

CONFIDENTIAL PATIENT CASE HISTORY

Please complete this questionnaire. This confidential history will be part of your permanent records.

Today's Date

 / /

Signature of Patient _____

Signature of Parent/Guardian _____

Patient Title: (check one)

- Mr.
 Mrs.
 Ms.
 Miss
 Dr.
 Prof.
 Rev.

First Name _____

Nick Name _____

Last Name _____

Middle Name _____

Suffix _____

Address 1 _____

Address 2 _____

City _____

State _____

Zip Code _____

Primary Phone _____

Secondary Phone _____

Mobile Phone _____

Home Email _____

Work Email _____

Which email address would you like us to use to communicate with you? (Check one)

- Home
 Work

(Check one)

Contact Method (Check one)

- Primary Phone
 Secondary Phone
 Mobile Phone
 Home Email
 Work Email

Date of Birth

 / /

Age _____

Gender (Check one)

- Male
 Female
 Unspecified

Marital Status (Check one)

- Single
 Married
 Other

SSN _____

Employment Status (Check one)

- Employed
 FT Student
 PT Student
 Other
 Retired
 Self Employed

Race (Check one)

- | | | | |
|--------------------------------|--|----------------------------------|---|
| <input type="radio"/> White | <input type="radio"/> Black/African American | <input type="radio"/> Hispanic | <input type="radio"/> American Indian/Alaskan Native |
| <input type="radio"/> Asian | <input type="radio"/> Asian Indian | <input type="radio"/> Chinese | <input type="radio"/> Filipino |
| <input type="radio"/> Japanese | <input type="radio"/> Korean | <input type="radio"/> Vietnamese | <input type="radio"/> Native Hawaiian or other Pacific Island |
| <input type="radio"/> Samoan | <input type="radio"/> Guamanian or Chamorro | <input type="radio"/> Other | <input type="radio"/> I choose not to specify |

Multi-Racial (Check one)

- Yes
 No
 Unknown

Ethnicity (Check one)

- Hispanic or Latino
 Not Hispanic or Latino
 I choose not to specify

Preferred Language (Check one)

- | | | | | | |
|-------------------------------|----------------------------------|--|-------------------------------------|---|------------------------------|
| <input type="radio"/> English | <input type="radio"/> Spanish | <input type="radio"/> American Sign Language | <input type="radio"/> Chinese | <input type="radio"/> French | <input type="radio"/> German |
| <input type="radio"/> Tagalog | <input type="radio"/> Vietnamese | <input type="radio"/> Italian | <input type="radio"/> Korean | <input type="radio"/> Russian | <input type="radio"/> Polish |
| <input type="radio"/> Arabic | <input type="radio"/> Portuguese | <input type="radio"/> Japanese | <input type="radio"/> French Creole | <input type="radio"/> Greek | <input type="radio"/> Hindi |
| <input type="radio"/> Persian | <input type="radio"/> Urdu | <input type="radio"/> Gujarati | <input type="radio"/> Armenian | <input type="radio"/> I choose not to specify | |

CASE HISTORY FORM

CONSTITUTIONAL

DENY ALL

CHILLS
FAINTING
FATIGUE
FEVER
NIGHT SWEATS
WEAKNESS
WEIGHT GAIN
WEIGHT LOSS

INTEGUMENTARY

DENY ALL

ECZEMA
HAIR GROWTH
HAIR LOSS
HIVES
ITCHING
PARESTHESIA
RASH
SKIN LESIONS

PSYCHIATRIC

DENY ALL

AGITATION
ANXIETY
APPETITE
CHANGES
BEHAVIORAL
CHANGES
BIPOLAR
DISORDER
CONFUSION
DEPRESSION
HOMICIDAL
INDICATION
INSOMNIA
MEMORY LOSS
SUBSTANCE
ABUSE
SUICIDAL
INDICATION

EYES

DENY ALL

BLURRED VISION
CATARACTS
CHANGE IN VISION
DOUBLE VISION
DRY EYES
GLAUCOMA
SENSITIVITY TO LIGHT
TEARING

GASTROINTESTINAL

DENY ALL

ABDOMINAL PAIN
BLACK, TARRY STOOLS
CONSTIPATION
DIARRHEA
HEARTBURN
HEMORRHOIDS
INDIGESTION
NAUSEA
RECTAL BLEEDING
VOMITING

ALLERGIC/IMMUNOLOGIC

DENY ALL

HISTORY OF
ANAPHYLAXIS
ITCHY EYES
SNEEZING

HEMATOLOGIC/LYMPHATIC

DENY ALL

ANEMIA
BLEEDING
BLOOD CLOTTING
BLOOD
TRANSFUSIONS
BRUISE EASILY
LYMPH NODE
SWELLING

MUSCULOSKELETAL

DENY ALL

ARTHRITIS
NECK PAIN
DECREASED MOTION
GOUT
INJURIES
JOINT PAIN
BACK PAIN
MUSCLE CRAMPS
MUSCLE PAIN
MUSCLE WEAKNESS
SWELLING

CARDIOVASCULAR

DENY ALL

ANGINA
CHEST PAIN
HEART MURMUR
HEART PROBLEMS
HIGH BLOOD PRESSURE
LOW BLOOD PRESSURE
PALPITATIONS
SHORTNESS OF BREATH
SWELLING OF LEGS
VARICOSE VEINS

GENITOURINARY

DENY ALL

BURNING URINATION
CRAMPS
FREQUENT URINATION
HESITANCY/DRIBBLING
HORMONE THERAPY
IRREGULAR MENSTRUATION
LACK OF BLADDER CONTROL
PROSTATE PROBLEMS
URINE RETENTION
VAGINAL BLEEDING
VAGINAL DISCHARGE

ENDOCRINE

DENY ALL

DIABETES
EXCESSIVE APPETITE
EXCESSIVE HUNGER
EXCESSIVE THIRST
GOITER
HAIR LOSS

NEUROLOGICAL

DENY ALL

CHANGE IN CONCENTRATION
CHANGE IN MEMORY
DIZZINESS
HEADACHE
IMBALANCE
LOSS OF CONSCIOUSNESS
LOSS OF MEMORY
NUMBNESS/TINGLING
SEIZURES
SLEEP DISTURBANCE
SLURRED SPEECH
STRESS
STROKES
TREMORS

RESPIRATORY

DENY ALL

ASTHMA
BRONCHITIS
DRY COUGH
PRODUCTIVE
COUGH
COUGHING
UP BLOOD
DIFFICULTY
BREATHING
PNEUMONIA
SPUTUM
PRODUCTION
WHEEZING

ENMT

DENY ALL

BAD BREATH
DENTURES
DIFFICULTY
SWALLOWING
EAR
DRAINAGE
EAR PAIN
FREQUENT
SORE
THROATS
HEAD INJURY
HEARING
LOSS
HOARSENESS
LOSS OF
SMELL
LOSS OF
TASTE
NASAL
CONGESTION
NOSE BLEEDS
SINUS
INFECTIONS
RUNNY NOSE
SNORING
SORE THROAT
RINGING IN
EARS

PATIENT NAME:

DOB:

ACCT #:

DOCTOR SIGNATURE: _____

PERSONAL HISTORY FORM

1. Do you smoke? Yes _____ No _____ How much? _____
2. Do you drink alcohol? Yes _____ No _____ How much? _____
3. Do you do any recreational drugs? Yes _____ No _____ How much? _____
4. Do you exercise? Yes _____ No _____ How much? _____

Who have you seen as your primary care/medical doctor?

Location: _____ Telephone: _____

Past Hospitalizations: (list date and reason)

____/____/____ _____
____/____/____ _____
____/____/____ _____

Past Surgeries: (list date and reason)

____/____/____ _____
____/____/____ _____
____/____/____ _____

Past Fractures: (list date and reason)

____/____/____ _____
____/____/____ _____
____/____/____ _____

List any chronic diseases you may have: _____

Are you currently taking any prescription drugs? [] Y [] N

Please list:

Dr. Signature: _____ Date: _____

Patient Name: _____ DoB: _____ Pt. Acct #: _____

Patient Health Questionnaire - PHQ

Patient Name _____

Date _____

1. Describe your symptoms

a. When did your symptoms start?

b. How did your symptoms begin?

2. How often do you experience your symptoms?

- 1 Constantly (76-100% of the day)
- 2 Frequently (51-75% of the day)
- 3 Occasionally (26-50% of the day)
- 4 Intermittently (0-25% of the day)

3. What describes the nature of your symptoms?

- 1 Sharp 2 Shooting
- 3 Dull ache 4 Burning
- 5 Numb 6 Tingling

4. How are your symptoms changing?

- 1 Getting Better
- 2 Not Changing
- 3 Getting Worse

5. During the past 4 weeks:

a. Indicate the average intensity of your symptoms

b. How much has pain interfered with your normal work (including both work outside the home, and housework)

- 1 Not at all 2 A little bit 3 Moderately 4 Quite a bit 5 Extremely

6. During the past 4 weeks how much of the time has your condition interfered with your social activities? (like visiting with friends, relatives, etc)

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

7. In general would you say your overall health right now is...

- 1 Excellent 2 Very Good 3 Good 4 Fair 5 Poor

8. Who have you seen for your symptoms?

- 1 No One 2 Medical Doctor 3 Other
- 2 Chiropractor 4 Physical Therapist

a. What treatment did you receive and when?

b. What tests have you had for your symptoms and when were they performed?

- 1 Xrays date: _____ 2 CT Scan date: _____
- 3 MRI date: _____ 4 Other date: _____

9. Have you had similar symptoms in the past?

a. If you have received treatment in the past for the same or similar symptoms, who did you see?

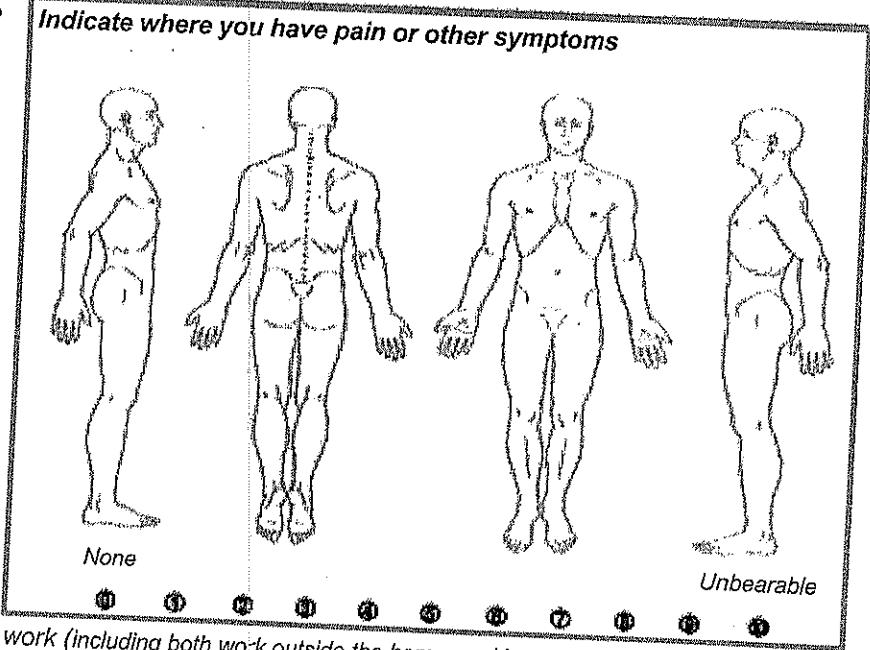
- 1 Yes 2 No
- 3 This Office 4 Medical Doctor 5 Other
- 2 Chiropractor 3 Physical Therapist

10. What is your occupation?

a. If you are not retired, a homemaker, or a student, what is your current work status?

- 1 Professional/Executive 2 Laborer 3 Retired
- 2 White Collar/Secretarial 3 Homemaker 4 Other
- 3 Tradesperson 4 FT Student
- 1 Full-time 2 Self-employed 3 Off work
- 2 Part-time 3 Unemployed 4 Other

Indicate where you have pain or other symptoms



Patient Signature _____

Date _____

HENDERSON CHIROPRACTIC CENTER, PA OFFICE FINANCIAL POLICY

Henderson Chiropractic Center's policy is to extend to you the courtesy of allowing you to assign your insurance benefits directly to Henderson Chiropractic Center. This policy reduces your out-of-pocket expenses and allows you to place your family under immediate care. Our payment plans make care an affordable part of your family budget.

IF YOU DO NOT HAVE INSURANCE

All payments are to be rendered at the time of service or pursuant to an authorized payment plan that is between you and Henderson Chiropractic Center. If your personal balance exceeds \$100.00 at any time, your care may be terminated.

IF YOU HAVE INSURANCE

All deductibles and co-payments are to be rendered at the time of service or pursuant to an authorized payment plan that is between you and Henderson Chiropractic Center. If your co-insurance balance (co-payments plus any deductibles) exceeds \$100.00 at any time, your care may be terminated.

You are considered to be a patient who does not have insurance (i.e. a cash patient) until you bring in *all* your necessary and completed insurance forms and Henderson Chiropractic Center qualifies and accepts your insurance coverage. Henderson Chiropractic Center does accept assignment for secondary insurance carriers. We will be happy to file this for you.

Our fees are considered usual, customary and reasonable by most insurance companies, and are therefore covered up the maximum allowance determined by each insurance carrier. Please note, however, that this statement does not apply to insurance companies who reimburse based on an arbitrary schedule of fees bearing no relationship to the current standard and care in this area.

NON-PAYMENT BY INSURANCE CARRIER

If your insurance carrier has not paid a claim submitted by Henderson Chiropractic Center within sixty (60) day of submission, you agree to take an active part in the recovery of your claim. You are then responsible for contacting your insurance company to try to recover your claim. If your insurance carrier has not paid a claim submitted by Henderson Chiropractic Center within ninety (90) days of submission, you will be **responsible for payment in full** of any outstanding balance.

DISCONTINUING CARE

If you discontinue care for any reason other than discharge by the doctor, your balance will become immediately due and payable in full to be paid by your personally unless the outstanding balance is an insurance balance.

COLLECTION OF PAST DUE BALANCES

If a collection agency is used to any collect past due balances, you will be responsible for any expenses incurred in collecting that debt including, but not limited to, attorney fees and court costs.

Patient's Printed Name: _____

Patient's Signature: _____ Date: _____

Front Desk Signature: _____ Date: _____

HENDERSON CHIROPRACTIC CENTER TEXT REMINDER

Do you consent to receive appointment reminders and other news about the office via text message? These will come through our text reminder system, **Zing It**. (Please Circle)

Yes or No

Patient's Signature: _____

Who referred you to us? _____
How else did you hear about us? _____

Your rights regarding your health information

1. Communications. You can request that our practice communicate with you about your health and related issues in a particular manner or at a certain location. For instance, you may ask that we contact you at home, rather than work. We will accommodate reasonable requests.
2. You can request a restriction in our use or disclosure of your health information for treatment, payment, or health care options. Additionally, you have the right to request that we restrict our disclosure of your health information to only certain individuals involved in your care or the payment for your care such as family members and friends. We are not required to agree to your request; however, if we do agree, we are bound to our agreement except when otherwise required by law, in emergencies, or when the information is necessary to treat you.
3. You have the right to inspect and obtain a copy of the health information that may be used to make decisions about you, including patient medical records, billing records, but not including psychotherapy notes.
4. You may ask us to amend your health information if you believe it is incorrect or incomplete and as long as the information is kept by or for our practice. You must provide us with a reason that supports your request for amendment.
5. Right to a copy of this notice. You are entitled to receive a copy of this Notice of Privacy Practices. You may ask us to give you a copy of this Notice at any time. To obtain a copy of this notice, contact our front desk receptionist.
6. Right to file a complaint. If you believe your privacy rights have been violated, you may file a complaint with our practice or the Secretary of the Department of Health and Human Services.
7. Right to provide an authorization for other uses and disclosures. Our practice will obtain your written authorization for uses and disclosures that are not identified by this notice or permitted by applicable law.
8. I authorize you to release any medical information about me to the people below. This release is valid until I revoke it in writing (enter N/A if you do not wish this information released to any 3rd party except under the circumstances covered by present HIPPA law).

a.

Relationship:

b.

Relationship:

c.

Relationship:

d.

Relationship:

If you have any questions regarding this notice or our health information privacy policies, please contact the office at 252-430-8000.

I have personally approved the release of my medical information to those people named above in section 8.

Signature _____

Date _____

Name of Patient _____

Patient's Name _____

Number _____

Date _____

NECK DISABILITY INDEX

This questionnaire has been designed to give the doctor information as to how your neck pain has affected your ability to manage in everyday life. Please answer every section and mark in each section only ONE box which applies to you. We realize you may consider that two of the statements in any one section relate to you, but please just mark the box which MOST CLOSELY describes your problem.

Section 1 - Pain Intensity

- I have no pain at the moment.
- The pain is very mild at the moment.
- The pain is moderate at the moment.
- The pain is fairly severe at the moment.
- The pain is very severe at the moment.
- The pain is the worst imaginable at the moment.

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

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

Section 3 -- Lifting

- I can lift heavy weights without extra pain.
- I can lift heavy weights but it gives extra pain.
- Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned, for example on a table.
- Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
- I can lift very light weights.
- I cannot lift or carry anything at all.

Section 4 -- Reading

- I can read as much as I want to with no pain in my neck.
- I can read as much as I want to with slight pain in my neck.
- I can read as much as I want with moderate pain.
- I can't read as much as I want because of moderate pain in my neck.
- I can hardly read at all because of severe pain in my neck.
- I cannot read at all.

Section 5-Headaches

- I have no headaches at all.
- I have slight headaches which come infrequently.
- I have slight headaches which come frequently.
- I have moderate headaches which come infrequently.
- I have severe headaches which come frequently.
- I have headaches almost all the time.

Section 6 -- Concentration

- I can concentrate fully when I want to with no difficulty.
- I can concentrate fully when I want to with slight difficulty.
- I have a fair degree of difficulty in concentrating when I want to.
- I have a lot of difficulty in concentrating when I want to.
- I have a great deal of difficulty in concentrating when I want to.
- I cannot concentrate at all.

Section 7--Work

- I can do as much work as I want to.
- I can only do my usual work, but no more.
- I can do most of my usual work, but no more.
- I cannot do my usual work.
- I can hardly do any work at all.
- I can't do any work at all.

Section 8 -- Driving

- I drive my car without any neck pain.
- I can drive my car as long as I want with slight pain in my neck.
- I can drive my car as long as I want with moderate pain in my neck.
- I can't drive my car as long as I want because of moderate pain in my neck.
- I can hardly drive my car at all because of severe pain in my neck.
- I can't drive my car at all.

Section 9 -- Sleeping

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

Section 10 -- Recreation

- I am able to engage in all my recreation activities with no neck pain at all.
- I am able to engage in all my recreation activities, with some pain in my neck.
- I am able to engage in most, but not all of my usual recreation activities because of pain in my neck.
- I am able to engage in a few of my usual recreation activities because of pain in my neck.
- I can hardly do any recreation activities because of pain in my neck.
- I can't do any recreation activities at all.

Comments _____

%ADL

Reference: Vernon, Mior. JMPT 1991; 14(7): 409-16

FORM 501

The Neck Bournemouth Questionnaire

NAME _____ DATE _____ AGE _____

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

1. Over the past week, on average, how would you rate your neck pain?
 No pain 0 1 2 3 4 5 6 7 8 9 10 Worst pain possible
2. Over the past week, how much has your neck pain interfered with your daily activities (housework, washing, dressing, lifting, reading, driving)?
 No interference 0 1 2 3 4 5 6 7 8 9 10 Unable to carry out activity
3. Over the past week, how much has your neck pain interfered with your ability to take part in recreational, social, and family activities?
 No Interference 0 1 2 3 4 5 6 7 8 9 10 Unable to carry out activity
4. Over the past week, how anxious (tense, uptight, irritable, difficulty in concentrating/relaxing) have you been feeling?
 Not at all anxious 0 1 2 3 4 5 6 7 8 9 10 Extremely anxious
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 0 1 2 3 4 5 6 7 8 9 10 Extremely depressed
6. Over the past week, how have you felt your work (both inside and outside the home) has affected (or would affect) your neck pain?
 Have made it no worse 0 1 2 3 4 5 6 7 8 9 10 Have made it much worse
7. Over the past week, how much have you been able to control (reduce/help) your neck pain on your own?
 Completely control it 0 1 2 3 4 5 6 7 8 9 10 No control whatsoever

The Back Bournemouth Questionnaire

NAME _____ DATE _____ AGE _____

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

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

No pain	Worst pain possible
0	10
1	9
2	8
3	7
4	6
5	5
6	4
7	3
8	2
9	1

2. Over the past week, how much has your back 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	10
1	9
2	8
3	7
4	6
5	5
6	4
7	3
8	2
9	1

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

No interference	Unable to carry out activity
0	10
1	9
2	8
3	7
4	6
5	5
6	4
7	3
8	2
9	1

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	10
1	9
2	8
3	7
4	6
5	5
6	4
7	3
8	2
9	1

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	10
1	9
2	8
3	7
4	6
5	5
6	4
7	3
8	2
9	1

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

Have made it no worse	Have made it much worse
0	10
1	9
2	8
3	7
4	6
5	5
6	4
7	3
8	2
9	1

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

Completely control it	No control whatsoever
0	10
1	9
2	8
3	7
4	6
5	5
6	4
7	3
8	2
9	1

Patient's Name _____

Number _____

Date _____

LOW BACK DISABILITY QUESTIONNAIRE (REVISED OSWESTRY)

This questionnaire has been designed to give the doctor information as to how your back pain has affected your ability to manage in everyday life. Please answer every section and mark in each section only ONE box which applies to you. We realize you may consider that two of the statements in any one section relate to you, but please just mark the box which **MOST CLOSELY** describes your problem.

Section 1 - Pain Intensity

- I can tolerate the pain without having to use painkillers.
- The pain is bad but I can manage without taking painkillers.
- Painkillers give complete relief from pain.
- Painkillers give moderate relief from pain.
- Painkillers give very little relief from pain.
- Painkillers have no effect on the pain and I do not use them.

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

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

Section 3 -- Lifting

- I can lift heavy weights without extra pain.
- I can lift heavy weights but it gives extra pain.
- Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned, for example on a table.
- Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
- I can lift very light weights.
- I cannot lift or carry anything at all.

Section 4 -- Walking

- Pain does not prevent me from walking any distance.
- Pain prevents me from walking more than one mile.
- Pain prevents me from walking more than one-half mile.
- Pain prevents me from walking more than one-quarter mile.
- I can only walk using a stick or crutches.
- I am in bed most of the time and have to crawl to the toilet.

Section 5 -- Sitting

- I can sit in any chair as long as I like
- I can only sit in my favorite chair as long as I like
- Pain prevents me from sitting more than one hour.
- Pain prevents me from sitting more than 30 minutes.
- Pain prevents me from sitting more than 10 minutes.
- Pain prevents me from sitting almost all the time.

Section 6 -- Standing

- I can stand as long as I want without extra pain.
- I can stand as long as I want but it gives extra pain.
- Pain prevents me from standing more than 1 hour.
- Pain prevents me from standing more than 30 minutes.
- Pain prevents me from standing more than 10 minutes.
- Pain prevents me from standing at all.

Section 7 -- Sleeping

- Pain does not prevent me from sleeping well.
- I can sleep well only by using tablets.
- Ever when I take tablets I have less than 6 hours sleep.
- Ever when I take tablets I have less than 4 hours sleep.
- Ever when I take tablets I have less than 2 hours sleep.
- Pain prevents me from sleeping at all.

Section 8 -- Social Life

- My social life is normal and gives me no extra pain.
- My social life is normal but increases the degree of pain.
- Pain has no significant effect on my social life apart from limiting my more energetic interests, e.g. dancing.
- Pain has restricted my social life and I do not go out as often.
- Pain has restricted my social life to my home.
- I have no social life because of pain.

Section 9 -- Traveling

- I can travel anywhere without extra pain.
- I can travel anywhere but it gives me extra pain.
- Pain is bad but I manage journeys over 2 hours.
- Pain is bad but I manage journeys less than 1 hour.
- Pain restricts me to short necessary journeys under 30 minutes.
- Pain prevents me from traveling except to the doctor or hospital.

Section 10 -- Changing Degree of Pain

- My pain is rapidly getting better.
- My pain fluctuates but overall is definitely getting better.
- My pain seems to be getting better but improvement is slow at the present.
- My pain is neither getting better nor worse.
- My pain is gradually worsening.
- My pain is rapidly worsening.

Comments _____

Reference: Fairbank, Physiotherapy 1981; 66(8): 271-3, Hudson-Cook. In Roland, Jenner (eds.), Back Pain New Approaches To Rehabilitation & Education. Manchester Univ Press, Manchester 1989: 187-204