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

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)

○ White ○ Black/African American ○ Hispanic ○ American Indian/Alaskan Native
○ Asian ○ Asian Indian ○ Chinese ○ Filipino
○ Japanese ○ Korean ○ Vietnamese ○ Native Hawaiian or other Pacific Island
○ Samoan ○ Guamanian or Chamorro ○ Other_____ ○ 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)

○ English ○ Spanish ○ American Sign Language ○ Chinese ○ French ○ German
○ Tagalog ○ Vietnamese ○ Italian ○ Korean ○ Russian ○ Polish
○ Arabic ○ Portuguese ○ Japanese ○ French Creole ○ Greek ○ Hindi
○ Persian ○ Urdu ○ Gujarati ○ Armenian ○ 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. Dull ache
3. Numb
4. Shooting
5. Burning
6. Tingling

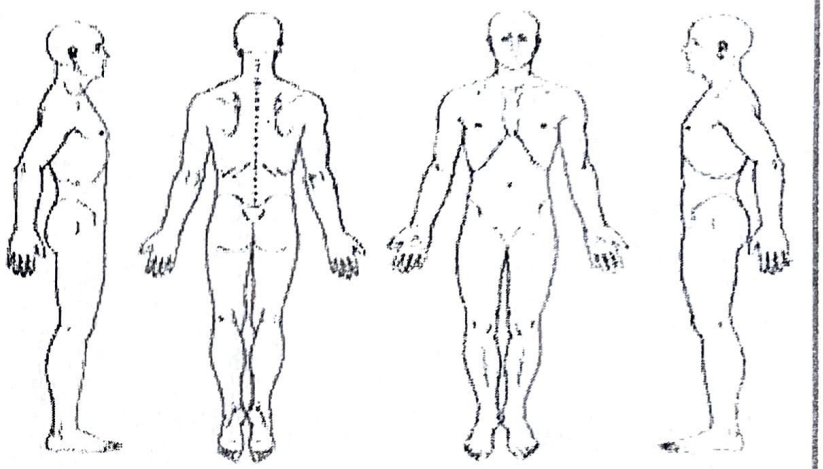
4. How are your symptoms changing?

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

5. During the past 4 weeks:

a. Indicate the average intensity of your symptoms

Indicate where you have pain or other 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. Chiropractor
3. Medical Doctor
4. Physical Therapist
5. Other

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. MRI *date:* _____
3. CT Scan *date:* _____
4. Other *date:* _____

9. Have you had similar symptoms in the past?

1. Yes
2. No

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

1. This Office
2. Chiropractor
3. Medical Doctor
4. Physical Therapist
5. Other

10. What is your occupation?

_____

1. Professional/Executive
2. White Collar/Secretarial
3. Tradesperson
4. Laborer
5. Homemaker
6. FT Student
7. Retired
8. Other

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

1. Full-time
2. Part-time
3. Self-employed
4. Unemployed
5. Off work
6. Other

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? _____

HENDERSON
CHIROPRACTIC CENTER

414 Dabney Drive
Henderson, NC 27536
Phone: 252-430-8000 • Fax: 252-430-8200

ACKNOWLEDGMENT OF NOTICE OF PRIVACY PRACTICES

Patient Name: _____
Date of Birth: _____
Address: _____
City, State, Zip: _____
Phone Number: _____

I, the undersigned, acknowledge that I have been made aware that I have been offered the opportunity to review the **Notice of Privacy Practices** from Henderson Chiropractic Center, which explains how my medical information will be used and disclosed, and how I can get access to this information. I also acknowledge that I am entitled to a copy of this Notice of Privacy Practices upon request.

I understand that the Notice of Privacy Practices may be revised periodically and that I can request a copy of any revisions by contacting the practice.

I also understand that if I have any questions regarding the Notice of Privacy Practices, I can contact the Privacy Officer at 252-430-8000 or in writing at 414 Dabney Drive, Henderson, NC 27536.

By signing below, I acknowledge that I have received and reviewed a copy of this notice.

I also give Henderson Chiropractic Center permission to:

- Leave a message on my answering machine or voicemail. ___ Yes ___ No
- Confirm appointments by leaving messages or speaking with family. ___ Yes ___ No
- Leave Pre-medication reminders (if applicable). ___ Yes ___ No
- Speak with the following family members regarding my care? ___Yes ___ No

Names of family members the practice may speak with regarding my care:

_____ *Relationship:* _____

_____ Relationship: _____

_____ Relationship: _____

_____ Relationship: _____

over →

Patient Signature: _____

Date: _____

If signed by a personal representative, please complete the following:

Personal Representative's Name: _____

Relationship to Patient: _____

Signature of Personal Representative: _____

Date: _____

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): 409-15

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									Worst pain possible
0	1	2	3	4	5	6	7	8	9	10

2. Over the past week, how much has your neck pain interfered with your daily activities (housework, washing, dressing, lifting, reading, driving)?

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 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 your 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 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 neck pain on your own?

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

Bolton JE, Breen AC. The Bournemouth Questionnaire: a short-form comprehensive outcome measure. I. Psychometric properties in neck pain patients. J Manipulative Physiol Ther 1999;22:503-10

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
0 1 2 3 4 5 6 7 8 9 10 Worst pain possible

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
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 back 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 your 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 back 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 back pain on your own?

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

Bolton JE, Breen AC. The Bournemouth Questionnaire: a short-form comprehensive outcome measure. I. Psychometric properties in back pain patients. J Manipulative Physiol Ther 1999;22:503-10

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.
☐ Even when I take tablets I have less than 6 hours sleep.
☐ Even when I take tablets I have less than 4 hours sleep.
☐ Even 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