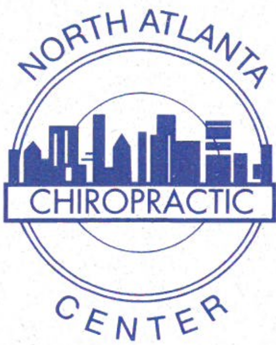

1533 Pleasant Hill Road • Suite 100 • Duluth, Georgia 30096
(770) 806-0644 • Fax (770) 806-0678

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PATIENT INTRODUCTION

Please answer the following questions completely.

Name ____ SS# ______________________________
Address __________________________________ Apt # ____ City _____________ State ___ Zip ______
Home Phone ( ) _______________________ Work Phone ( ) ___________________________
Best Place to Reach You: □ Home □ Work □ Cell Phone ( ) ______________________
E-mail Address: ____
Employer: ___________________________________ Occupation ______________________
Sex: M F Marital Status: S M D W Age: _____ Date of Birth ____/_____/_____

Describe Chief Complaint: ____

Have you had Chiropractic Care before? _____ Yes _____ No
Is it possible you are Pregnant? _____ Yes _____ No

Do you have health insurance? _____ Yes _____ No
Are you on Medicare? _____ Yes _____ No

Are you here because of: _____ An auto accident? _____ An on the job injury?

Date Injured: ______________________
Do you have an attorney? _____ Yes _____ No

Date of last physical exam: _______________________ Reason: _______________________________

Please list all accidents, falls, injuries, surgeries, and major illnesses.

TYPE	DATE	DESCRIBE/COMMENTS

Are you presently taking any medications?

NAME OF DRUG	AMOUNT	DESCRIBE/COMMENTS

PLEASE CHECK ANY OF THE FOLLOWING THAT GIVE YOU DIFFICULTY

__Headaches
__Shooting head pains
__Sinus pain
__Loss of smell
__Hay fever
__Loss of taste
__Tightness in throat
__Inflammation in throat
__Thyroid trouble
__Face flushed
__Twitching of face
__Loss of memory
__Fatigue
__Depression

__Head feels too heavy
__Dizziness
__Fainting
__Loss of balance
__Ringing in ears
__Muscle spasms in neck
__Grating in neck
__Tight shoulder muscles
__Neuritis-arms/shoulders
__Pins & needles
__Arms/hand pain
__Cold hands
__Chest pains
__Shortness of breath

__Heart pain
__Heart palpation
__Mid-back pain
__Heart attacks
__High blood pressure
__Anemia
__ Nervous stomach
__Stomach trouble
__Ulcers
__Nerves & nervousness
__Irritability
__Cold sweats
__Liver trouble
__Gallbladder trouble

__Indigestion
__Intestinal gas
__Low back pain
__Constipation
__Menstrual cramps
__Menstrual irregularity
__Diabetes
__Swelling
__Arthritis
__Slipped disc
__Pinched nerve
__Irregular sleep
__Leg/feet pain
__Neck pain

Are any of your family members experiencing any of the above difficulties?

Family Members: ____________________ Difficulties ______________________
____________________ ______________________
____________________ ______________________

Payment/Insurance Information

Please complete all applicable information

How did you hear about our office:____

OUR OFFICE POLICY STATES THAT PAYMENT IS DUE WHEN SERVICES ARE RENDERED. AS A COURTESY TO YOU, WE WILL FILE YOUR INSURANCE CLAIMS FOR YOU.

- ☐ **Cash/Check/Credit Card:** Payment is due in full when services are rendered. We accept Visa, Master Card, American Express, and Discover cards for payment.
- ☐ **Insurance:** We will file your medical insurance for you. We must have a copy of your health insurance card as well as your driver's license for your file. Deductible amounts and co-payment amounts are due in full as services are rendered. Any charges not covered by the insurance company will be billed directly to you for payment.
- ☐ **Automobile Insurance:** We must have verification of insurance, a copy of your insurance card, a copy of your driver's license, and the accident report. Any charges not covered by the insurance company will be billed directly to you for payment.
- ☐ **Workers Compensation:** Authorization for treatment must be in writing from your employer. If this is not possible on the first visit, we will accept verbal authorization until authorization can be obtained in writing.
- ☐ **Medicare:** We must have a copy of your Medicare card for verification of coverage.

Insurance Information:

Insured Full Name: ______________________________ Insured Date of Birth ____/____/____

Relationship to the Insured: ____________________ Insured Home Phone (   ) ____________

Insured SS#: ____

Insurance Company Name: ____________________________________

Insurance Company Phone: (   ) ____________________ Group #: ____________

Insured Employer: ____________________________ Employer Phone: (   ) ____________

*I authorize the release of any information pertinent to my case to any insurance company or adjuster for purposes of obtaining payment for my bills. **Signed:** X______________________________

*I further authorize and direct the ____________________ Insurance Company to pay North Atlanta Chiropractic Center directly for services rendered to me.

Signed: X______________________________ Date ____________________

*Due to new government regulations, please give North Atlanta Chiropractic Center permission to display your name in our office for our patient showcase's such as sign in sheets and our display boards, etc.

I give permission for North Atlanta Chiropractic Center to display my name for in office use only.

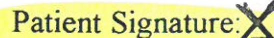
Signed: X______________________________ Date ____________________

*I ______________________________, have read the above and checked of one method of payment. I have agreed that the unpaid balance is my responsibility and will pay any balance that has gone unpaid over 60 days.

Patient Signature: X____

Witness: ____

Date: ____________________

Patient Name: ____________________  Patient Signature: ____________________

Effective Date: April 14, 2003

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

A. PURPOSE OF THE NOTICE

North Atlanta Chiropractic Center is committed to preserving the privacy and confidentiality of your health information that is created and/or maintained at our center. State and federal laws and regulations require us to implement policies and procedures to safeguard the privacy of your health information. This Notice will provide you with information regarding our privacy practices and applies to all of your health information created and/or maintained at our center, including any information that we received from other health care providers or facilities. The Notice describes the ways in which we may use or disclose your health information and also describes your rights and our obligations concerning such uses or disclosures.

We will abide by the terms of this Notice, including any future revisions made to the Notice as required or authorized by law. We reserve the right to change this Notice and to make the revised Notice effective for past and future health information about you. We will post a copy of the current Notice, which will identify its effective date, in our clinic.

B. USES AND DISCLOSURES OF HEALTH INFORMATION FOR TREATMENT, PAYMENT, AND HEALTH CARE OPERATIONS.

Treatment, Payment, and Health Care Operations. The following section describes the different ways that we may use and disclose your health information for purposes of treatment, payment, and health care operations. We explain each of these purposes below and include examples of the types of uses or disclosures that may be made for each purpose. We have not listed every type of use or disclosure, but the ways in which we use or disclose your information will fall under one of these purposes.

Treatment. Your health information will be used to provide you with health care treatment and services. We may disclose your health information to doctors, chiropractic technicians, chiropractic assistants, exam doctors, or other personnel who are involved in your health care.

For example, if we need to refer you to another health care provider to receive certain services, we will share information with that health care provider in order to coordinate your care and services.

Payment. Disclosure of your health information may be necessary to bill and receive payment from you, an insurance company, or another third party for the health care services you receive from us. We also may disclose health information about you to your health plan in order to obtain prior approval for the services provided to you, or to determine that your health plan will pay for the treatment.

For example, we may need to give health information to your health plan in order to obtain prior approval to refer you to a health care specialist, such as a neurologist or orthopedic surgeon, or to perform a diagnostic test such as a magnetic resonance imaging scan ("MRI") or a CT scan.

Health Care Operations. Your health information may be disclosed in order to perform the necessary administrative, educational, quality assurance, and business functions of our clinic.

For example, your health information may be used to evaluate the performance of our staff in caring for you. We also may use your health information to evaluate whether certain treatment or services offered by our center are effective. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name. We may also call you by name in the waiting room when your chiropractor is ready to see you. We may use pictures and testimonials and your name may appear on one of our office boards.

C. USES AND DISCLOSURES OF HEALTH INFORMATION IN SPECIAL SITUATIONS.

We may use or disclose your health information in certain special situations as described below. For these situations, you have the right to limit these uses and disclosures as provided for in Section F of this Notice.

Appointment Reminders. Your health information may be used for the purpose of contacting you to remind you of a health care appointments.

Treatment Alternatives & Health-Related Products and Services. Disclosure of your health information may be necessary in the process of informing you of treatment alternatives or health-related products or services that may be of interest to you.

For example, if you are diagnosed with a subluxation condition, we may contact you to inform you of a subluxation instruction class we offer at our center.

Family Members and Friends. Your health information may be disclosed to individuals, such as family members and friends, who are involved in your care or who help pay for your care. We may make such disclosures when: (a) we have your verbal agreement to do so; (b) we make such disclosures and you do not object; or (c) we can infer from the circumstances that you would not object to such disclosures.

For example, if your spouse comes comes into the exam room with you, we will assume that you agree to our disclosure of your information while your spouse is present in the room.

We also may disclose your health information to family members or friends in instances when you are unable to agree or object to such disclosures, provided that we feel it is in your best interests to make such disclosures and the disclosures relate to that family member or friend's involvement in your care.

For example, if you present to our center with an emergency medical condition, we may share information with the family member or friend that comes with you to our center.

D. OTHER PERMITTED OR REQUIRED USES AND DISCLOSURES OF HEALTH INFORMATION.

There are certain instances in which we may be required or permitted by law to use or disclose your health information without your permission. These instances are as follows:

As required by law. We may disclose your health information when required by federal, state, or local law to do so. For example, we are required by the Department of Health and Human Services (DHHS) to disclose your health information in order to allow DHHS to evaluate whether we are in compliance with the federal privacy regulations.

Public Health Activities. Your health information may be disclosed to public health authorities that are authorized by law to receive and collect health information for the purpose of preventing or controlling disease, injury, or disability; to report births, deaths, suspected abuse or neglect, reactions to medications; or to facilitate product recalls.

Health Oversight Activities. Your health information may be disclosed to a health oversight agency that is authorized by law to conduct health oversight activities, including audits, investigations, or licensure and certification surveys. These activities are necessary for the government to monitor the persons or organizations that provide health care to individuals and to ensure compliance with applicable state and federal laws and regulations.

Judicial or administrative proceedings. We may disclose your health information to courts or administrative agencies charged with the authority to hear and resolve lawsuits or disputes. Disclosure of your health information pursuant to a court order, subpoena, a discovery request, or other lawful process issued by a judge or other person involved in the dispute may be necessary, but only if efforts have been made to (i) notify you of the request for disclosure or (ii) obtain an order protecting your health information.

Worker's Compensation. When your health condition arises out of a work-related illness or injury, we may disclose your health information to worker's compensation programs.

Law Enforcement Official. Your health information may be disclosed in response to a request received from a law enforcement official to report criminal activity or to respond to a subpoena, court order, warrant, summons, or similar process.

Research. Under certain limited circumstances, we may use or disclose your health information for research purposes.

To Avert a Serious Threat to Health or Safety. When necessary to prevent a serious threat to the health or safety of you or other individuals, we may use or disclose your health information.

Military and Veterans. If you are a member of the armed forces, we may use or disclose your heath information as required by military command authorities.

National Security and Intelligence Activities. For purposes of intelligence, counterintelligence, and other national security activities, as authorized by law, we may use or disclose your health information to authorized federal officials.

Inmates. If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may use or disclose your health information to the correctional institution or to the law enforcement official as may be necessary (i) for the institution to provide you with healthcare; (ii) to protect the health or safety or you or another person; or (iii) for the safety and security of the correctional institution.

E. USES AND DISCLOSURES PURSUANT TO YOUR WRITTEN AUTHORIZATION

Except for the purposes identified in Section B through D, we will not use or disclose your health information for any other purposes unless we have your specific written authorization. You have the right to revoke a written authorization at any time as long as you do so in writing. If you revoke your authorization, we will no longer use or disclose your health information for the purposes identified in that authorization, except to the extent that we may have already taken some action due to your previously signed authorization.

Uses and Disclosures Subject to State and Other Laws. In addition to the federal privacy regulations that require this notice (called the HIPAA regulations), there are Georgia and other federal health information privacy laws. These laws on occasion may require your specific written permission prior to disclosures of certain particularly sensitive information (such as mental health, drug/alcohol abuse, or HIV/AIDS information) in circumstances that the HIPAA regulations would permit disclosure without your permission. NACC is required to comply not only with the HIPAA regulations but also with any other applicable laws that impose more strict nondisclosure requirements.

F. YOUR RIGHTS REGARDING YOUR HEALTH INFORMATION.

You have the following rights regarding your health information. You may exercise each of these rights, in writing, by providing us with a completed form that you obtain from NACC Medical Records Department. In some instances, we may charge you for the cost(s) associated with providing you with the requested information. Additional information regarding how to exercise your rights, and the associated costs, can be obtained from the NACC Medical Records Department.

Right to Inspect and Copy. You have the right to inspect and copy health information that may be used to make decisions about your care. We may deny your request to inspect and copy your health information in certain limited circumstances. If you are denied access to your health information, you may request that the denial be reviewed.

Right to Amend. You have the right to request an amendment of your health information that is maintained by or for our center. We may deny your request if it is not properly submitted or does not include a reason to support your request. We may also deny your request if the information sought to be amended: (a) was not created by us, unless the person or entity that created the information is no longer available to make the amendment; (b) is not part of the information that is kept by or for our center; (c) is not part of the information which you are permitted to inspect and copy; (d) is accurate and complete.

Right to an Accounting of Disclosures. You have the right to request and accounting of the disclosures of your health information made by us. This accounting of disclosures will not include the following: (a) disclosures made before April 14, 2003, (b) disclosures to carry out treatment, payment, and health care operations, (c) disclosures to an individual regarding their own information, (d) disclosures for national security or intelligence purposes, (e) disclosures to correctional institutions or law enforcement officials.

Right to Request Restrictions. You have the right to request a restriction or limitation on the health information we use or disclose about your for treatment, payment, or health care operations. You also have the right to request a limit on the health information we disclose about you to someone, such as a family member or friend, who is involved in your care or in the payment of your care. For example, you could ask that we not use or disclose information regarding a particular treatment that you received. We are not required to agree to your request. If we do agree, that agreement must be in writing and signed by you and us.

Right to Request Confidential Communications. You have the right to request that we communicate with you about your health care in a certain way or at a certain location. For example, you can ask that we only contact you at work or by mail.

Right to a Paper Copy of this Notice. You have the right to receive a paper copy of this Notice. You may ask us to give you a copy of this Notice at any time. Even if you have agreed to receive this Notice electronically, you are still entitled to a paper copy of this Notice.

G. QUESTIONS OR COMPLAINTS.

If you have any questions regarding this Notice or wish to receive additional information about our privacy practices, please contact our Privacy Officer at 770-840-0692. If you believe that your privacy rights have been violated, you may file a complaint, in writing, with our clinic or with the HHS Office of Civil Rights (OCR). There will be no retaliation for filing a complaint with either the NACC Privacy Officer or OCR.

North Atlanta Chiropractic Center
Stephanie Jack, Privacy Officer
7050 Jimmy Carter Boulevard
Suite 121-AA
Norcross, GA 30092
Telephone: 770-840-0692
Fax: 770-840-1095

Automobile Accident Information

Today's Date: _____/_____/_____
Name: ____
Date & Time of Accident: _____/_____/_____ ___:___ ___A.M. ___P.M.
Were you the: __Driver __Front Passenger __Rear Passenger
If a traffic violation was issued, to whom was it issued?

____

Please list the other people involved in the accident: ____________________

____

Where the other people injured? __Yes __No
Did the police come to the accident site? __Yes __No
Was a police report filed? __Yes __No
Were there any witnesses? __Yes __No
Were you wearing your seat belt? __Yes __No
Was this vehicle equipped with airbags? __Yes __No
If yes, did it/they inflate? __Yes __No
In relation to the base of your skull, where was the headrest?
__Above __Below __At the bas of skull
What did your vehicle impact? __Another vehicle __Other
If other, explain: ____________________
Did any part of your body strike anything in the vehicle? __Yes __No
If yes, please describe: ____________________

____

Make & model of the vehicle you were occupying:

____

Name of the location/street on which you were traveling:

____

In which direction were you headed? __N __S __E __W
What was the approximate speed of your vehicle? ____________________
Did the impact to your vehicle come from the:
__Front __Rear __Right side __Left side __Other
Were you: __aware of or __surprised by the impact?
If accident vehicle made impact with another vehicle:
Make & model of the other vehicle:

____

Direction the other vehicle was headed? __N __S __E __W
Speed of the other vehicle?__________________
In your words, please describe the accident: ____________________

____

____

For re-ordering information, contact:
ACTIVATOR METHODS, INC., P.O. Box 80317, Phoenix, AZ 85060-0317
Phone: (602) 224-0220; Facsimile (602) 224-0230

NECK PAIN DISABILITY INDEX QUESTIONNAIRE

NAME (Please Print): ______________________________ DATE: ______________

AGE: ________ DATE OF BIRTH: ______________ OCCUPATION: ______________________

HOW LONG HAVE YOU HAD NECK PAIN? ___YEARS ___MONTHS ___WEEKS

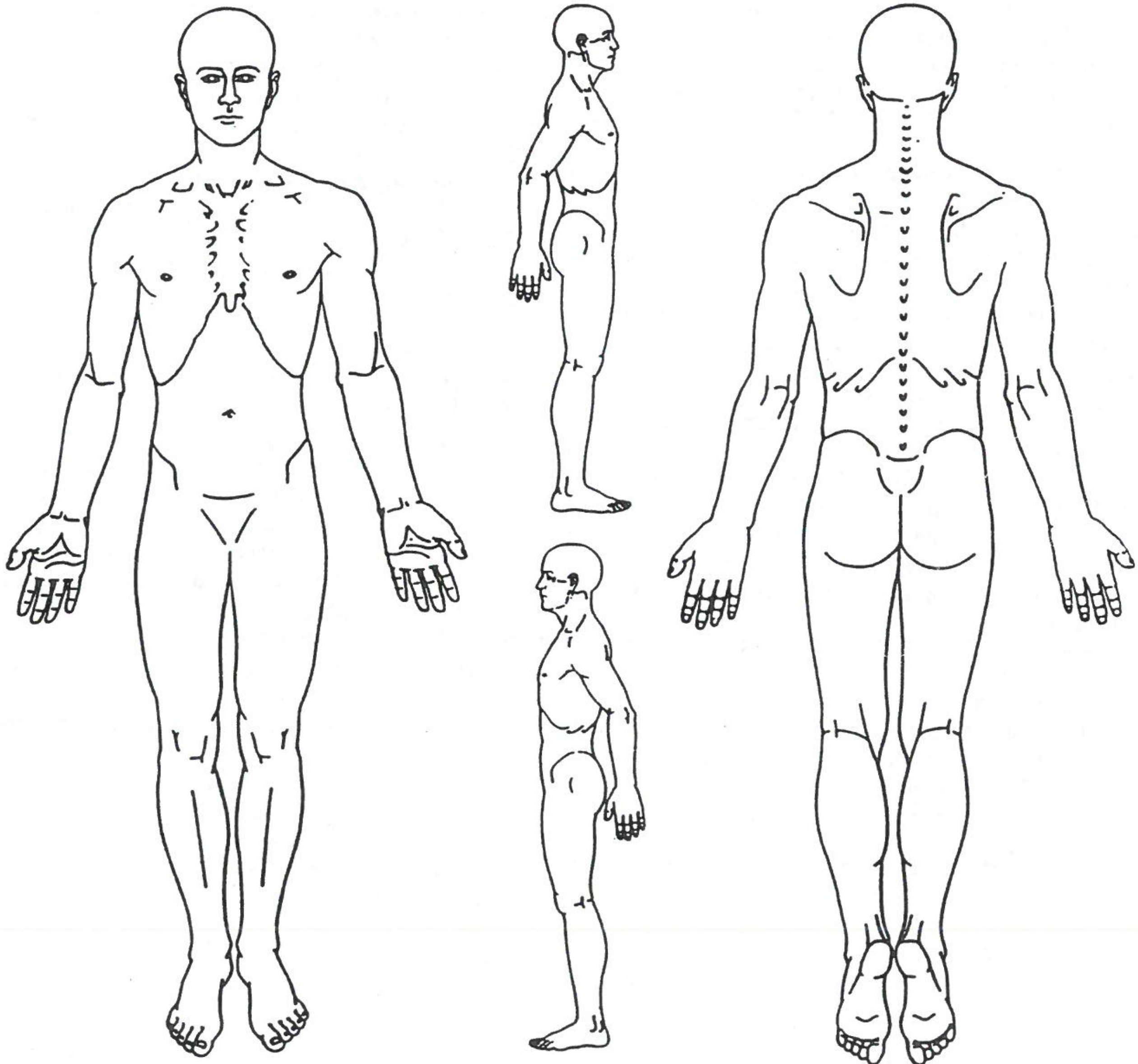
IS THIS YOUR FIRST EPISODE OF NECK PAIN? ___YES ___NO

USE THE LETTERS BELOW TO INDICATE THE TYPE AND LOCATION OF YOUR SENSATIONS RIGHT NOW

(Please remember to complete both sides of this form.)

KEY:

A=ACHE	B=BURNING	N=NUMBNESS
P=PINS & NEEDLES	S=STABBING	O=OTHER



OVER PLEASE

For re-ordering information, contact:
ACTIVATOR METHODS, INC., P. Box 80317, Phoenix, AZ 85060-0317
Phone: (602) 224-0220; Facsimile (602) 224-0230

NECK PAIN 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 your 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 MOST CLOSELY DESCRIBES YOUR PROBLEM RIGHT NOW.**

Section 1 — Pain Intensity

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

Section 2 — Personal Care (Washing, Dressing, etc.)

A I can look after myself normally without causing extra pain.
B I can look after myself normally, but it causes extra pain.
C It is painful to look after myself and I am slow and careful.
D I need some help, but manage most of my personal care.
E I need help every day in most aspects of self care.
F I do not get dressed, I wash with difficulty and stay in bed.

Section 3 — Lifting

A I can lift heavy weights, without extra pain.
B I can lift heavy weights, but it gives extra pain.
C Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned, 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 to 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 — Headaches

A I have no headaches at all.
B I have slight headaches which come infrequently.
C I have moderate headaches which come infrequently.
D I have moderate headaches which come frequently.
E I have severe headaches which come frequently.
F I have headaches almost all the time.

After Vernon & Mior, 1991
Reprinted by permission of the Journal of Manipulative and Physiological Therapeutics

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 any neck pain.
B I can drive my car as long as I want with slight pain in my neck.
C I can drive my car as long as I want with moderate pain 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 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 to engage in all of my recreational activities, with no neck pain at all.
B I am able to engage in all of my recreational activities, with some pain in my neck.
C I am able to engage in most, but not all of my usual recreational activities because of pain in my neck.
D I am able to engage in a few of my usual recreational activities because of pain in my neck.
E I can hardly do any recreational activities because of pain in my neck.
F I cannot do any recreational activities at all.

REVISED January 1, 1995

Comments: ______________________________

Patient Signature: ______________________ Date: ____________

ACTIVAT[illegible] METHODS, INC., P.O. Box 80317, Phoe[illegible] AZ 85060-0317
(602) 224-0220 Fax: (602) 224-0230

REVISED OSWESTRY CHRONIC LOW BACK PAIN DISABILITY QUESTIONNAIRE

NAME (Please Print): ______________________ DATE: __________

AGE: ______ DATE OF BIRTH: __________ OCCUPATION: ______________

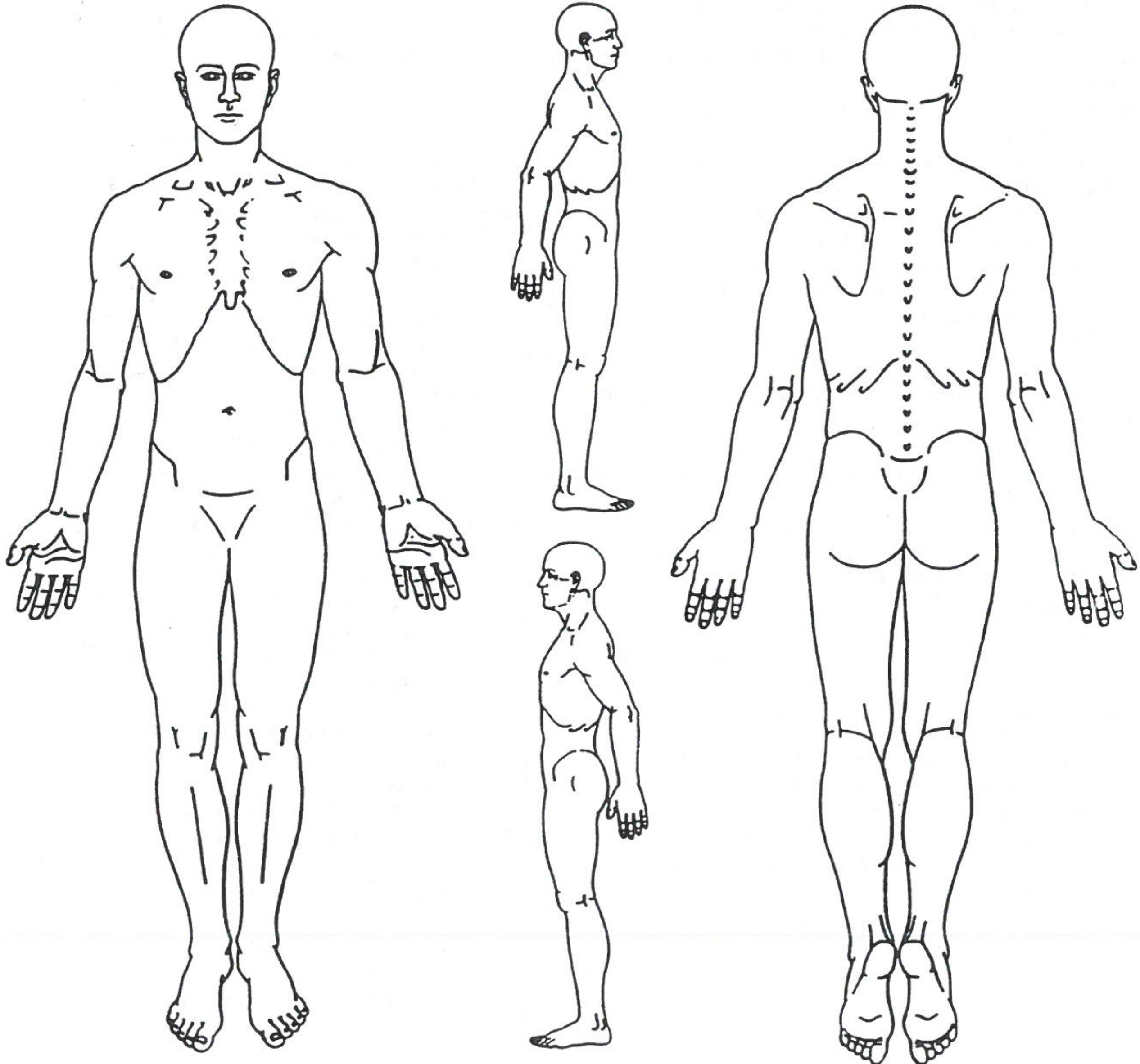
HOW LONG HAVE YOU HAD LOW BACK PAIN? ___YEARS ___MONTHS ___WEEKS

IS THIS YOUR FIRST EPISODE OF LOW BACK PAIN? ___YES ___NO

USE THE LETTERS BELOW TO INDICATE THE TYPE AND LOCATION OF YOUR SENSATIONS RIGHT NOW

(Please remember to complete both sides of this form.)

KEY: **A**=ACHE **B**=BURNING **N**=NUMBNESS **P**=PINS & NEEDLES **S**=STABBING **O**=OTHER



OVER PLEASE

REVISED OSWESTRY CHRONIC LOW BACK PAIN DISABILITY QUESTIONNAIRE

Please Read: This questionnaire is designed to enable us to understand how much your low back pain has affected your ability to manage your 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 MOST 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 comes and goes and is severe.
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 increases the pain, but I manage not to change my way of doing it.
D Washing and dressing increases the pain and I find it necessary to change my way of doing it.
E Because of the pain, I am unable to do some 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 manage if they are conveniently positioned, e.g., 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.

From: N. Hudson, K. Tome-Nicholson, A. Breen; 1989

REVISED 9/11/92

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 cannot stand for longer than 1/2 hour without increasing pain.
E I cannot stand for longer than ten minutes without increasing pain.
F I avoid standing, because it increases the pain straight away.

SECTION 7 -- Sleeping

A I get no pain in bed.
B I get pain in bed, but it does not prevent me from sleeping well.
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 I have hardly any social life because of the pain.

SECTION 9 -- Traveling

A I get no pain while traveling.
B I get some pain while traveling, but none of my usual forms of travel make it any worse.
C I get extra pain while traveling, but it does not compel me to seek alternative forms of travel.
D I get extra pain while traveling which compels me to seek alternative forms of travel.
E Pain restricts all forms of travel.
F Pain prevents all forms of travel except that done lying down.

SECTION 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.

Comments: ______________________________

Patient Signature: ______________________________ Date: ______________