input type="checkbox"/> Tumors/Growths     |
| <input type="checkbox"/> Arthritis          | <input type="checkbox"/> Epilepsy            | <input type="checkbox"/> Liver Disease      | <input type="checkbox"/> Prostate Problems    | <input type="checkbox"/> Typhoid Fever      |
| <input type="checkbox"/> Asthma             | <input type="checkbox"/> Fractures           | <input type="checkbox"/> Measles            | <input type="checkbox"/> Prosthesis           | <input type="checkbox"/> Ulcers             |
| <input type="checkbox"/> Bleeding Disorders | <input type="checkbox"/> Glaucoma            | <input type="checkbox"/> Migraines          | <input type="checkbox"/> Psychiatric Care     | <input type="checkbox"/> Vaginal Infections |
| <input type="checkbox"/> Breast Lump        | <input type="checkbox"/> Goiter              | <input type="checkbox"/> Miscarriage        | <input type="checkbox"/> Rheumatoid Arthritis | <input type="checkbox"/> Venereal Disease   |
| <input type="checkbox"/> Bronchitis         | <input type="checkbox"/> Gonorrhea           | <input type="checkbox"/> Mononucleosis      | <input type="checkbox"/> Rheumatic Fever      | <input type="checkbox"/> Whooping Cough     |
| <input type="checkbox"/> Bulimia            | <input type="checkbox"/> Gout                | <input type="checkbox"/> Multiple Sclerosis | <input type="checkbox"/> Scarlet Fever        |   |
|   | <input type="checkbox"/> Heart Disease       | <input type="checkbox"/> Mumps              | <input type="checkbox"/> Other _____          |   |

Are you currently under drug and/or medical care?  Yes  No If yes, explain \_\_\_\_\_

Please list any medications you are currently taking: \_\_\_\_\_

Please list any surgeries and/or hospitalizations you have had (type & date): \_\_\_\_\_

Please list any allergies: \_\_\_\_\_

Please list any supplements you are currently taking (vitamins/herbs/minerals): \_\_\_\_\_

Is there a family history of any of the following conditions? (indicate family member including parents, grandparents & siblings)

- |  |  |                                      |
|--|--|--------------------------------------|
| <input type="checkbox"/> Heart Disease _____ | <input type="checkbox"/> Diabetes _____  | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Cancer _____        | <input type="checkbox"/> Arthritis _____ |                                      |

Do you exercise:  Frequently  Moderately  Occasionally  None

Do your work activities mostly involve:  Sitting  Standing  Light Labor  Heavy Labor

Do you sleep on your:  Back  Side  Stomach Do you use a cervical pillow?  Yes  No

What is your daily/weekly intake of the following:

Caffeine \_\_\_\_\_ cups/day Alcohol \_\_\_\_\_ drinks/week Cigarettes \_\_\_\_\_ packs/day

- I certify that the above questions were answered accurately. I understand that providing incorrect information can be dangerous to my health.

**SIGNATURE (X)** \_\_\_\_\_ **DATE** \_\_\_\_\_

A&E Integrated Health

**NEUROLOGICAL/ MRI/ VASCULAR PATIENT QUESTIONNAIRE**

**NAME** \_\_\_\_\_ **DATE** \_\_\_\_\_

For any YES answer, please explain under comment and notify the Doctor:

- |   |    |     |
|---|----|-----|
| 1. Do you suffer from neck pain with pain in your shoulder, arms or hands?<br>Comment: _____  | NO | YES |
| 2. Do you have weakness, numbness or burning in your shoulder, arms or hands?<br>Comment: _____   | NO | YES |
| 3. Do your hands or arms fall asleep regularly?<br>Comment: _____   | NO | YES |
| 4. Do you have reduced feeling (sensation) or swelling in your hands or arms?<br>Comment: _____   | NO | YES |
| 5. Do you suffer from a loss of handgrip strength?<br>Comment: _____  | NO | YES |
| 6. Do you suffer from back pain with pain in your buttocks, legs or feet?<br>Comment: _____   | NO | YES |
| 7. Do you have weakness, numbness or burning in your buttocks, legs or feet?<br>Comment: _____  | NO | YES |
| 8. Do your legs or feet fall asleep regularly?<br>Comment: _____  | NO | YES |
| 9. Do you have reduced feeling (sensation) or swelling in your legs, feet?<br>Comment: _____  | NO | YES |
| 10. Do you suffer from cold hands or feet?<br>Comment: _____  | NO | YES |
| 11. Have you tried any medications such as anti-inflammatory?<br>If yes, what kind of medication? _____<br>_____                          | NO | YES |
| 12. Have you tried any Physical Therapy or Chiropractic treatments before?<br>If yes: When? For how long? What kind? _____<br>_____       | NO | YES |
| 13. Have you had an MRI?<br>If yes: When? Who ordered it? What was it ordered for? _____  | NO | YES |
| 14. Have you used any splint or braces or other prescribed treatment by an MD?<br>If yes: When? What kind? Who ordered it? _____<br>_____ | NO | YES |
| 15. If you have tried any treatment or medications, did this make your problem better?<br>Comment: _____                                  | NO | YES |

<p><b>NOTE: Your health information will be kept strictly confidential.</b> Any information that we collect about you on this form will be kept confidential in our office. If a claim is submitted to Medicare, your health information on this form may be shared with Medicare. Your health information which Medicare sees will be kept confidential by Medicare.</p>
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# CONSENT TO CARE

A patient coming to the doctor gives him/ her permission and authority to care for them in accordance with appropriate test, diagnosis, and analysis. The clinical procedures performed are usually beneficial and seldom cause any problem. In rare cases underlying physical defects, deformities or pathologies, may render the patient susceptible for injury. The doctor, of course, will not provide specific healthcare, if he/ she is aware that such care may be contraindicated. It is the responsibility of the patient to make it known or to learn through health care procedures from whatever he/ she is suffering from: latent pathological defects, illnesses, or deformities, which would otherwise not come to the attention of the physician.

I agree to settle any claim or dispute I may have against or with any of these persons or entities, whether related to the prescribed care or otherwise, will be resolved by binding arbitration under the current malpractice terms which can be obtained by written request.

I have read and understand the foregoing.

\_\_\_\_\_  
Patient's Signature

\_\_\_\_\_  
Date

**X-ray Questionnaire: For women only**

Our consultation and examination may indicate that x-rays are necessary to accurately diagnose and analyze your condition. Should x-rays be necessary we would like to confirm that you are not pregnant at this time.

Name: \_\_\_\_\_

There is a possibility that I a may be pregnant at this time.

Yes, I am definitely pregnant

No, I am definitely not pregnant at this time

I request that x-ray films not be taken because: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Date of last menstrual period: \_\_\_\_\_

\_\_\_\_\_  
Patient's Signature

\_\_\_\_\_  
Date

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

Food Tolerance Survey

Please complete the following food and chemical sensitivity questionnaire. Mark each symptom based upon your experiences over the last 60 days. Some of these symptoms may have been repeated previously in this paperwork.

Symptom Scoring System:

- = NO Symptoms
- = Experience Mild Symptoms
- = Experience Moderate Symptoms
- = Severe Symptoms

Digestive Symptoms

- 0000 Stomach Pains or Cramping
- 0000 Constipation
- 0000 Diarrhea
- 0000 Reflux of Heartburn
- 0000 Bloating
- 0000 Gas
- 0000 Nausea or Vomiting

Weight

- 0000 Inability to Lose Weight
- 0000 Food Cravings
- 0000 Binge Eating
- 0000 Water Retention

Sinus/respiratory

- 0000 Stuffy or Runny Nose
- 0000 Asthma
- 0000 Chest Congestion
- 0000 Chronic Cough
- 0000 Wheezing
- 0000 Frequent Sneezing

Head/Ears

- 0000 Migraines
- 0000 Headaches
- 0000 Earaches
- 0000 Ear Infections
- 0000 Ringing in Ears

Eyes & Throat

- 0000 Itchy eyes
- 0000 Watery Eyes
- 0000 Sore Throat
- 0000 Persistent Canker Sore

Emotional/Mental

- 0000 Depression
- 0000 Anxiety
- 0000 Mood Swings
- 0000 Irritability
- 0000 Poor Concentration

Energy

- 0000 Fatigue
- 0000 Hyperactivity
- 0000 Lethargy
- 0000 Restlessness
- 0000 Insomnia

Skin Disorders

- 0000 Eczema
- 0000 Dermatitis
- 0000 Excessive Sweating
- 0000 Rashes
- 0000 Hives

Other Symptoms

- 0000 Joint Pain
- 0000 Arthritis
- 0000 Irregular Heartbeat
- 0000 Chest Pains
- 0000 Muscle Aches

Please list any symptoms not mentioned above:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_



**NAME** \_\_\_\_\_ **DATE** \_\_\_\_\_ **CASE#** \_\_\_\_\_  
 Rand 36-Item Health Survey 1.0

1. In general, would you say your health is:
  - Excellent..... 1
  - Very good..... 2
  - Good..... 3
  - Fair..... 4
  - Poor..... 5
  
2. **Compared to 1 year ago**, how would you rate your health in general **now**?
  - Much better now than 1 year ago..... 1
  - Somewhat better now than 1 year ago..... 2
  - About the same..... 3
  - Somewhat worse now than 1 year ago..... 4
  - Much worse now than 1 year ago..... 5

The following items are about activities you might do during a typical day. **Does your health now limit you** in these activities? If so, how much?

**CIRCLE ONE NUMBER ON EACH LINE**

Yes Limited a lot	Yes limited a little	No not limited At all
-------------------	----------------------	-----------------------

3. **Vigorous activities**, such as running, lifting heavy objects, participating in strenuous sports      1                      2                      3
  
4. **Moderate activities**, such as moving a table, pushing a vacuum cleaner, bowling or playing golf      1                      2                      3
  
5. Lifting or carrying groceries      1                      2                      3
  
6. Climbing **several** flights of stairs      1                      2                      3
  
7. Climbing **one** flight of stairs      1                      2                      3
  
8. Bending, kneeling or stooping      1                      2                      3
  
9. Walking **more than a mile**      1                      2                      3
  
10. Walking **several blocks**      1                      2                      3
  
11. Walking **one block**      1                      2                      3
  
12. Bathing or dressing yourself      1                      2                      3

During the **past 4 weeks**, have you had any of the following problems with your work or other regular daily activities **as a result of your physical health?**

CIRCLE ONE NUMBER ON EACH LINE

	<u>Yes</u>	<u>No</u>
13. Cut down the <b>amount of time</b> you spend on work or other activities	1	2
14. <b>Accomplished less</b> than you would like	1	2
15. Were limited in the <b>kind</b> of work or other activities	1	2
16. Had <b>difficulty</b> performing the work or other activities (for example it took extra effort)	1	2

During the **past 4 weeks**, have you had any of the following problems with your work or other regular daily activities **as a result of any emotional problems** (such as feeling depressed or anxious)

CIRCLE ONE NUMBER ON EACH LINE

	<u>Yes</u>	<u>No</u>
17. Cut down the <b>amount of time</b> you spend on work or other activities	1	2
18. <b>Accomplished less</b> than you would like	1	2
19. Didn't do work or other activities as <b>carefully</b> as usual	1	2

20. During the **past 4 weeks**, to what extent has your physical health or emotional problems interfered with your normal social activities with family, friends, neighbors or groups?

- (circle 1 number)**
- Not at all..... 1
  - Slightly..... 2
  - Moderately..... 3
  - Quite a bit..... 4
  - Extremely..... 5

21. How much **bodily** pain have you had in the **past 4 weeks?**

- (circle 1 number)**
- None..... 1
  - Very mild..... 2
  - Mild..... 3
  - Moderate..... 4
  - Severe..... 5
  - Very severe..... 6

NAME \_\_\_\_\_ DATE \_\_\_\_\_ CASE# \_\_\_\_\_

22. During the **past 4 weeks**, how much did **pain** interfere with your normal work (Including work outside the house **and** housework)

(circle 1 number)

- Not at all..... 1
- Slightly..... 2
- Moderately..... 3
- Quite a bit..... 4
- Extremely..... 5

These questions are about how you feel and how things have been with you **during the last 4 weeks**. For each question, please give the 1 answer that comes closest to the way you have been feeling. **How much of the time during the last 4 weeks...**

CIRCLE ONE NUMBER ON EACH LINE

All of the time	Most of the time	A good bit of the time	Some of the time	A little of the time	None of the time
-----------------	------------------	------------------------	------------------	----------------------	------------------

- |   |   |   |   |   |   |   |
|---|---|---|---|---|---|---|
| 23. Did you feel full of pep?   | 1 | 2 | 3 | 4 | 5 | 6 |
| 24. Have you been a very nervous person?                                | 1 | 2 | 3 | 4 | 5 | 6 |
| 25. Have you felt so down in the dumps that nothing could cheer you up? | 1 | 2 | 3 | 4 | 5 | 6 |
| 26. Have you felt calm and peaceful?                                    | 1 | 2 | 3 | 4 | 5 | 6 |
| 27. Did you have a lot of energy?                                       | 1 | 2 | 3 | 4 | 5 | 6 |
| 28. Have you felt downhearted and blue?                                 | 1 | 2 | 3 | 4 | 5 | 6 |
| 29. Did you feel worn out?  | 1 | 2 | 3 | 4 | 5 | 6 |
| 30. Have you been a happy person?                                       | 1 | 2 | 3 | 4 | 5 | 6 |
| 31. Did you feel tired?   | 1 | 2 | 3 | 4 | 5 | 6 |

32. During the **past 4 weeks**, how much of the time has your **physical health or emotional problems** interfered with your social activities (like visiting with friends, relatives, etc.)?

- All of the time..... 1
- Most of the time.... 2
- Some of the time.... 3
- A little of the time 4
- None of the time.... 5

How TRUE or FALSE is each of the following statements for you?

**CIRCLE ONE NUMBER ON EACH LINE**

Definitely true	Mostly true	Don't know	Mostly false	Definitely false
-----------------	-------------	------------	--------------	------------------

- |   |   |   |   |   |   |
|---|---|---|---|---|---|
| 33. I seem to get sick a lot easier than other people | 1 | 2 | 3 | 4 | 5 |
| 34. I am as healthy as anybody I know                 | 1 | 2 | 3 | 4 | 5 |
| 35. I expect my health to get worse.                  | 1 | 2 | 3 | 4 | 5 |
| 36. My health is excellent                            | 1 | 2 | 3 | 4 | 5 |

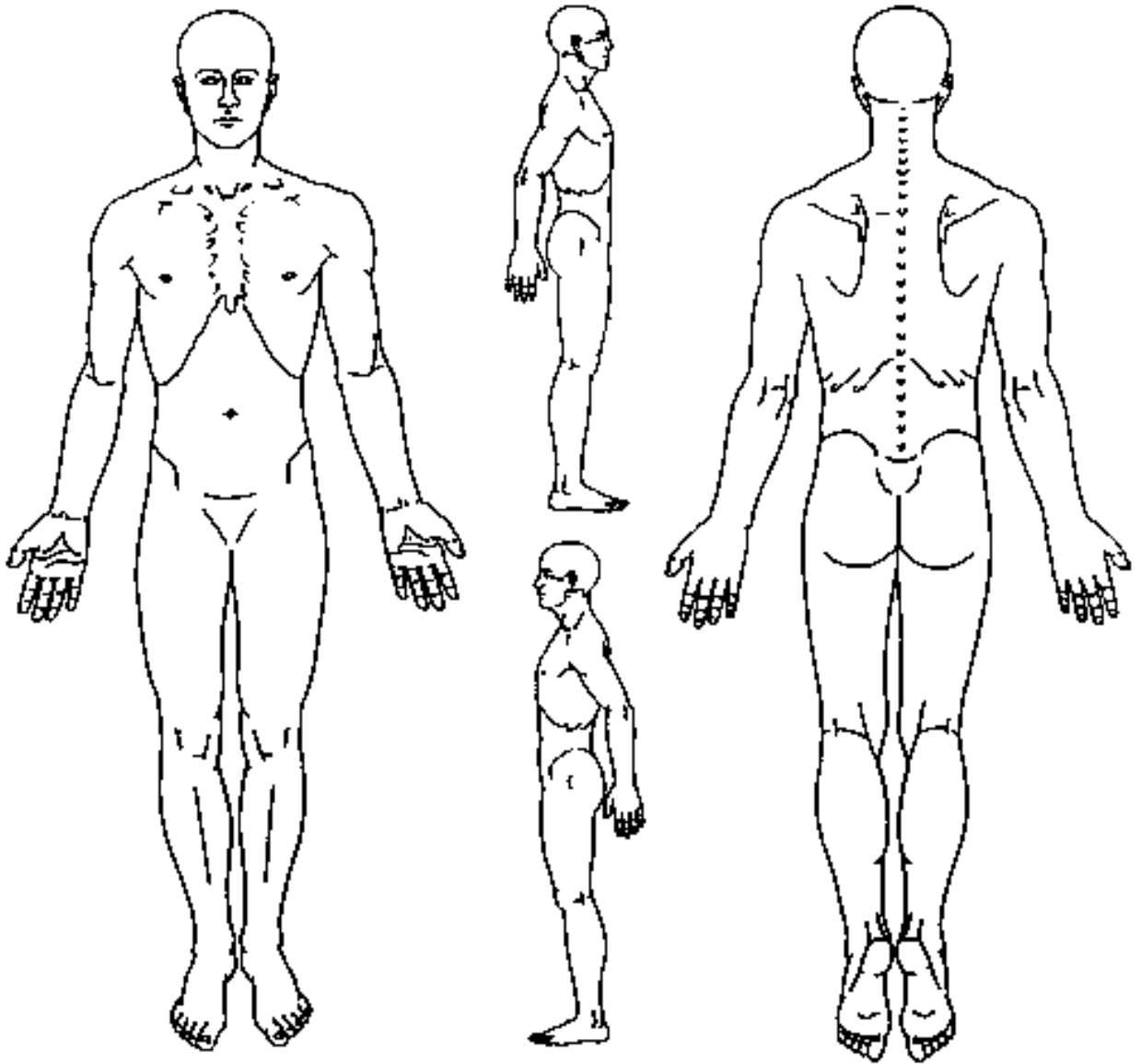
# THE DISABILITY INDEX QUESTIONNAIRE

NAME \_\_\_\_\_

DATE \_\_\_\_\_

How long have you had neck pain \_\_\_\_\_ years \_\_\_\_\_ months \_\_\_\_\_ weeks

On the diagram below, please indicate where you are experiencing pain or other symptoms, right now. Please complete both sides of this form.



**A** = ACHE  
**P** = PINS & NEEDLES

**B** = BURNING  
**S** = STABBING

**N** = NUMBNESS  
**O** = OTHER

**Neck Disability Index Questionnaire**

Please Read: This questionnaire is designed to enable us to understand how much your neck pain has affected your ability to manage everyday activities. Please answer each Section by circling the **ONE CHOICE** that most applies to you. We realize that you may feel that more than one statement may relate to you, but Please **just circle the one choice which closely describes your problem right now.**

**SECTION 1--Pain Intensity**  
 A. I have no pain at the moment  
 B. The pain is mild at the moment.  
 C. The pain comes and goes and is moderate.  
 D. The pain is moderate and does not vary much.  
 E. The pain is severe but comes and goes.  
 F. The pain is severe and does not vary much.

**SECTION 2--Personal Care (Washing, Dressing etc.)**  
 A. I can look after myself 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 weights without extra pain.  
 B. I can lift heavy weights, but it causes extra pain.  
 C. Pain prevents me from lifting heavy weights off the floor but I can if they are conveniently positioned, for example on a table.  
 D. Pain prevents me from lifting heavy weights, but I can manage light to 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 to 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 cannot read as much as I want because of moderate pain in my neck.  
 E. I cannot read as much as I want because of severe pain in my neck.  
 F. I cannot read at all.

**SECTION 5--Headache**  
 A. I have no headaches at all.  
 B. I have slight headaches which come infrequently.  
 C. I have moderate headaches which come in-frequently.  
 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 to with no difficulty.  
 B. I can concentrate fully when I want to with slight difficulty.  
 C. I have a fair degree of difficulty in concentrating when I want to.  
 D. I have a lot of difficulty in concentrating when I want to.  
 E. I have a great deal of difficulty in concentrating when I want to.  
 F. I cannot concentrate at all.

**SECTION 7--Work**  
 A. I can do as much work as I want to.  
 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 cannot do my usual work.  
 E. I can hardly do any work at all.  
 F. I cannot do any work at all.

**SECTION 8--Driving**  
 A. I can drive my car without 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 in my neck.  
 D. I cannot drive my car as long as I want because of moderate pain in my neck.  
 E. I can hardly drive my car at all because of severe pain in my neck.  
 F. I cannot drive my car at all.

**SECTION 9--Sleeping**  
 A. I have no trouble sleeping  
 B. My sleep is slightly disturbed (less than 1 hour sleepless).  
 C. My sleep is mildly disturbed (1-2 hours sleepless).  
 D. My sleep is moderately disturbed (2-3 hours sleepless).  
 E. My sleep is greatly disturbed (3-5 hours sleepless).  
 F. My sleep is completely disturbed (5-7 hours sleepless).

**SECTION 10--Recreation**  
 A. I am able engage in all recreational activities with no pain in my neck at all.  
 B. I am able engage in all recreational activities with some pain in my neck.  
 C. I am able engage in most, but not all recreational activities because of pain in my neck.  
 D. I am able 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 in my neck.  
 F. I cannot do any recreational activities all all.

**SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_**

**DISABILITY INDEX SCORE: % \_\_\_\_\_**

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**Low Back Disability Index Questionnaire**

Please Read: This questionnaire is designed to enable us to understand how much your low back pain has affected your ability to manage everyday activities. Please answer each Section by circling the **ONE CHOICE** that most applies to you. We realize that you may feel that more than one statement may relate to you, but Please **just circle the one choice which closely describes your problem right now.**

**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 is severe but comes and goes.  
 F. The pain is severe and does not vary much.

**SECTION 2--Personal Care**  
 A. I would not have to change my way of washing or dressing in order to avoid pain.  
 B. I do not normally change my way of washing or dressing even though it causes some pain.  
 C. Washing and dressing increase the pain, but I manage not to change my way of doing it.  
 D. Washing and dressing increase the pain and it is necessary to change my way of doing it.  
 E. Because of the pain, I am unable to do any washing and dressing without help.  
 F. Because of the pain, I am unable to do any washing or dressing without help.

**SECTION 3--Lifting**  
 A. I can lift heavy weights without extra pain.  
 B. I can lift heavy weights, but it causes extra pain.  
 C. Pain prevents me from lifting heavy weights off the floor.  
 D. Pain prevents me from lifting heavy weights off the floor but I can if they are conveniently positioned, for example on a table.  
 E. Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.  
 F. I can only lift very light weights, at the most.

**SECTION 4 --Walking**  
 A. Pain does not prevent me from walking any distance.  
 B. Pain prevents me from walking more than one mile.  
 C. Pain prevents me from walking more than 1/2 mile.  
 D. Pain prevents me from walking more than 1/4 mile.  
 E. I can only walk while using a cane or on crutches.  
 F. I am in bed most of the time and have to crawl to the toilet.

**SECTION 5--Sitting**  
 A. I can sit in any chair as long as I like without pain.  
 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 1/2 hour.  
 E. Pain prevents me from sitting more than ten minutes.  
 F. Pain prevents me from sitting at all.

**SECTION 6 -- Standing**  
 A. I can stand as long as I want without pain.  
 B. I have some pain while standing, but it does not increase with time.  
 C. I cannot stand for longer than one hour without increasing pain.  
 D. I can't stand for longer than 1/2 hour without increasing pain.  
 E. I can't stand for more than 10 minutes without increasing pain.  
 F. I avoid standing because it increases pain right away.

**SECTION 7--Sleeping**  
 A. I get no pain in bed.  
 B. I get pain in bed, but it does not prevent me from sleeping.  
 C. Because of pain, my normal night's sleep is reduced by less than one-quarter.  
 D. Because of pain, my normal night's sleep is reduced by less than one-half.  
 E. Because of pain, my normal night's sleep is reduced by less than three-quarters.  
 F. Pain prevents me from sleeping at all.

**SECTION 8—Social Life**  
 A. My Social Life is normal and gives me no pain.  
 B. My social life is normal, but increases the degree of my pain.  
 C. Pain has no significant effect on my social life apart from limiting 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. Pain prevents me from sleeping at all.

**SECTION 9--Sleeping**  
 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 when done lying down.

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

**SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_**

**DISABILITY INDEX SCORE: % \_\_\_\_\_**