Important Information About Your Injury, Treatment and Recovery

- It is EXTREMELY important that you Take Your Time to fill out the information in this packet. Please fill it out to the best of your ability. In order to get your recovered to pre-injury status, our clinic needs the most accurate information – no detail is too large or small. If you have any questions at any time, stop and contact us.
- During your care at this clinic we ask THREE items from you as the patient:
    1. Stay off all Social Media Sites – **GO DARK**. Information about you and your condition can be gathered online and may be used against you; which prevents you from obtaining the care that you need to heal from this injury.
    2. Journaling – we ask that you make a journal entry each day during your treatment at our clinic. This information helps us to see what your daily status of pain is affecting your life and to ensure that our services are aiding in your healing process.
    3. Follow Your Treatment Care Plan – it is imperative that you follow through with all recommended treatment care plans. Make your treatments a priority – by doing this you will ensure that you will heal in a timely manner and achieve recovery goals.
- Finally – if at any time you have questions about your treatment at our clinic, please ask freely of your provider or front desk staff. Your feedback and ultimately your recovery are our priorities.

MOTOR VEHICLE COLLISION BILLING

Advanced Health Chiropractic and Massage will bill an auto insurance company for services related to a motor vehicle collision ONLY under the following circumstances:

1) The auto insurance company we are billing is your own- A.K.A your Personal Injury Protection (PIP) coverage.
2) The auto insurance company we are billing is for the vehicle in which you were a passenger- A.K.A. **their** PIP coverage.

If PIP coverage is not available to you, Advanced Health Chiropractic and Massage DOES NOT wait for settlement to receive payment for these collision related services. Depending on your circumstances, your billing for these services will be handled as follows:

If you have health insurance:

Your health insurance policy will be billed. You are responsible for notifying your health plan that these services are related to a Motor Vehicle Collision. They will want to collect from the party at fault when your treatment is concluded. You will be responsible for payment of any co-payments, deductibles, co-insurance, or any other insurance deemed patient remainders as services are rendered.

If you do not have health insurance:

In the event you are not covered by PIP coverage AND you do not have health insurance, you are solely responsible for payment for these services at the time services are rendered.

Signature_____ Date_____

For PIP coverage billing, please provide the following information:

Name of Motor Vehicle Insurance: _____

Insurance Plan Address:_____

Street/ PO Box:_____

City:_____ State:_____ Zip Code:_____

Claim Number:_____ Date of Accident:_____

Claim Adjustor's Name:_____ Phone #:_____

Patient Information Today's Date: _____

Name _____ Age _____ Gender: M F (Pregnant: Yes No)

Home Address _____ Phone _____

City, State, Zip _____ Appointment Reminders? No Yes (See Next Line)

Email Address _____ Cell Phone Provider: _____

Birth date _____ Social Security Number _____ Marital Status: S M D W P

Occupation, Employer _____How many people in your household? _____

Emergency Contact _____ Phone _____

How were you referred to this office? _____

Who is your Primary Care Doctor? _____

Is This Visit Related To A: Work Injury Car Collision Injury Home Injury Non-Injury Symptoms Gradual Onset Other

Experience with Chiropractic **DO YOU HAVE P.I.P.?** Yes No Not Sure

Have you seen a Chiropractor before? □Yes □No Who? _____

Reason for visit(s) with previous provider: _____

Did your previous provider take x-rays? □Yes: Year _____ □No What was the diagnosis? _____

Did they recommend a specific course of treatment? □Yes □No

Did they recommend a home health care program? □Yes □No If yes, what? _____

How long were you treated? _____ Last treatment date: _____

How did you respond? _____ Have you ever had Massage Therapy Treatments? Yes No

Health & Lifestyle

Do you exercise? □Yes □No How often? _____ day(s) per week; Do You Play An Instrument:_____

What are your current Hobbies? _____

Do you smoke? □Yes □No How much/how often? _____

Do you drink alcohol? □Yes □ No How much/how often? _____

Do you drink coffee? □Yes □No How much/how often?_____

How much water do you drink daily? _____ cups (1 cup = 8oz)

Do you take supplements? □Yes □No Please list: _____

Do you sleep on your: □ Back □ Side □ Stomach

Health History

Indicate whether **F**ather, **M**other, **S**ister, **B**rother, or **Y**ourself have been diagnosed with the following:

___ **STROKE**	___ Diabetes	___ Neurological Problems	___ Lung Disease	___ Lumbago
___ Heart Disease	___ Circulatory Problems	___ Whooping Cough	___ Heart Murmur	___ Eczema/Psoriasis
___ Cancer	___ Broken Bones/Fractures	___ Pneumonia/Bronchitis	___ Osteoporosis	___ Varicose Veins
___ High Blood Pressure	___ Paralysis	___ Arthritis	___ Rheumatic Fever	___ Small Pox
___ Liver Disease	___ Metal Implants	___ Infectious Disease	___ Gall Bladder	___ Measles
___ Migraine Headaches	___ Appendectomy	___ Tonsillectomy	___ Hernia	___Pleurisy
___ Kidney Disease	___ Polio	___ Tuberculosis	___ Anemia	___ Mumps
___ Epilepsy/Seizures	___ Chicken Pox/Shingles	___ Blood Sugar Problems	___ Influenza	___Thyroid Problems

___ Other: _____

Injury History

List **ALL** past **Auto Collisions**, Month/Year, type of collision (rear-end, side impact) and if care was given.

1._____

2._____

List ALL **Worker's Compensation** claims, Injured Body Regions, Month/Year, and what type of care received.

1. _____

2. _____

List ALL past **Hospitalizations and Surgeries** (including augmentation), Month/Year, and type of injury.

1. _____

2. _____

3. _____

Please list all **medications** you are currently taking:_____

Patient Name: _____ Today's Date: _____

Claim #: _____ Date of Collision: _____

Please answer the questions below. If you do not know the answer to a question, do not answer that question.

1. Your Vehicle Type
□ Car □ Truck
□ Van □ Bus
Year: _____
Make: _____
Model: _____

2. Your Position in the Car
□ Driver □ Front Passenger
□ Left Rear Passenger
□ Right Rear Passenger
□ Other _____

3. What was your vehicle doing at the time of the collision?
□ Stopped @ Intersection □ Stopped in traffic □ Stopped at Light
□ Making a Right Turn □ Making a Left Turn □ Parking
□ Proceeding along □ Slowing Down □ Accelerating
□ Other _____

4. Time/Speed/Damage
Time of Accident: _____
Your Speed: _____ mph
Their Vehicle's Speed:
_____ mph
Cost of Damage to Car?
$_____
Was Vehicle Totalled?
Yes □ □ No

5. Details of Collision
Visability at time of collision
□ Poor □ Fair □ Good

Who hit who/what?
□ You hit other vehicle/object
□ Other Vehicle hit you

You Hit….(object)
_____

6. Road Conditions
Road conditions at the time of collision
□ Icy □ Snowy □ Sandy □ Dark □ Clean and Dry
Weather conditions at time of collision
□ Sunny □ Cloudy □ Foggy □ Rainy □ Snowing
Point of Impact
□ Head-On □ Left Front □ Right Front
□ Rear-End □ Left Rear □ Right Rear
Was your vehicle moved during the impact?
□ No □ Less than 1/2 car length □ 1/2 car length
□ One car length □ More than one car length

7. Other Vehicle Type
□ Car □ Truck
□ Van □ Bus
Year: _____
Make: _____
Model: _____

8. What was their vehicle doing at the time of the collision?
□ Stopped @ Intersection □ Stopped in traffic □ Stopped at Light
□ Making a Right Turn □ Making a Left Turn □ Parking
□ Proceeding along □ Slowing Down □ Accelerating
□ Other _____

9. Body Position
Did you see the collision coming? Yes □ □ No
Were you braced for the impact? Yes □ □ No
Did you have a seat belt on? Yes □ □ No
Did you have a shoulder harness on? Yes □ □ No
Do you have any bruising/tenderness in the area of the seatbelt? Yes □ □ No

At the time of the collision, what was the position of your hands?
_____
At the time of the collision, what was the position of your legs?
_____
At the time of the collision, were you wearing:
□ Eyeglasses □ Hat □ Other _____

Driver steering wheel air bag deploy? **Yes** □ □ **No** Passenger airbag deploy? **Yes** □ □ **No** Side airbags deploy? **Yes** □ □ **No**
If yes, did you receive any injury from the airbag? _____

Does your vehicle have headrests? Yes □ □ No
What was the position of your headrest a the time of the impact?
□ Even with top of head □ Even with bottom of head □ Middle of Neck
Did your head go back over the top of the headrest?
□ Yes □ No □ Unsure
Was the headrest altered or damaged in the collision?
□ Yes □ No
What was the direction of your head at the time of the impact?
□ Facing straight forward □ Turned to the right □ Turned to the left
□ Forward and looking up □ Forward and looking down

On what part of the vehicle did the following body parts hit:

Head Hit:
Chest Hit:
Right/Left Shoulder:
Right/Left Arm:
Right/Left Hip:
Right/Left Leg:
Right/Left Knee:
Other:

Which of the following car parts were damaged during this collision?
□ Windshield □ Steering Wheel □ Seat Belt
□ Drivers Window □ Front Seat Back
□ Passenger Window □ Other _____

What bruises and cuts did you get from this collision?:

10. Treatment History
Fill in any other doctor(s) seen prior to your first visit to this office.
1. Dr. _____ First visit date: _____
Specialty: _____ XRAYS done: Yes □ □ No
Type of treatment received? _____
How many treatments received? _____
Did treatments benefit you? Yes □ □ No Last Visit Date: _____

Patient Name: _____ Today's Date: _____

11. After the accident

Did authorities show up?
□ WA State Patrol □ City Police
□ County Police □ No Investigation

When did you first notice pain or symptoms?
□ Immediately □ Within 24 Hours
□ Within 1-7 Days □ Other

Did your head hit any part of the car?
Windshield Yes □ □ No
Dashboard Yes □ □ No
Other Passenger Yes □ □ No
Steering Wheel Yes □ □ No
Side Car Window Yes □ □ No
Mirror Yes □ □ No

What part of your head was hit?
Forehead Yes □ □ No
Back of head Yes □ □ No
Left side of head Yes □ □ No
Right Side of head Yes □ □ No
Top of head Yes □ □ No
Other: _____

Did you black out? Yes □ □ No

Have you lost any memories prior to your injury? Yes □ □ No

Immediately after were you:
□ Dazed □ Angry □ Confused
□ In Shock □ Scared □ Other:

Has your memory been different since your injury? Yes □ □ No

Did you have a lump or bruise on a part of your head? Yes □ □ No

Have you had any head injuries in your past? Yes □ □ No

Please Explain:

Where did you go after the accident?
□ Home □ Work □ ER □ Private Doctor

How did you get there?
□ Drove Self □ Police □ Ambulance □ Somebody Else

Were XRAYS taken? Yes □ □ No **Was lab work done? Yes □ □ No**

Body parts XRAYed? _____

What lab work? _____

The XRAYS revealed: _____

Did you have an MRI or CT Scan? Yes □ □ No

Treatments: □ Cervical Collar □ Ice □ Other: _____

Medications: _____

Follow-Up Instructions: _____

Check off your symptoms right after and a few days following:

□ Headaches □ Dizziness □ Loss of Concentration
□ Neck pain □ Nausea □ Reduced Drive/Motivation
□ Neck Stiffness □ Confusion □ Reduced Tolerance to Alcohol
□ Fainting □ Fatigue □ Absence of ability to Anticipate
□ Ringing in Ears □ Tension □ Difficulty Finishing Task
□ Loss of Smell □ Irritability □ Abnormal Levels of Anxiety
□ Poor Memory □ Inflexibility □ Impaired Sexual Function
□ More Assertive □ LanguageDifficulty □ Difficulty handling multiple tasks
□ Forgetful □ Personality Change □ Less Diplomatic than Normal
□ Anger Outbursts □ Head Tremors □ Reduced Attention Span
□ Depression □ Mood Swings □ Indifference to other People
□ Mid Back Pain □ Cold Hands □ More Shallow Relationships
□ Low Back Pain □ Cold Feet □ Difficulty with Problem Solving
□ Nervousness □ Diarrhea □ Less Mental Stamina
□ Loss of Taste □ Depression □ Performance Inconsistencies
□ Toe Numbness □ Anxious □ Verbal Learning Problems
□ Constipation □ Chest Pain □ Slower Reaction Times
□ Fatigue □ Impaired Judgement □ Sleeping Problems
□ Blackouts □ Blurry Vision □ Shortness of Breath
□ Loss of Balance □ Need Reminders
□ Pain behind eyes
□ Others: _____

12. Please describe, to the best of your knowledge, exactly what happened minutes before the collision to when you arrived home. Including car positioning, surroundings, road conditions, car speed, who helped, etc.

Please draw the position of the car(s), the street(s) and any other objects.

Is This Visit Related To A:	Work Injury	Car Collision Injury	Home Injury	Non-Injury Symptoms	Gradual Onset	Other

Patient Name:

What brought you in to see us today?

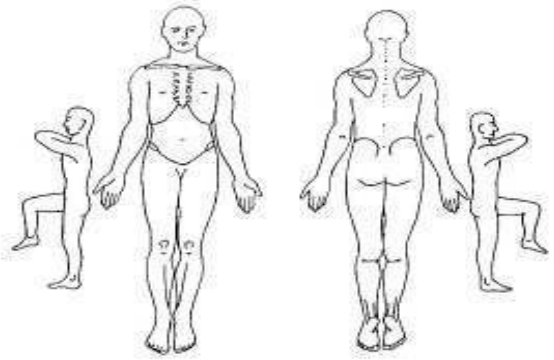
How did you hurt yourself?

When did the symptoms begin?

On the picture below, use the **indicated marks** to show areas where you have, at any time, experienced:

Indicator Marks:

Pain:	**XXXX**
Numbness:	**////**
Tingling:	********



Please indicate your pain from 0-10; with 10 being the worst pain and 0 being no pain.
Circle all that Apply

Neck ____/10; At Worst ____/10; At Best ____/10

Is the pain on the: **Left** **Right** **Center**

Type of Pain:

Burning Numbness
Stabbing Dull Sharp
Throbbing Tight Aching
Tingling Tender

How Often is Pain during Waking Hours?

Intermittent (0-25%) Frequent (51-75%)
Occasional (26-50%) Constant (76-100%)

Are you experiencing Headaches? Yes □ □ No
If yes how often?

Are you experiencing pain down your arms? Yes □ □ No
If yes, Left Arm or Right Arm or Both

How do the following motions affect your pain?

	No Change	Relieves	Increased
Looking Up	□	□	□
Looking Down	□	□	□
Right Head Rotation	□	□	□
Left Head Rotation	□	□	□

Mid-Back ___/10; At Worst ___/10; At Best ____/10

Is the pain on the: **Left** **Right** **Center**

Type of Pain:

Burning Numbness
Stabbing Dull Sharp
Throbbing Tight Aching
Tingling Tender

How Often is Pain during Waking Hours?

Intermittent (0-25%) Frequent (51-75%)
Occasional (26-50%) Constant (76-100%)

Do you get pain with breathing? Yes □ □ No
If Yes, Where? _____

Does your pain wrap around your ribs? Yes □ □ No
If Yes, Where? _____

How many hours per day do you sit in a chair? _____ hrs

How many hours per day are you at a computer? _____ hrs

Low-Back ___/10; At Worst __/10; At Best ___/10

Is the pain on the: **Left** **Right** **Center**

Type of Pain:

Burning Numbness
Stabbing Dull Sharp
Throbbing Tight Aching
Tingling Tender

How Often is Pain during Waking Hours?

Intermittent (0-25%) Frequent (51-75%)
Occasional (26-50%) Constant (76-100%)

Do you have pain with coughing, sneezing or going to the bathroom? Yes □ □ No
If Yes, Where? _____

Do you have pain in butt or down the leg? Yes □ □ No

How do the following motions affect your pain?

	No Change	Relieves	Increased
Sitting	□	□	□
Walking	□	□	□
Standing	□	□	□
Lying Down	□	□	□
Lifting	□	□	□
Bending	□	□	□

Patient: _____ Date: _____

List of Extremities:

Shoulder	TMJ/Jaw	Knee
Elbow	Ribs	Ankle
Wrist	Hand	Foot

Please indicate Right or Left by Circling R or L

Extremity: **R L**_____ ___/10

Type of Pain:	Burning	Numbness
Stabbing	Dull	Sharp
Throbbing	Tight	Aching
Tingling	Tender	

How Often is Pain during Waking Hours?

Intermittent (0-25%)	Frequent (51-75%)
Occasional (26-50%)	Constant (76-100%)

Extremity: **R L**_____ ___/10

Type of Pain:	Burning	Numbness
Stabbing	Dull	Sharp
Throbbing	Tight	Aching
Tingling	Tender	

How Often is Pain during Waking Hours?

Intermittent (0-25%)	Frequent (51-75%)
Occasional (26-50%)	Constant (76-100%)

What have you done to try to relieve the pain?

Heat	Ice	Stretching	Nothing Helps
Rest	Medicine	Massage	Other:

Have you seen another professional for this condition?

Medical Doctor: _____

Chiropractor: _____

Physical Therapist: _____

Other: _____

Prior Similar Symptoms

□ I have NOT had prior symptoms similar to my current complaints

□ My current complaints DID exsist before, but have not been bothering me.

□ My current complaints ALREADY existed and were worsened.

Has your History contributed to your current symptoms?

□ My history HAS contributed to my current symptoms.

□ My history HAS NOT contributed to my current symptoms.

□ I'm NOT SURE if my history has contributed.

Circle the TOP 3 activities which are most affected by your pain. Circling an activity does not necessarily mean you are unable to perform it, it simply means your pain affects the activity, even just your enjoyment.

Walking	Sitting	Showering	Jogging	Standing	Dishes
Reading	Driving	Sex	Shaving	Gym	Chores
Working	Swimming	Sleeping	Bending	Dressing	Gardening

Please mark each that apply to your Daily Activities:

□ Stays at home most of the time due to the problem

□ Changes position frequently to try and get comfortable

□ Walks more slowly than usual because of the problem

□ Does not do jobs about the house because of the problem

□ Has to use handrails to get up the stairs

□ Has to lie down and rest frequently due to the problem

□ Has to hold onto something to sit or stand from a chair

□ Has to get other people to do things for you

□ Has difficulty getting dressed due to the problem

□ Can only stand for short periods due to the problem

□ Has difficulty bending or kneeling due to the problem

□ Has difficulty turning over in bed due to the problem

□ Has a loss of appetite due to the problem

□ Can only walk short distances because of the problem

□ Has difficulty sleeping because of the problem

□ Has to get dressed with someone's help

□ Has to sit most of the day because of the problem

□ Is more irritable because of the problem

□ Stays in bed most of the day because of the problem

How often do you have to stop activities to sit or lie down to control your pain?

□ All Day

□ Several times a day

□ Occasionally

□ Approx Once per day

□ Never

Patient: _____ Date: _____

NECK PAIN DISABILITY INDEX QUESTIONNAIRE

Name: _____ **Date:** _____

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 apply to you, but please just circle the one choice which most clearly describes your problem right now.

Section 1: Pain Intensity
1) I have no pain at the moment.
2) The pain is very mild at the moment.
3) The pain is moderate at the moment.
4) The pain is fairly severe at the moment.
5) The pain is very severe at the moment.
6) The pain is the worst imaginable at the moment.

Section 2: Recreation
1) I am able to engage in all of my recreational activities, with no neck pain at all.
2) I am able to engage in all of my recreational activities, with some pain in my neck.
3) I am able to engage in most, but not all of my usual recreational activities because of pain in my neck.
4) I am able to engage in a few of my usual recreational activities.
5) I can hardly do any recreational activities because of pain in my neck.
6) I cannot do any recreational activities at all.

Section 3: Lifting
1) I can lift heavy weights without extra pain.
2) I can lift heavy weights, but it causes extra pain.
3) Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned, e.g. on a table
4) Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
5) I can lift very light weights.
6) I cannot lift or carry anything at all.

Section 4: Reading
1) I can read as much as I want to with no pain in my neck.
2) I can read as much as I want to with slight pain in my neck.
3) I can read as much as I want to with moderate pain in my neck.
4) I cannot read as much as I want because of moderate pain in my neck.
5) I cannot read as much as I want because of severe pain in my neck.
6) I cannot read at all.

Section 5: Headaches
1) I have no headaches at all.
2) I have slight headaches, which come frequently.
3) I have moderate headaches, which come infrequently.
4) I have moderate headaches, which come frequently.
5) I have severe headaches, which come frequently.
6) I have headaches almost all of the time.

Section 6: Concentration
1) I can concentrate fully when I want to with no difficutly.
2) I can concentrate fully when I want to with slight difficuly.
3) I have a fair degree of dificulty in concentrating when I want to.
4) I have a great deal of difficulty in concentrating when I want to.
5) I have a great deal of difficulty in concentrating when I want to.
6) I cannot concentrate at all.

Section 7: Work
1) I can do as much work as I want to.
2) I can do only my usual work, but no more.
3) I can do most of my usual work, but no more.
4) I cannot do my usual work.
5) I can hardly do any work at all.
6) I cannot do any work at all.

Section 8: Driving
1) I can drive my car without any neck pain.
2) I can drive my car as long as I want with slight pain in my neck.
3) I can drive my car as long as I want with moderate pain in my neck.
4) I cannot drive my car as long as I want because of moderate pain in my neck.
5) I can hardly drive at all because of severe pain in my neck.
6) I cannot drive my car at all.

Section 9: Sleeping
1) I have no trouble sleeping.
2) My sleep is slightly disturbed (less than 1 hr sleepless.)
3) My sleep is mildly disturbed (1-2 hrs sleepless).
4) My sleep is moderately disturbed (2-3 hrs sleepless).
5) My sleep is greatly disturbed (3-5 hrs sleepless).
6) My sleep is completely disturbed (5-7 hrs sleepless).

Section 10: Personal Care
1) I can look after myself normally without causing extra pain
2) I can look after myself normally, but it causes extra pain
3) It is painful to look after myself and I am slow and careful
4) I need some help, but manage most of my personal care.
5) I need help every day in most aspects of self-care.
6) I do not get dressed, I was with difficulty and stay in bed.

REVISED OSWESTRY CHRONIC LOW BACK PAIN DISABILITY QUESTIONNAIRE

Name: _____ **Date:** _____

Section 1: Pain Intensity
1) The pain comes and goes and is very mild.
2) The pain is mild and does not vary much.
3) The pain comes and goes and is moderate.
4) The pain is moderate and does not vary much.
5) The pain comes and goes and is severe.
6) The pain is severe and does not vary much.

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

Section 3: Lifting
1) I can lift heavy weights without extra pain.
2) I can lift heavy weights but it causes extra pain.
3) Pain prevents me from lifting heavy weights off the floor.
4) Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned, e.g. on a table.
5) Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are convienently positioned.
6) I can only lift very light weights, at the most.

Section 4: Walking
1) Pain does not prevent me from walking any distance.
2) Pain prevents me from walking more than one mile.
3) Pain prevents me from walking more than 1/2 mile.
4) Pain prevents me from walking more than 1/4 mile.
5) I can only walk while using a cane or on crutches.
6) I am in bed most of the time and have to crawl to move.

Section 5: Sitting
1) I can sit in any chair as long as I like without pain.
2) I can only sit in my favorite chair as long as I like.
3) Pain prevents me from sitting more than one hour.
4) Pain prevents me from sitting for more than 1/2 hour.
5) Pain prevents me from sitting more than ten minutes.
6) Pain prevents me from sitting at all.

Section 6: Standing
1) I can stand as long as I want without pain.
2) I have some pain while standing, but it does not increase with time.
3) I can not stand for longer than one hour without increasing pain.
4) I can not stand for longer than 1/2 hour, without increasing pain.
5) I can not stand for longer than ten minutes, without increasing pain.
6) I avoid standing, because it increases the pain right away.

Section 7: Sleeping
1) I get no pain in bed.
2) I get pain in bed, but it doesn't prevent me from sleeping well.
3) Because of my pain, my normal night's sleep is reduced by less than 1/4
4) Because of my pain, my normal night's sleep is reduced by less than 1/2
5) Because of my pain, my ormal night's sleep is reduced by less than 3/4
6) Pain prevents me from sleeping at all.

Section 8: Social Life
1) My social life is normal; it gives me no pain.
2) My social life is normal, but increases the degree of my pain.
3) Pain has no significant effect on my social life apart from limiting my more energetic interests, e.g. dancing, etc.
4) Pain has restricted my social life; I do not go out very often.
5) Pain has restricted my social life to my home.
6) I have hardly any social life because of the pain.

Section 9: Traveling
1) I get no pain while traveling.
2) I get some pain while traveling, but none of my usual forms of travel make it any worse.
3) I get extra pain while traveling, but it does not compel me to seek alternate forms of travel.
4) I get extra pain while traveling which compels me to seek alternative forms of travel.
5) Pain restricts all forms of travel.
6) Pain prevents all forms of travel except that done lying down.

Section 10: Changing Degree of Pain
1) My pain is rapidly getting better.
2) My pain fluctuates, but overall is definitely getting better.
3) My pain seems to be getting better, but improvement is slow at present.
4) My pain is neither getting better nor worse.
5) My pain is gradually worsening.
6) My pain is rapidly worsening.

Pain Disability Questionnaire

Name: _____ Date: _____

Instructions: This survey asks for your views about how your pain affects how you function in everyday activities. This information will help you and your doctor know how you feel and how well you are able to do your daily tasks at this time.

Please answer every question by marking and "X" along the line to show how much your pain problem has affected you (from having no problems at all to having the most severe problems you can imagine).

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

Work Normally				Unable to work at all

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

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

3. Does your pain interfere with your traveling?

Travel anywhere I like				Only travel to see Doctors

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

No problems				Cannot do at all

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

No problems				Cannot do at all

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

No problems				Cannot do at all

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

No problems				Cannot do at all

Complete Page 2 ⟶

Pain Disability Questionnaire

Name: _____ Date: _____

8. Has your income declined since your pain began?

No Decline Lost all income

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

No medication needed On pain medication throughout the day

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

Never see doctors See doctors weekly

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

No problem Never see them

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

No interference Total interference

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

Never need help Need help all the time

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

No depression/tension Severe depression/tension

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

No problems Severe Problems

Office Use Only

Functional: 1_____ +2_____ +3_____ +4_____ +5_____ +6 _____ +7_____ +12 _____ +13 _____ = _____

Psychosocial: 8 _____ +9 _____ +10 _____ +11 _____ +14 _____ +15 _____ = _____

Total = _____