Allen Chiropractic Center

Confidential Patient Information

To help us provide the best care possible you must fill out ***ALL*** information in **print**. You will not be seen until *all* information is filled out completely. Please read *all* information and sign to acknowledge accuracy and understanding.

Full name:_____ **Today's date:**_____ **Date of birth:**_____

Primary street address: _____

City: _____ **State:** _____ **Zip code:** _____

Social security # _____**Name of parent/guardian if child is minor**: _____

Email:_____ **Home phone:** _____

Cell-phone: _____ **Work phone**: _____ **ALT phone:** _____

Cell carrier: _____ **Height:** _____ **Weight:**_____ **Age:**_____ **Sex** *(circle one)* Male Female

Employer: _____ **Occupation:** _____

Marital status *(circle one)* Married Single Widow Divorced **Are you pregnant**? *(Circle one)* Yes No

Name of spouse: _____ **Number of children**: _____

Emergency contact: _____ **& Phone number:** _____

How did you hear about our clinic? _____

List current medications (you may attach separate sheet) _____

_____

_____

List previous surgeries & approximate dates (you may attach separate sheet) _____

_____

_____

Reason(s) for appointment & related health problems	**Date condition started & how long**	**Previous condition?** *(circle one)*	**Injury related?** *(circle one)*
1._____	_____	Yes / No	Yes / No
2._____	_____	Yes / No	Yes / No
3._____	_____	Yes / No	Yes / No

Medical doctors consulted in the past year *(name & date of your last visit)***:**

_____

_____

Chiropractors consulted in the past year *(name & date of your last visit)*:

_____

Do you smoke? *(Circle one)* Yes No If yes, how many packs per day? _____ & for how long? _____

Do you drink? *(Circle one)* Yes No If yes, how many glasses per day? _____ how many days per week? _____

Related Health Conditions

Please circle the following conditions you may have had in the past or have now.

Allergies	Chicken Pox	Eczema	Headaches	Low Blood Sugar	Multiple Sclerosis	Pneumonia	Thyroid Problems
Anemia	Cold Sores	Epilepsy	Heart Attack	Malaria	Mumps/Rubella	Polio	Tuberculosis
Arthritis	Constipation	Fainting	Heart Disease	Measles	Neck Pain	Roseola	Ulcers
Back Pain	Convulsions	Flat Feet	High Blood Pressure	Menstrual Cramps	Nervousness	Scoliosis	Uterine Cysts/Tumors
Bladder Infections	Depression	Gall Bladder	HIV/AIDS	Migraine	Neuritis	Sinus Trouble	Venereal Disease
Blood Vessel Disease	Diabetes	Glaucoma	Irregular Periods	Miscarriage	Pleurisy	Stroke	Whooping Cough
Cancer	Diarrhea	Gout	Kidney Disease	Other_____			

Payment Policies

1. **Payment for your first day's service is due in full at the completion of your office visit**.
2. At the completion of your first visit **you will be advised to return for a second consultation** and the doctor will then report his findings and inform you of your examinations results. He will determine whether or not your case has been accepted. You will then be advised concerning treatment options, financial arrangements, and insurance coverage.
3. Insurance (including health, auto, work comp, etc.) *must* be provided to our clinic ***prior*** to your visit on the day you would like to use it. Allen Chiropractic Center will not retroactively file claims but we will provide you with a receipt so that you may do this on your own. Regarding insurance: we are given a *review* of benefits and this is not a guarantee of payment. We will advise you what we were told by your insurance company. For questions regarding coverage you must contact your insurance company. Familiarize yourself with your benefits prior to your first visit. Be aware or prior authorizations, visit limits, and how many visits you have used. Allen Chiropractic Center does not have any way of alerting you when your limits are reached. **Any amount not covered by insurance is your financial responsibility.**

Assignment & Release

I authorize the release of information to family physicians and employer(s).
I authorize the release of information to insurance companies.
I authorize the taking of photographs and x-rays to be used for treatment purposes.
I authorize the performance of other diagnostic and therapeutic procedures for treatment purposes.
I authorize my insurance benefits to be paid directly to:

Allen Chiropractic Center
100 Willow Road
Starkville, MS 39759

I acknowledge that I am financially responsible for non-covered services. I acknowledge that I am financially responsible for all services that insurance does not pay Allen Chiropractic Center. I also understand that if I terminate my care and treatment, any and all fees for professional services rendered me will be IMMEDIATELY due and payable. I acknowledge that all information provided is correct and true.

Patient Signature_____ **Date** _____

Allen Chiropractic Center

100 Willow Road Starkville, MS 39759 Office: (662) 320-9300 AllenChiropracticCenter@gmail.com

Consent of Treatment Form

Doctors of Chiropractic Medicine, who use manual therapy techniques, are required to advise patients that there are risks associated with such treatment. In particular you should note:

1. While rare, some patients may experience short term aggravation of symptoms including: soreness, muscle tightness, and ligament pain.

2. There are reported cases of stroke associated with common neck movements including rotation manipulation of the upper cervical spine. Present medical and scientific evidence does not establish definite cause of effect relationship between the cervical spine manipulation and the occurrence of a stroke. There are reported rates of spine manipulation resulting in a stroke, the occurrence of a stroke. There are reported rates of spine manipulation resulting in a stroke, however, the statistics state that 1 in 1 million to 1 in 5 million will experience a stroke. Therefore, you are being informed of the possibility regardless of the extreme remote chance.

3. There are reported cases of strain/sprain injuries of ligament and muscle as well as cracked ribs where pre-existing weakness exists. Again, this is rare and the techniques employed by Dr. Allen reduce that risk even more.

Chiropractic treatment, including manipulation, has been the subject of government and multidisciplinary studies. It has been demonstrated to be a safe and effective care option for the treatment of back pain, neck pain, and headaches. Condition involving radiating pain, numbness, tingling, muscle spasm, loss of mobility, and other symptoms also respond well with chiropractic care.

I acknowledge I have had the opportunity to discuss the associated risk as well as the nature and purpose of treatment with my chiropractor.

I consent to chiropractic treatments offered or recommended to me by my chiropractor or referring physician; including spinal manipulation. I intend this consent to apply to all of my present and future chiropractic care.

Patient Name (Print) _____

Patient Signature _____ Date _____

Witness Signature _____ Date _____

Allen Chiropractic Center

100 Willow Road Starkville, MS 39759 Office: (662) 320-9300 AllenChiropracticCenter@gmail.com

FINANCIAL AGREEMENT

*You **MUST** ready and sign this sheet in order to be treated. **PLEASE** read this sheet in its entirety as you are signing to acknowledge your understanding.*

We highly recommend that you verify your insurance benefits with your insurance company before receiving treatment. We will verify your insurance benefits for use in our office. We verify benefits as quickly as possible but this may take a few days as we see many patients. Even after benefits are reviewed and a co-pay or co-insurance payment is made, if your insurance fails to pay in full you will be billed for the balance. Failure to pay owed balances will result in legal action. It is ultimately your responsibility to know and understand your insurance benefits. We file insurance with all we are "in—network" with. "Out of network" coverage will only be billed if the services are coverable and the insurance company is able to provide a *Payer ID*.

***We request, that you familiarize yourself with your Chiropractic Benefits by calling your insurance company and speaking with a representative. You should familiarize yourself with whether your insurance is IN or OUT of our Network, your co-pays, co-insurance, deductible amounts, and limits prior to treatment. If we are *not* In Network with your insurance company we are not required to file insurance claims but do so as a courtesy to you. Regardless of In or Out of Network agreements, it is *not* the responsibility of Allen Chiropractic Center to know your insurance benefits. We do our best to review your benefits correctly. ***

*Laser Packages are not covered with insurance. If purchasing a laser package, all lasers are **NON-TRANSFERABLE**, and there will be **NO REFUND** to the remaining lasers. *

All Payments are due in full after services are rendered.

Payable to: Allen Chiropractic Center or Dr. David Allen DC
100 Willow Road Starkville, MS 39759
662-320-9300

When contacting your insurance company, we are given a "review" of benefits. The information provided to us by your insurance company is **NOT** a guarantee of payment as stated by your insurance company. You will be asked to pay your co-insurance or co-pay every visit; in addition, you may be billed for services your insurance did not cover.

Your insurance company may require prior-authorization. It is *your* responsibility to know if prior authorization is necessary before treatment. Often, prior authorization is required 7-10 days before services are rendered. We will be more than happy to assist you with prior authorization but it is not the responsibility of Allen Chiropractic Center to be aware of prior-authorization validations. Please contact your insurance company before treatment to inquire if prior authorization is necessary.

I acknowledge that I am financially responsible for non-covered services. I acknowledge that I am financially responsible for all services that my insurance does not pay Allen Chiropractic Center. I acknowledge that I have chosen this treatment and I understand my financial responsibility. I acknowledge that should I neglect my financial responsibility legal action will be taken against me. I acknowledge that I have read this sheet and understand its content.

Patient Name Printed _____ Date_____

Patient Signature _____Date_____

Office Staff Witness _____Date_____

Allen Chiropractic Center

100 Willow Road Starkville, MS 39759 Office: (662) 320-9300 AllenChiropracticCenter@gmail.com

MENU OF SERVICES

Allen Chiropractic Center verifies insurance benefits before services are rendered. It may take several days for us to verify your insurance benefits. If we are not in network with your insurance company and you have not verified chiropractic benefits yourself you will pay full price until benefits are verified. We are in network with Blue Cross Blue Shield, Medicare, MPBEET, Fox-Everett; we will verify your benefits before requesting payment from patients with those two types insurance. Benefit reviews are *NOT* guarantees of payment and you may be billed additionally if your insurance does not pay as they advised.

Adjustments

98940 $36
98941 $47
98942 $62

Electrical Stimulation

97014 $21

Traction

97012 $22

New Patient Exam

99201 $45
99202 $80
99203 $113

X-Rays

Cervical $59
Thoracic $59
Lumbar $64

Laser

1st Treatment- Free
1 Treatment $50
Variety of laser packages starting at $200 and up

The staff at Allen Chiropractic Center cannot tell you exactly how much a first visit will be. Dr. Allen treats each patient on an individual basis and exam fees are based on how much time is involved in the examination. Through the examination, Dr. Allen will determine the necessity of X-Rays. If this is your first visit OR if it has been 2 years or more since having seen Dr. Allen, an exam is required. If there are other services you are not comfortable receiving you can deny them at any time.

To allow you more affordable care we do participate with **ChiroHEALTHUSA** which is a discount card for Chiropractic Services. The card is good for you and every member of your house hold for **ONE YEAR** and valid at participating chiropractors. We do not benefit from participating with the ChiroHEALTHUSA program at all. ChiroHEALTHUSA allows uninsured patients or patients with high deductibles access to affordable chiropractic care. Generally, most patients' Initial Visit is $150 - $250. The Chiro HEALTHUSA card allows you a 25% discount on all subsequent services. The cost of the card is **$49**. The fee for the card is not paid to us; card fee is paid to ChiroHEALTHUSA. You can fill out an application in the office and we will submit payment and mailing information via ChiroHEALTHUSA website. Paid membership is required at time of services for you to receive the discount that day. ChiroHEALTHUSA will send you a discount card in the mail within 3 weeks.

We do not offer in house payment plans. We do participate with **Care Credit** which is a line of credit for medical expenses. You may apply at www.carecredit.com or with an application in office. We have additional materials regarding Care Credit that we will be happy to share with you. Payment plan may only be set up once financial hardship is determined. To determine financial hardship, you will need to meet with the office manager.

It is your responsibility to pay for all services rendered, to inquire about fees, and to know your Insurance benefits regarding Chiropractic Care. Allen Chiropractic Center verifies and submits all out of network insurance as a courtesy to you. You should call your insurance company on your first visit and request benefits for Chiropractic Care for IN or OUT of network. Most Out-of-Network insurance benefits will have a large deductible. Please be advised that insurance companies give a "review" of benefits and that is in no way a GAURANTEE of payment. You may be charged a co-insurance or co-pay fee when you come but after your insurance pays you may be billed by Allen Chiropractic Center for any additional balance.

Totals on the menu of services do not reflect PPO adjustments for In Network insurance. If you are curious about these PPO adjustments, we will be happy to tell you what your discount is on each service.

Allen Chiropractic Center

100 Willow Road Starkville, MS 39759 Office: (662) 320-9300 AllenChiropracticCenter@gmail.com

Acknowledgement of Receipt of Menu of Services

I acknowledge that Allen Chiropractic Center has provided me with a copy of their Menu of Services which lists the price of common services offered by Dr. Allen. The Menu of Services also briefly describes how insurance benefits are verified and what my responsibilities are. Additionally, the Menu of Services briefly describes what will be expected on a first visit. The Menu of Services also includes payment options and discount pricing.

I acknowledge that I have received a copy of the Menu of Services. I acknowledge that I understand my responsibility regarding insurance benefit verification. I acknowledge I understand what will be expected of me regarding payment. I acknowledge that I understand verification of benefits is NOT a guarantee of payment. I acknowledge that I may be charged a co-insurance or co-pay but I may be billed for remaining amounts after insurance has paid.

I acknowledge that I understand there are two options open for help with payment; ChiroHealthUSA and Care Credit. I acknowledge that Allen Chiropractic Center does not have “in house” payment plans. I acknowledge that I understand I will have to meet with the office manager and provide proof of financial hardship in order to qualify for payment plans.

I acknowledge that I understand it is my responsibility to inquire about fees and it is my responsibility to deny services I do not wish to have. I understand that I am responsible for all fees and charges accrued at Allen Chiropractic Center.

Print Name _____

Signature _____ Date _____

Allen Chiropractic Center

100 Willow Road Starkville, MS 39759 Office: (662) 320-9300 AllenChiropracticCenter@gmail.com

Notice of Privacy Practices

This notice describes how medical information about you may be used and disclosed and how to gain access to that information. Please review this notice carefully and retain for future reference.

Allen Chiropractic Center is committed to maintaining the privacy of your protected health information (PHI), which includes information about your health condition, and care and treatment received from this practice. All employees, volunteers, and interns of Allen Chiropractic Center are legally responsible for protecting your PHI. In the process of administering care and treatment Allen Chiropractic Center will create a detailed record pertaining to care and treatment. This notice details how your PHI will be used and disclosed to third parties. This notice also details your rights regarding PHI. Allen Chiropractic Center will guard and protect the privacy of your information in both electronic and physical form. If you have further questions regarding the security of your PHI please direct them to the Privacy Officer, Dr. Allen.

Allen Chiropractic Center may use and/or disclose your PHI for the purpose of:

(a) Treatment- In order to provide you with the health care you require, the practice will provide your PHI to those health care professionals, whether employed by Allen Chiropractic Center or not, directly involved in your care.
(b) Payment- In order to be paid for services provided to you, the practice will provide your PHI directly to, or through billing services of, third party payers.
(c) Health Care Operations- In order for Allen Chiropractic Center to operate in accordance with applicable law and insurance requirements and in order for the practice to continue to provide quality and efficient care, it may be necessary for the practice to compile, use and/or disclose your PHI.

Allen Chiropractic Center May use and/or disclose your PHI, without a written consent from you, in the following instances:

(a) De-identified information- Information that does not identify you and, even without your name, cannot be used to identify you.
(b) Business Associate- To a business associate, in accordance with applicable law, if we have obtained satisfactory assurance, through a contract, that the business associate will protect your PHI.
(c)Personal Representative- To a person who, under applicable law, has the authority to represent you in making decisions related to your health care.
(d) Emergency Situations- for the purpose of obtaining or rendering emergency treatment to you provided that Allen Chiropractic Center attempts to obtain your consent as soon as possible.
(e) Disaster relief- To a public or private entity authorized by law or by its charter to assist in disaster relief efforts, for the purpose of coordinating your care with such entities in an emergency situation.
(f) Communication Barriers- If, due to a substantial communication barrier or inability to communicate, Allen Chiropractic Center has been unable to obtain your consent and we determine, in the exercise of professional judgment, that your consent to receive treatment is clearly inferred from the circumstances.
(f) Public Health Activities - Information of such as activities and information collected by a public health authority, as authorized by law, for the prevention or control of disease.
(g)Abuse, Neglect, or Domestic Violence- To a government authority as required by law to make such a disclosure. Allen Chiropractic Center will only disclose this information if we believe the disclosure is necessary to prevent serious harm.
(h)Health Oversight Activities- Such activities, required by law, involve government agencies and may include, for example, criminal investigations, disciplinary actions, or general oversight activities relating to the community's health care system.
(i)Judicial and Administrative Proceeding- Allen Chiropractic Center may be required by law to disclose your PHI in response to a court order or lawfully issued subpoena.
(j)Law Enforcement Purposes- In certain instances your PHI may have to be disclosed to a law enforcement official. Allen Chiropractic Center may also disclose your PHI if we believe your death was the result of criminal conduct.
(k)Coroner or Medical Examiner- Allen Chiropractic Center may disclose your PHI to a coroner or medical examiner for the purpose of identifying or determining your cause of death.
(l) Organ, Eye, or Tissue Donation- If you are an organ donor, Allen Chiropractic Center may disclose your PHI to the entity to whom you have agreed to donate your organs.

(m)Research- If Allen Chiropractic Center is involved in research activities your PHI may be used, but such use is subject to numerous governmental requirements intended to protect the privacy of your PHI and such information does not identify you and, even without your name, cannot be used to identify you in any way.
(n) Avert a Threat to Health or Safety- Allen Chiropractic Center may disclose your PHI if it believes that such disclosure in necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public and the disclosure is to an individual who is reasonably able to prevent or lessen the threat.
(o) Workers' Compensation- If you are involved in a workers' compensation claim, Allen Chiropractic Center may be required to disclose your PHI to an individual or entity that is part of the Workers Compensation system.

Your individual rights pertaining to your PHI are as follows:

(1) Confidential Communication- You have the right to restrict communication of your PHI. You also have the right to determine (within reasonable limits) how that information is communicated to you. All restricted communications must be submitted in writing to Allen Chiropractic Center.
(2) Right to Copy of PHI- You have the right to request and inspect a copy of your PHI held within a designated record set. You have the right to one free copy per year and any additional copies may be obtained at a reasonable cost. Copies must be requested in writing. There may be fees assessed for non-electronic options (e.g., shipping, copies, or physical electronic copies)
(3) Right to Amend- You have the right to request an amendment to your PHI if you believe it contains errors. Allen Chiropractic Center does have the right to deny this amendment based on review and consideration of the information in question. We also have the right to deny amendments, if it is information we did not create or the information is no longer available, is not part of the health record that we kept, is accurate and complete. In the case of a denial you have the right to submit a rebuttal and request the rebuttal be made part of your medical record. You also have the right to request that all documents associated with the amendment request (including rebuttal) be transmitted to any other party any time that portion of the medical record is disclosed. All requests for amendments and rebuttals must be submitted to Allen Chiropractic Center in writing.
(4) Right to Disclosure Accountings- You have the right to request an account that describes who has accessed your PHI outside of Allen Chiropractic Centers normal disclosures for Treatment, Payment, and Operations, authorizations made by you, and limited circumstances involving law enforcement, national security, and correctional institutions. To obtain this list you must submit your request in writing to Allen Chiropractic Center. Your request should indicate what time period for which you are requesting disclosures. The first accounting in a 12 month period is required to be provided to you free of charge. Any additional requests within that 12 month period will be assessed a reasonable fee. You may also be charged for shipping, copies, or physical electronic copies.
(5) Right to Notice- It is your right to have a copy of this notice at any time you request it. You may obtain this copy from Allen Chiropractic Center but fees may be assessed if notice needs to be mailed or copies made.

****HIPAA laws require we respond to your request(s) for copies of PHI, amendment requests, and accounts of disclosure within 30 days (with one 30 day extension which we will provide to you, if necessary, before the 30 day period expires.) It is the goal of Allen Chiropractic Center to provide you with these records within 7-10 business days of receiving your requests.*

Changes to This Notice

This is a living document and will be updated as our policies and procedures change. In the event this document is changed a revised copy will be provided to you at the earliest convenience. Current revisions of this document will be available to all patients at all times at Allen Chiropractic Center.

If you believe Allen Chiropractic Center has violated your rights you can lodge a complaint with Dr. Allen. You may also file a complaint with the Secretary of Health and Human Services

The U.S. Department of Health and Human Services
200 Independence Avenue, S.W.
Washington, D.C. 20201
Toll Free: 1-877-696-6775.

Allen Chiropractic Center will not, in any way, seek retaliation for filing the complaint.

For additional information regarding information you have received in this notice you may contact the Allen Chiropractic Security Officer at 662-320-9301.

Allen Chiropractic Center

100 Willow Road Starkville, MS 39759 Office: (662) 320-9300 AllenChiropracticCenter@gmail.com

HIPAA Acknowledgement of Receipt of Allen Chiropractic Center's Notice of Privacy Practices

This authorization is prepared pursuant to the requirements of the Health Insurance Portability and Accountability Act of 1996 (HIPAA Public Law 104-191), 42 U.S.C Section 1320d, et seq. and regulations there under, as amended from time to time. This authorization affects your rights in the privacy of your personal healthcare information.

By signing this authorization, you acknowledge and agree that Allen Chiropractic Center or its Business Associates may use or disclose your Protected Health Information for the purpose of providing treatment, for purposes relating to payment of services rendered, and for the daily healthcare operations of this practice.

Further, by signing this authorization you acknowledge that you have been provided a copy of and have read and understand Allen Chiropractic Center's Privacy Notice containing a complete description of your rights and the permitted uses and disclosures under HIPAA laws. While our office has reserved the right to change the terms of our Privacy Notice, copies of the Privacy Notice will always be available to you in paper format at our office. Additionally, if you are a current patient and our Privacy Notice has been amended a new Notice of Privacy Practices will be given to you at the time of your appointment and made available to you anytime thereafter.

By signing below, you are acknowledging that you have received, reviewed, understand, and agree to the Notice of Privacy Practices of Allen Chiropractic Center, which describes our policies and procedures regarding the use and disclosure of any of your Protected Health Information created, received, or maintained by us.

Print Name _____

Signature _____ Date _____

<u>Neck Pain</u> Disability Index Questionnaire

Name: _____ Date: _____

Age: _____ Date of Birth: _____ Occupation: _____

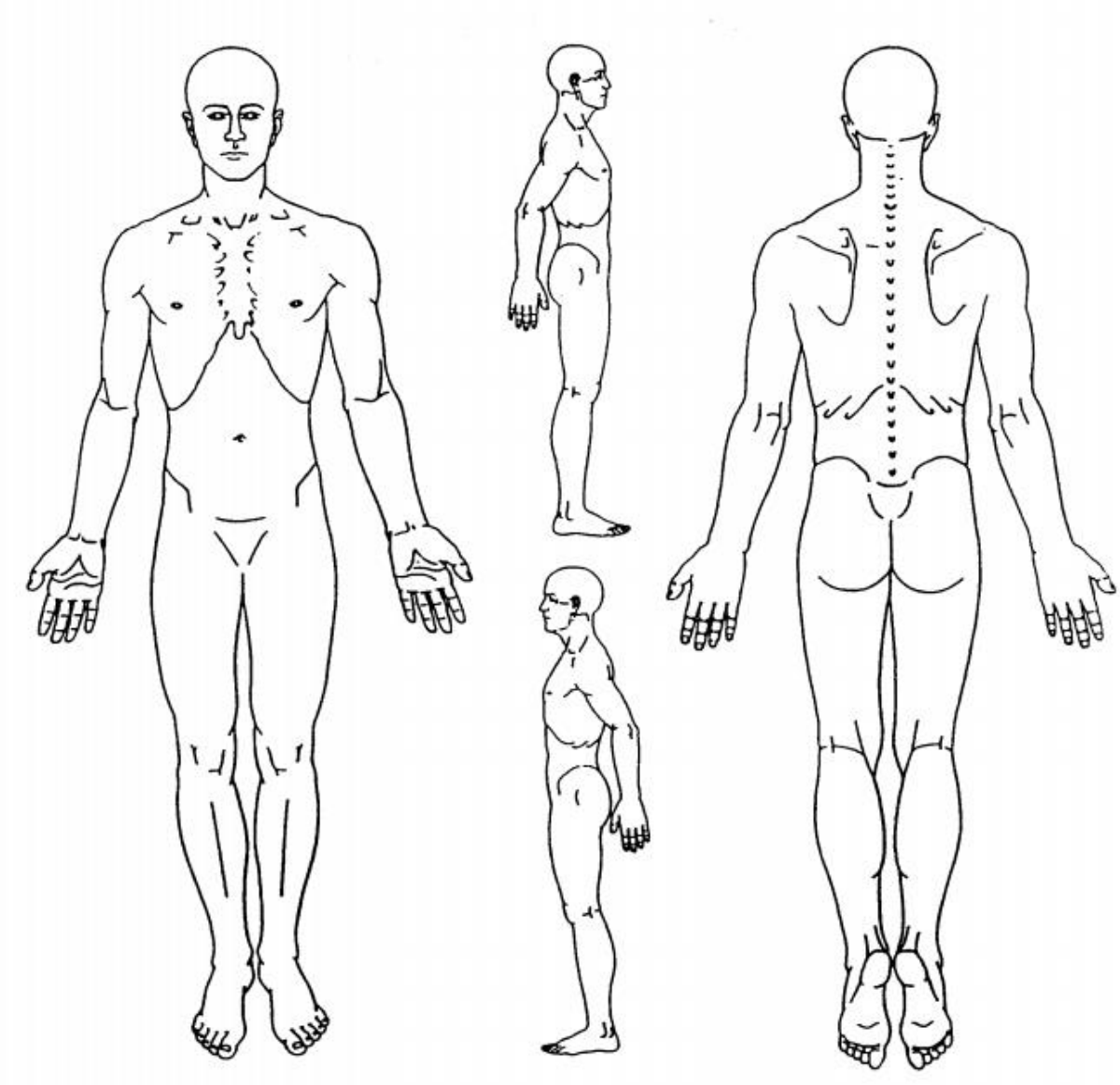
When did your neck pain start? (mm/dd/yyyy) _____

Is this your first episode of neck pain? Please circle one: Yes No

<u>Please circle the area of the current pain/ sensation on the diagram below and use the key letters below to indicate the type of pain by the circled area:</u>

A = Ache **B** = Burning **N** = Numbness

P = Pins & needles **S** = Stabbing **O** = Others



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 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 to 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.

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 recreational activities because of pain in my neck.
D I am able to engage in a few of my 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.

BACK/NECK BOURNEMOUTH QUESTIONNAIRE

Patient Name _____ Date _____

Instructions: The following scales have been designed to find out about your back/neck pain and how it is affecting you. Please answer ALL the scales, and mark the ONE number on EACH scale that best describes how you feel.

1. Over the past week, on average, how would you rate your back/neck pain?

No pain — Worst pain possible

0 1 2 3 4 5 6 7 8 9 10

2. Over the past week, how much has your back/neck pain interfered with your daily activities (housework, washing, dressing, walking, climbing stairs, getting in/out of bed/chair)?

No interference — Unable to carry out activity

0 1 2 3 4 5 6 7 8 9 10

3. Over the past week, how much has your back/neck pain interfered with your ability to take part in recreational, social, and family activities?

No interference — Unable to carry out activity

0 1 2 3 4 5 6 7 8 9 10

4. Over the past week, how anxious (tense, uptight, irritable, difficulty in concentrating/relaxing) have you been feeling?

Not at all anxious — Extremely anxious

0 1 2 3 4 5 6 7 8 9 10

5. Over the past week, how depressed (down-in-the-dumps, sad, in low spirits, pessimistic, unhappy) have you been feeling?

Not at all depressed — Extremely depressed

0 1 2 3 4 5 6 7 8 9 10

6. Over the past week, how have you felt your work (both inside and outside the home) has affected (or would affect) your back/neck pain?

Have made it no worse — Have made it much worse

0 1 2 3 4 5 6 7 8 9 10

7. Over the past week, how much have you been able to control (reduce/help) your back/neck pain on your own?

Completely control it — No control whatsoever

0 1 2 3 4 5 6 7 8 9 10

Signature: _____ Date: _____

Roland-Morris Acute Low Back Pain Disability Questionnaire

(Please print)

Name: _____ Date: _____

Age: _____ Date of Birth: _____ Occupation: _____

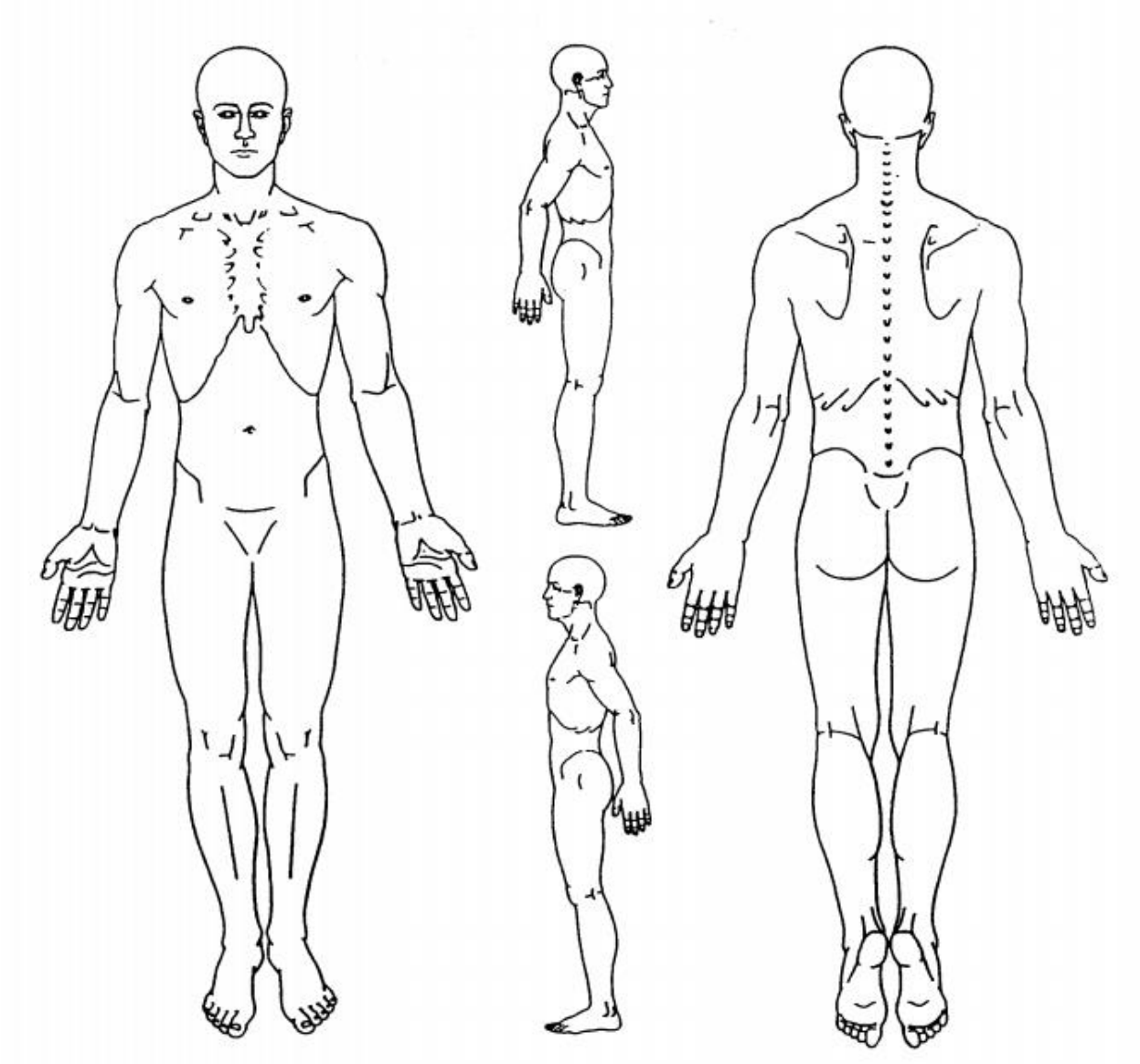
When did your neck pain start? (mm/dd/yyyy) _____

Is this your first episode of neck pain? Please circle one: Yes No

Please circle the area of the current pain/ sensation on the diagram below and use the key letters below to indicate the type of pain by the circled area:

A = Ache **B** = Burning **N** = Numbness

P = Pins & needles **S** = Stabbing **O** = Others



Roland-Morris Acute Low Back Pain Disability Questionnaire

When your back hurts, you may find it difficult to do some of the things you normally do. This list contains some sentences that people have used to describe themselves when they have back pain. When you read them, you may find that some stand out because they describe you today. As you read the list, think of yourself today. Check the box next to any sentence that describe you today. If the sentence does not describe you, then leave the space blank and go on to the next one.

1. ❑ I stay at home most of the time because of my back.
2. ❑ I change position frequently to try to get my back comfortable.
3. ❑ I walk more slowly than usual because of my back.
4. ❑ Because of my back, I am not doing the job that I usually do around the house.
5. ❑ Because of my back, I use handrail to get upstairs.
6. ❑ Because of my back, I lie down to rest more often.
7. ❑ Because of my back, I have to hold on to something to get out of an easy chair.
8. ❑ Because of my back, I try to get other people to do things for me.
9. ❑ I get dressed more slowly than usual because of my back.
10. ❑ I only stand up for short periods of time because of my back.
11. ❑ Because of my back, I try not to bend or kneel down.
12. ❑ I find it difficult to get out of a chair because of my back.
13. ❑ My back is painful almost all the time.
14. ❑ I find it difficult to turn over in bed because of my back.
15. ❑ My appetite is not very good because of my back.
16. ❑ I have trouble putting on my socks (or stockings) because of the pain in my back.
17. ❑ I only walk short distances because of my back.
18. ❑ I sleep less well because of my back.
19. ❑ Because of my back, I get dressed with help from someone else.
20. ❑ I sit down for most of the day because of my back.
21. ❑ I avoid heavy jobs around the house because of my back.
22. ❑ Because of my back pain, I am more irritable and bad tempered with people than usual.
23. ❑ Because of my back, I go upstairs more slowly than usual.
24. ❑ I stay in bed most of the time because of my back.

Signature: _____ **Date:** _____

BACK/NECK BOURNEMOUTH QUESTIONNAIRE

Patient Name _____ Date_____

Instructions: The following scales have been designed to find out about your back/neck pain and how it is affecting you. Please answer ALL the scales, and mark the ONE number on EACH scale that best describes how you feel.

1. Over the past week, on average, how would you rate your back/neck pain?

No pain Worst pain possible

0 1 2 3 4 5 6 7 8 9 10

2. Over the past week, how much has your back/neck pain interfered with your daily activities (housework, washing, dressing, walking, climbing stairs, getting in/out of bed/chair)?

No interference Unable to carry out activity

0 1 2 3 4 5 6 7 8 9 10

3. Over the past week, how much has your back/neck pain interfered with your ability to take part in recreational, social, and family activities?

No interference Unable to carry out activity

0 1 2 3 4 5 6 7 8 9 10

4. Over the past week, how anxious (tense, uptight, irritable, difficulty in concentrating/relaxing) have you been feeling?

Not at all anxious Extremely anxious

0 1 2 3 4 5 6 7 8 9 10

5. Over the past week, how depressed (down-in-the-dumps, sad, in low spirits, pessimistic, unhappy) have you been feeling?

Not at all depressed Extremely depressed

0 1 2 3 4 5 6 7 8 9 10

6. Over the past week, how have you felt your work (both inside and outside the home) has affected (or would affect) your back/neck pain?

Have made it no worse Have made it much worse

0 1 2 3 4 5 6 7 8 9 10

7. Over the past week, how much have you been able to control (reduce/help) your back/neck pain on your own?

Completely control it No control whatsoever

0 1 2 3 4 5 6 7 8 9 10

Signature:_____ Date:_____