DEWALD CHIROPRACTIC
PATIENT QUESTIONNAIRE

Dear Patient:

It is important in any patient treatment to establish a complete and accurate base of personal and historical information. This information is very helpful in the proper diagnosis of any present and past problems, and aids in the direction making process on an effective treatment plan. Therefore, **your help and cooperation in answering this questionnaire as completely and accurately as possible is necessary and appreciated.** This information will help all the people involved in handling your treatment to insure that you receive your maximum benefit.

PATIENT INFORMATION:

Name: ____________________ Age: _______
Address: ____________________
City:____________________ State:__________ Zip:__________
Phone No.: (___)__________Cell No.: (___)__________Work No.: (___)__________
Date Of Birth: __________ SSN: __________
E-mail:____________________
Are You? ( ) Married ( ) Single ( ) Separated ( ) Divorced ( ) Widowed
Spouse/Parent Name____________________
Number Of Children: ____ Boys ____Girls Ages:__________
____ Male ____ Female ____ Right Handed ____Left Handed ____Both
Whom may we thank for referring you?____________________
Name and Phone # To Notify In Case Of Emergency____________________
Relationship to you:____________________

EMPLOYER INFORMATION: (__) Check If None

Name Of Business: ____________________ Phone No.: (____) __________
Address:____________________
Occupation:____________________

INSURANCE INFORMATION: (__) Check If None

Insurance Carrier: ____________________Phone No.: (____)__________
Address:____________________
Health Plan: ____________________
Group No.:____________________ID#__________
Primary Insured:____________________ SSN:__________
Insured's Employer:____________________ Date of Birth:__________

Information About Your Pain/ Injury

Please describe how your pain started:____

____

____

Did your symptoms come on ___Suddenly ___Gradually **If "gradually"**, over what period of time?____

What makes it better?____

What makes it worse?____

Do you treat yourself?____ YES ____ NO If yes, please explain how:______________

____

____

Are you currently taking medication to relieve the effects of this injury? ___ YES___ NO
If YES, please list what you take, how much, how often you take it, etc.: ______________

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Are you currently using a brace, support, cane, crutch(es), wheelchair, tens unit, or other aid because of the effects of the injury?___ YES ___NO If YES, please describe type and how often it is used:____

____

____

Have you ever experienced the same or similar symptoms/problems **BEFORE** this injury?
___ YES ___ NO If yes, please explain in detail:_____________________________

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Have you had any **PRIOR** work injury(ies)? ___ YES ___NO If yes, please explain:

____

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Have you ever had any sprains/starins, slip/falls, Motor Vehicle Accidents, Cumulative or repetitive traumas, etc.? ___YES ___NO If yes, please explain:______________________

____

____

CURRENT SYMPTOMS:

COMPLAINT #1: ______________________________
What Percentage Of The Time Do You Experience/Feel This Symptom? ________%
What Activities Make This Symptom Worse? ______________________________
____
What Makes This Symptom Better? ______________________________
____
Can/Do You Have This Symptom Without Activity? ______________________________
Pain Scale ________________ 0 (no pain) – 10 (severe pain).
Which side is worse? Right_____ Left_____ Both_____

COMPLAINT #2: ______________________________
What Percentage Of The Time Do You Experience/Feel This Symptom? ________%
What Activities Make This Symptom Worse? ______________________________
____
What Makes This Symptom Better? ______________________________
____
Can/Do You Have This Symptom Without Activity? ______________________________
Pain Scale ________________ 0 – 10.
Which side is worse? Right_____ Left_____ Both_____

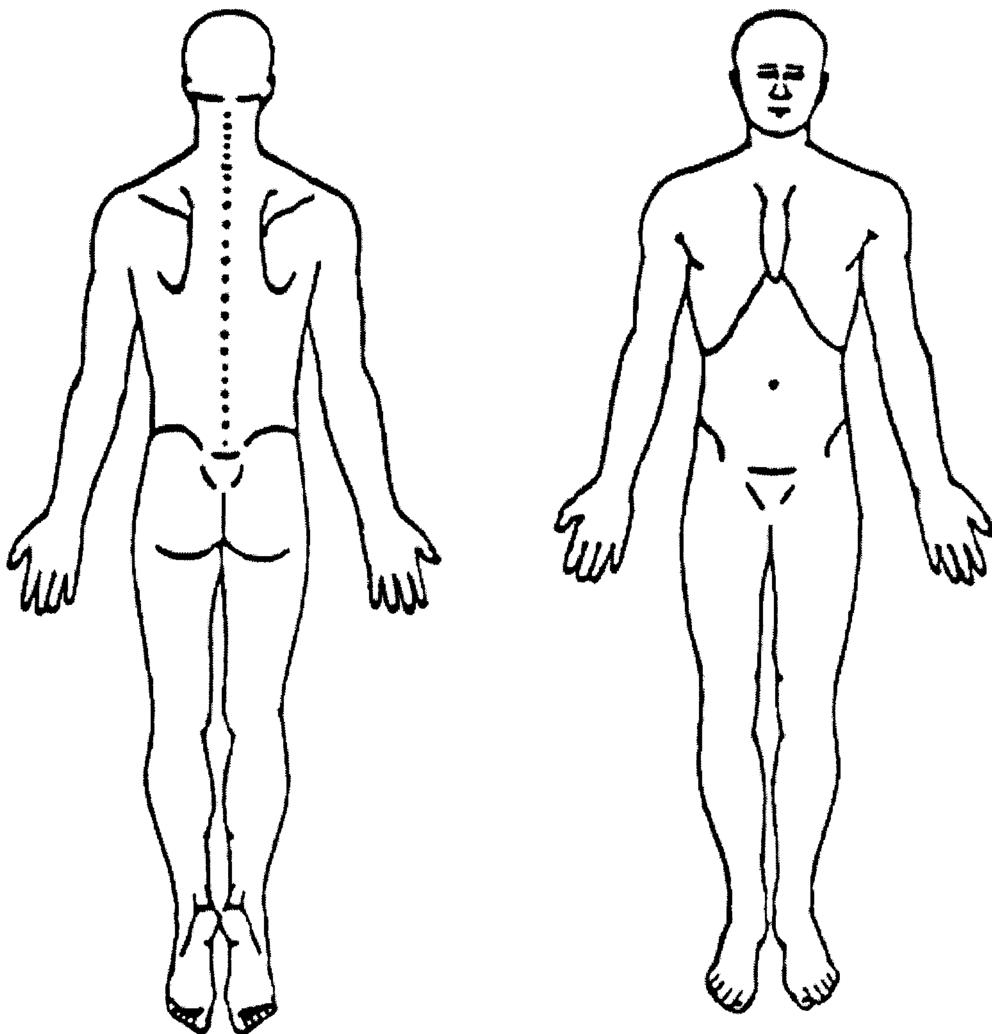
COMPLAINT #3: ______________________________
What Percentage Of The Time Do You Experience/Feel This Symptom? ________%
What Activities Make This Symptom Worse? ______________________________
____
What Makes This Symptom Better? ______________________________
____
Can/Do You Have This Symptom Without Activity? ______________________________
Pain Scale ________________ 0 – 10.
Which side is worse? Right_____ Left_____ Both_____

PAIN SCALE

0-1	=	**Minimal**	=	The pain is an annoyance but does not stop me from working.
2-3	=	**Slight**	=	I can tolerate the pain but it causes some difficulty in doing my work. However, it does not stop me from working.
5	=	**Moderate**	=	The pain causes a marked handicap in my ability to work, but I can continue.
7-8	=	**Moderate To Severe**	=	The pain is approaching the worst I have ever experienced or could imagine. It causes a significant problem with working and most of the time I can't.
10	=	**Severe**	=	The pain is the worst I have ever experienced or could imagine and causes me to stop all work and activity.

Mark The Areas On Your Body Where You Are Having Symptoms.

P = Pain **N** = Numbness/Tingling **T** = Tenderness **B** = Burning **R** = Radiating



Time of day that pain is worse?________________________________

Does pain increase with activity?________________________________

Any difficulty doing household duties (outside)?________________________

Any difficulty doing work duties?________________________________

Any difficulties doing domestic duties (indoor)?________________________

JOB DESCRIPTION:

What Is Your Job Title?: ______________________________
How Many Hours Per Day Do You Normally Work? ______________________
What Hours Do You Normally Work?______________________________
How Many Days Per Week Do You Work? ______________________

At Work, How Many Hours Per Day Do You Do These Activities?

____ Sit ____ Walk ____ Stand ____ Kneel
____ Squat ____ Climb ____ Bend ____ Twist
____ Reach ____ Crawl ____ Push ____ Pull
____ Keyboard ____ Type ____ Mouse ____ Write
____ Finger ____ Grasp
____ Work Overhead
____ Flex/Twist/Side-Bend/Extend Your Neck

Please list your job duties/ activities at work:
A)______________________________
B)______________________________
C)______________________________
D)______________________________
E)______________________________

Are you required to **LIFT AT WORK?** ____YES ____ NO If yes, please answer the following:

Objects Lifted	Weight in Pounds	Times Per Day	Distance Carried
1)			
2)			
3)			
4)			

Do you have to bend over or lean forward while lifting?______ YES ______ NO
Does your job require you to reach below, above or at shoulder level? ___ YES ___ NO If yes, please explain:______________________________
____

Are you required to move your feet in a repetitive movement/ activity ___YES ___ NO If yes, please describe:______________________________
____

Are you required to use your hands for fine manipulation, grasping, pushing, pulling, torquing?___YES ___ NO If yes, please describe:______________________________
____

PAST MEDICAL HISTORY:

Please List **The Information About Your Medical History** In The Sections Below, With The **Approximate Dates**. If A Section Does Not Apply, Simply Mark An **(X)** In The 'Denied' Box:

Illnesses: ( ) Denied ______________________
Injuries: ( ) Denied ______________________
Allergies: ( ) Denied ______________________
Present Medications Taken (Prescription & Over-The-Counter): ( ) Denied ______________________

Surgeries: ( ) Denied ______________________

Hospitalizations: ( ) Denied ______________________

Doctor(s) Seen Previous To Your Current Work Injury: Name & Location/City: ( ) Denied ___

Prior Chiropractors: ( ) Denied Who?______________________
Where?______________________When?______________________Why?______________________

REVIEW OF SYSTEMS:

Please List Any Problems That You **Now Have** With The Following Body Systems:

Ears/Nose/Throat: ( ) Denied ______________________
Eyes: ( ) Denied ______________________
Lungs: ( ) Denied ______________________
Liver: ( ) Denied ______________________
G-I Tract (Stomach, Intestines, Bowels, etc.): ( ) Denied ______________________
Kidney/Bladder: ( ) Denied ______________________
Reproductive System: ( ) Denied ______________________
Skin: ( ) Denied ______________________
Neurological: ( ) Denied ______________________
Heart/Circulation: ( ) Denied ______________________
Psychological: ( ) Denied ______________________

FAMILY HISTORY:

Please Tell Us About **Your Immediate Family**: (Mother, Father, Brother, Sister)

Father: Alive____ Deceased____ Year_____ Age_____
Mother: Alive____ Deceased____ Year_____ Age_____
Brother: Alive____ Deceased____ Year_____ Age_____
Sister: Alive____ Deceased____ Year_____ Age_____

OFF WORK ACTIVITIES:

Do You Exercise? ___ YES ___ NO If 'YES', Please Describe Type & Frequency. If 'NO', Please Explain Why You Don't: ____________________

____

Do You Participate In Any Sports Activities? ___ YES ___ NO If 'YES', Please Describe Type & Frequency: ____________________

____

Do You Have Any Hobbies? ___ YES ___ NO If 'YES', Please Describe Type & Frequency:
Are You Able To Perform Your Normal/Regular Household Chores/Activities? ___ YES ___ NO
If 'NO', Please Explain What You Cannot Do & Why: ____________________

____

SOCIAL HISTORY:

How Many Years Of Schooling Have You Had? ____________________
List Degrees, Diplomas, Licenses, Certifications You Hold: ____________________
Do You Use Alcohol? ___ YES ___ NO If 'YES', How Many Drinks Per Week? ________
Do You Use Tobacco? ___ YES ___ NO If 'YES', What Kind & Times Per Day Or Week?

____

Do You Use Drugs? ___ YES ___ NO If 'YES', What Kind & How Many Times Per Day Or Week? ____________________

INFORMED CONSENT FOR TREATMENT

I understand that, as with any medical treatment, there are side effects associated with chiropractic treatment. These may include, but are not limited to: pain, stiffness, headaches, dizziness or fatigue. I also understand that although the doctor will examine me to rule out any high-risk situations, there is still a remote chance of paralysis, stroke or even death. To help the doctor with his treatment, I certify that I have filled out this questionnaire to the best of my ability, and am responsible for any errors or omissions.

(*initial*)________

ASSIGNMENT OF BENEFITS

I, the undersigned certify that I, (or my dependent) have insurance coverage, and hereby assign any benefits paid on my behalf for services rendered, to be paid directly to Dewald Chiropractic, Inc. I hereby authorize Dewald Chiropractic to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions. However, I clearly understand and agree that although insurance billing services are provided as a courtesy, ***all services rendered to me are my personal and direct responsibility***, as well as any co-pays or deductibles which may apply.

(*initial*)________

FINANCIAL POLICY

Unless prior arrangements are made, payment is due at the time the services are rendered. I understand that I will be charged a $10.00 late fee for all unpaid balances past the one time 30 day courtesy billing, and that interest may be added at 1.5% per month for any unpaid balances. In the unfortunate event that it becomes necessary, any collection costs will also be added.
****** Any appointment not cancelled / rescheduled within 24 hours will be charged $20.00 no-show fee for every ½ Hours worth of therapy/ Massage***. (*initial*)________

PATIENT/PARENT SIGNATURE: ____________________ **DATE:**__________

FINANCIAL POLICY FOR
DEWALD CHIROPRACTIC, INC.

Thank you for choosing Dewald Chiropractic, Inc. as your healthcare provider. We are committed to your successful treatment. Our Billing Department and Patient Finance Department will work very hard to make sure that your account remains in a current and compensated status.

BILLING
We will bill your primary insurance carrier as a courtesy to you. Our office, as a service and a convenience to you, will absorb all costs incurred for that billing. Our billing staff has undergone extensive and rigorous training to maximize your insurance reimbursement, while reducing the time by which they pay.

We are a chiropractic facility and our aim is to assist you in leading a healthy, pain free lifestyle. We are not a professional billing service. Please understand that insurance reimbursement can be a long and difficult process for any healthcare office. We will submit the billing and wait for payment until ***sixty days***. If there are complications or disputes on your coverage that delay reimbursement of your claim; ***you, the insured, are responsible to this office for satisfaction of the payment immediately.***

PATIENT CO-INSURANCE
We have already agreed to accept the discounted rates from your insurance company, so copayments, coinsurances and deductibles are to be paid on each and every visit. ***There can be no exceptions due to contracting and uniform compliance rules of the insurance companies.***

EASY-PAY
This office is working to implement a Paperless Billing Procedure. It is mandated that by October 2003 we be in compliance. To that end, we will be **REQUIRING** that all patients provide us with a credit card number to ***guarantee*** your account. We will simply maintain the information in your confidential patient file to satisfy all copayments, deductibles and balances not covered by your insurance. After your insurance has cleared, **you may leave the balance on your card or you may send a check within seven days of notification by this office.**

COLLECTIONS
If we are unable to keep your account in a current and compensated status due to lack of cooperation on your part, there will be a **$10.00 billing fee** for each of the monthly statements that we send you. If it is necessary to send your account to a collection agency, **50% will be added to the unpaid balance**.

MISSED APPOINTMENTS
This office does have a **No-Show policy**. If you are unable to make your appointment and do not cancel more than **24 hours in advance**, a **$20 fee per half hour you were scheduled for** will be deducted from your account. So, please call and reschedule in advance if at all possible so that we may staff our office accordingly.

I understand this Financial Policy completely and all questions have been answered to my satisfaction. I authorize Dewald Chiropractic, Inc. to charge my credit card for services rendered. This agreement is valid for the entire time of my treatment.

Patient/Guardian signature:_______________________________________ Date:______________

Staff signature:____ Date:______________

Visa/MasterCard#:____ Exp:______________

This notice is effective as of _April 15, 2003

I have read the Privacy Notice and understand my rights contained in the notice.

By way of my signature, I provide Dewald Chiropractic with my authorization and consent to use and disclosed my protected health care information for the purposes of treatment, payment and health care operations as described in the Privacy Notice

____
Patient's Name (print)

____ ______________
Patient's Signature Date

____ ______________
Authorized Facility Signature Date

Your Health Information Rights

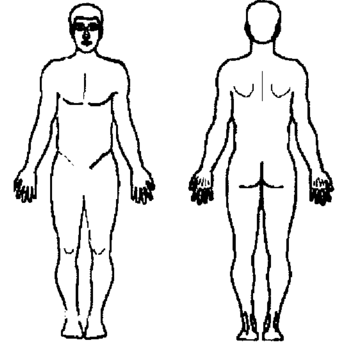
- You have the right to request restrictions on certain uses and disclosures of your health information. Please be advised, however, that Dewald Chiropractic, Inc. is not required to agree to the restriction that you requested.
- You have the right to have our health information received or communicated through an alternative method or sent to an alternative location other than the usual method of communication or delivery, upon your request.
- You have the right to inspect and copy your health information.
- You have a right to request that Dewald Chiropractic, Inc. amend your protected health information. Please be advised, however, that Dewald Chiropractic, Inc. is not required to agree to amend your protected health information. If your request to amend your health information has been denied, you will be provided with an explanation of our denial reason(s) and information about how you can disagree with the denial.
- You have a right to receive an accounting of disclosures of your protected health information made by Dewald Chiropractic, Inc.
- You have a right to a paper copy of this Notice of Privacy Practices at any time upon request.

American Specialty Health (ASH)
P.O. Box 509001, San Diego, CA 92150-9001
California Only Fax: 877.427.4777 All Other States Fax: 877.304.2746

INITIAL HEALTH STATUS
Chiropractic

Patient Name________________________ Birthdate______________ Sex: M / F
Address________________________ City______________
State______ Zip__________ Phone (____)__________ Patient Primary Language______________
Occupation______________ Employer______________ Work Phone__________
Address______________ City______________ State________ Zip________
Subscriber Name______________ Health Plan______________
Subscriber ID #______________ Group #______________ Spouse Name______________
Spouse Employer______________ City______________ State________ Zip________
Primary Care Physician Name______________ PCP Phone______________

MARK AN **X** ON THE PICTURE WHERE YOU HAVE PAIN OR OTHER SYMPTOMS.



DESCRIBE YOUR CURRENT PROBLEM AND HOW IT BEGAN:
☐ Headache ☐ Neck Pain ☐ Mid-Back Pain ☐ Low Back Pain
☐ Other______________
Is this? ☐ Work Related ☐ Auto Related ☐ N/A
Date Problem Began______________
How Problem Began

Current complaint (how you feel today):
0 1 2 3 4 5 6 7 8 9 10
No Pain Unbearable Pain

How often are your symptoms present?
(Occasional) ☐ 0 – 25% ☐ 26 – 50% ☐ 51 – 75% ☐ 76 – 100% (Constant)

In the past week, how much has your pain interfered with your daily activities (e.g., work, social activities, or household chores?
No interference 0 1 2 3 4 5 6 7 8 9 10 Unable to carry on any activities

In general would you say your overall health right now is:
☐ Excellent ☐ Very Good ☐ Good ☐ Fair ☐ Poor

HAVE YOU HAD SPINAL X-RAYS, MRI, CT SCAN FOR YOUR AREA(S) OF COMPLAINT? ☐ No ☐ Yes
Date(s) taken______________ **What areas were taken?**______________

Please check all of the following that apply to you:
☐ Alcohol/Drug Dependence
☐ Recent Fever
☐ Diabetes
☐ High Blood Pressure
☐ Stroke (Date)______________
☐ Corticosteroid Use (Cortisone, Prednisone, etc.)
☐ Taking Birth Control Pills
☐ Dizziness/Fainting
☐ Numbness in Groin/Buttocks
☐ Cancer/Tumor (Explain)______________
☐ Osteoporosis
☐ Epilepsy/Seizures
☐ Other Health Problems (Explain)______________
☐ Prostate Problems
☐ Menstrual Problems
☐ Urinary Problems
☐ Currently Pregnant, # Weeks__________
☐ Abnormal Weight ☐ Gain ☐ Loss
☐ Marked Morning Pain/Stiffness
☐ Pain Unrelieved by Position or Rest
☐ Pain at Night
☐ Visual Disturbances
☐ Surgeries______________
☐ Tobacco Use - Type______________
Frequency______________/Day
☐ Medications______________

Family History: ☐ Cancer ☐ Diabetes ☐ High Blood Pressure ☐ Heart Problems/Stroke ☐ Rheumatoid Arthritis

I certify to the best of my knowledge, the above information is complete and accurate. If the health plan information is not accurate, or if I am not eligible to receive a health care benefit through this provider, I understand that I am liable for all charges for services rendered and I agree to notify this doctor immediately whenever I have changes in my health condition or health plan coverage in the future. I understand that my chiropractor may need to contact my physician if my condition needs to be co-managed. Therefore I give authorization to my chiropractor to contact my physician, if necessary.

Patient Signature______________________ **Date**______________

NECK DISABILITY INDEX QUESTIONNAIRE

NAME____________________________**AGE**______ **DATE**____________ **SCORE**____________

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 THAT 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)

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.

COMMENTS: ____

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Vernon H, Mior S. The Neck Disability Index: A study of reliability and validity. J Manipulative Physiol Ther 1991;14:409-415.

OSWESTRY DISABILITY INDEX 2.0

NAME______________________________ **DATE**_______________ **SCORE**___________

PLEASE READ: Could you please complete this questionnaire. It is designed to give us information as to how your back (or leg) trouble has affected your ability to manage in everyday life.

Please answer ***every section***. Mark ***one box only*** in each section that most closely describes you ***today***.

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 is very painful.
- 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, wash with difficulty and stay in bed.

SECTION 3 - Lifting
- A ☐ I can lift heavy weights without extra pain.
- B ☐ I can lift heavy weights, but it causes extra pain.
- C ☐ Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned, e.g. 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 only lift very light weights, at the most.
- F ☐ I cannot lift or carry anything at all.

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 1/4 mile.
- D ☐ Pain prevents me from walking more than 100 yards.
- E ☐ I can only walk while using a stick or 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.
- B ☐ I can only sit in my favorite chair as long as I like.
- C ☐ Pain prevents me from sitting more than 1 hour.
- D ☐ Pain prevents me from sitting more than 1/2 hour.
- E ☐ Pain prevents me from sitting more than ten minutes.
- F ☐ Pain prevents me from sitting at all.

SECTION 6 - Standing
- A ☐ I can stand as long as I want without extra pain.
- B ☐ I can stand as long as I want but it gives me extra pain.
- C ☐ Pain prevents me from standing for more than 1 hour.
- D ☐ Pain prevents me from standing for more than 1/2 hour.
- E ☐ Pain prevents me from standing for more than 10 minutes.
- F ☐ Pain prevents me from standing at all.

SECTION 7 - Sleeping
- A ☐ My sleep is never disturbed by pain.
- B ☐ My sleep is occasionally disturbed by pain.
- C ☐ Because of pain I have less than 6 hours' sleep.
- D ☐ Because of pain I have less than 4 hours' sleep.
- E ☐ Because of pain I have less than 2 hours' sleep.
- F ☐ Pain prevents me from sleeping at all.

SECTION 8 - Sex Life (if applicable)
- A ☐ My sex life is normal and causes me no extra pain.
- B ☐ My sex life is normal, but causes some extra pain.
- C ☐ My sex life is nearly normal but is very painful.
- D ☐ My sex life is severely restricted by pain.
- E ☐ My sex life is nearly absent because of pain.
- F ☐ Pain prevents any sex life at all.

SECTION 9 - Social Life
- A ☐ My social life is normal and causes me no extra pain.
- B ☐ My social life is normal, but increases the degree of pain.
- C ☐ Pain has no significant effect on my social life apart from limiting my more energetic interests, e.g., sport, etc.
- D ☐ Pain has restricted my social life and I do not go out as often.
- E ☐ Pain has restricted my social life to my home.
- F ☐ I have no social life because of the pain.

SECTION 10 - Traveling
- A ☐ I can travel anywhere without pain.
- B ☐ I can travel anywhere but I gives extra pain.
- C ☐ Pain is bad but I manage journeys over 2 hours.
- D ☐ Pain restricts me to journeys of less than 1 hour.
- E ☐ Pain restricts me to short necessary journeys under 30 minutes.
- F ☐ Pain prevents me from traveling except to receive treatment.

COMMENTS: ____

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Roland, M. and J. Fairbank (2000). "The Roland-Morris Disability Questionnaire and the Oswestry Disability Questionnaire." Spine 25(24): 3115-24.