New Patient Paperwork

Date______________________________

Title: (Check one) ☐ Mr. ☐ Mrs. ☐ Ms. ☐ Miss ☐ Dr. **Gender:** ☐ Male ☐ Female

First Name ______________________ **Middle Initial** _____ **Last Name** ________________________

Address ____

City ____ **State** ________ **Zip Code** ______________

Home Phone (______) ________-__________ **Work Phone** (______) ________-__________

Cell Phone (_____) _______-_________ **Email** ____________________________________
May we contact you via email? Y N

Date of Birth ______/______/_______ **Social Security Number:** _________-________-__________

Marital Status: Single Married Divorced Other **FEMALE PATIENTS:** Are you pregnant? Y N

Emergency Contact Name _____________________________**Phone** (_____) _________-__________

Do you have Health Insurance? Yes: _____ No: _____	If yes, would you like us to bill your insurance for you? Yes: _____ No: _____	**Please note** that for all insurance cases, our office will need a copy of your card, and a photo ID will be required.
Is this related to an accident?	Yes: _____ No: _____	AUTO WORK OTHER
Date of Injury:	Has a claim been filed? Yes: _____ No: _____	Were you hospitalized? Yes: _____ No: _____
If your current condition is due to an accident, please immediately inform the office staff so that we may properly assist you in your care.		
Have you ever seen a Chiropractor? Yes: ___ No: ___	Who may we thank for your referral? ______________________________	Have you recently had any X-Rays/MRIs? Yes: _____ No: _____

<u>Inclement Weather Policy</u>: Our policy is aligned with the Douglas County School District (DCSD). If schools in Douglas County are closed due to weather Hatch Chiropractic will also be closed.

We will open at 10:00 AM when school start times are delayed.

Medical Conditions: (Check all that apply)

- ☐ Arthritis ☐ Cancer ☐ Diabetes ☐ Heart Disease
- ☐ Hypertension ☐ Psychiatric Illness ☐ Skin Disorder ☐ Stroke
- ☐ Concussion #_______ Dates ____________________ ☐ Other ________________

Surgeries: (Check all that apply)

- ☐ Appendectomy ☐ Cardiovascular ☐ Cervical Spine ☐ Hysterectomy
- ☐ Joint Replacement ☐ Prostate ☐ Lumbar Spine ☐ Gall Bladder
- ☐ Brain ☐ Shoulder ☐ Thoracic Spine ☐ Knee
- ☐ Carpal tunnel ☐ Gastrointestinal ☐ Urogenital ☐ Hernia
- ☐ Cesarean Section #_____ ☐ Other ________________

Allergies: (Check all that apply)

- ☐ Eggs ☐ Fish and Shellfish ☐ Milk or Lactose ☐ Peanuts
- ☐ Soy ☐ Sulfites ☐ Wheat/Glutens ☐ Other ___________

Social History

Caffeine use	☐ Occasional	☐ Often	☐ Never
Drink Alcohol	☐ Occasional	☐ Often	☐ Never
Chew Tobacco	☐ Occasional	☐ Often	☐ Never
Cigarettes	☐ Occasional	☐ Often	☐ Never
Wear Seat Belts	☐ Occasional	☐ Often	☐ Never
Marijuana Use	☐ Occasional	☐ Often	☐ Never

Family History

Arthritis	☐ Parent	☐ Sibling
Cancer	☐ Parent	☐ Sibling
Diabetes	☐ Parent	☐ Sibling
Heart Disease	☐ Parent	☐ Sibling
Hypertension	☐ Parent	☐ Sibling
Stroke	☐ Parent	☐ Sibling
Thyroid	☐ Parent	☐ Sibling

Please list all current medications and OTC supplements being taken:

____

____

____

Review of Systems – (Check box if you have had trouble with any of the following)

Cardiovascular	Past	Present	No	Neurologic	Past	Present	No	Gastrointestinal	Past	Present	No
Poor Circulation				Stroke				Gall Bladder Problems			
Hypertension				Seizures				Bowel Problems			
Aortic Aneurism				Head Injury				Constipation			
Heart Disease				Brain Aneurysm				Liver Problems			
Heart Attack				Numbness				Ulcers			
Chest Pain				Severe Headaches				Diarrhea			
High Cholesterol				Pinched Nerves				Nausea/Vomiting			
Pacemaker				Parkinson's				Bloody Stools			
Jaw Pain				Carpal Tunnel				Poor Appetite			
Irregular Heartbeat				Vertigo							
Swelling of Legs											
Respiratory	**Past**	**Present**	**No**	**Hematologic**	**Past**	**Present**	**No**	**Ear, Nose and Throat**	**Past**	**Present**	**No**
Asthma				Hepatitis				Difficulty Swallowing			
Tuberculosis				Blood Clots				Dizziness			
Short Breath				Cancer				Hearing Loss			
Emphysema				Bruising				Sore Throat			
Cold/Flu				Bleeding				Nosebleeds			
Cough				Fever, Chills				Bleeding Gums			
Wheezing				Sweating				Sinus Infections			
Musculoskeletal	**Past**	**Present**	**No**	**Genitourinary**	**Past**	**Present**	**No**	**Allergic/Immunologic**	**Past**	**Present**	**No**
Gout				Kidney Disease				Hives			
Arthritis				Burning Urination				Immune Disorder			
Joint Stiffness				Frequent Urination				HIV/AIDS			
Muscle Weakness				Blood in Urine				Allergy Shots			
Osteoporosis				Kidney Stones				Cortisone Use			
Broken Bones				Lower Side Pain							
Joints Replaced											
Constitutional	**Past**	**Present**	**No**	**Psychiatric**	**Past**	**Present**	**No**	**Eyes**	**Past**	**Present**	**No**
Weight Loss/Gain				Depression				Glaucoma			
Low Energy Level				Anxiety				Double Vision			
Difficulty Sleeping				Stress				Blurred Vision			

Nutrition History

Have you made any changes in your eating habit because of your health?

If yes, please describe ______________________________

Do you avoid any foods? ☐ Yes ☐ No

If yes, type and reason ______________________________

Do you current follow a special diet or nutritional program? Yes No Check all that apply:

☐ Low Fat	☐ Low Carbohydrate	☐ High Protein	☐ Low Sodium
☐ Diabetic	☐ No Dairy	☐ No Wheat	☐ Gluten Restricted
☐ Vegetarian	☐ Vegan	☐ Weight Loss	☐ Other

Do you drink water? ☐ Yes ☐ No If yes, amount consumed in a 24-hour period ____________

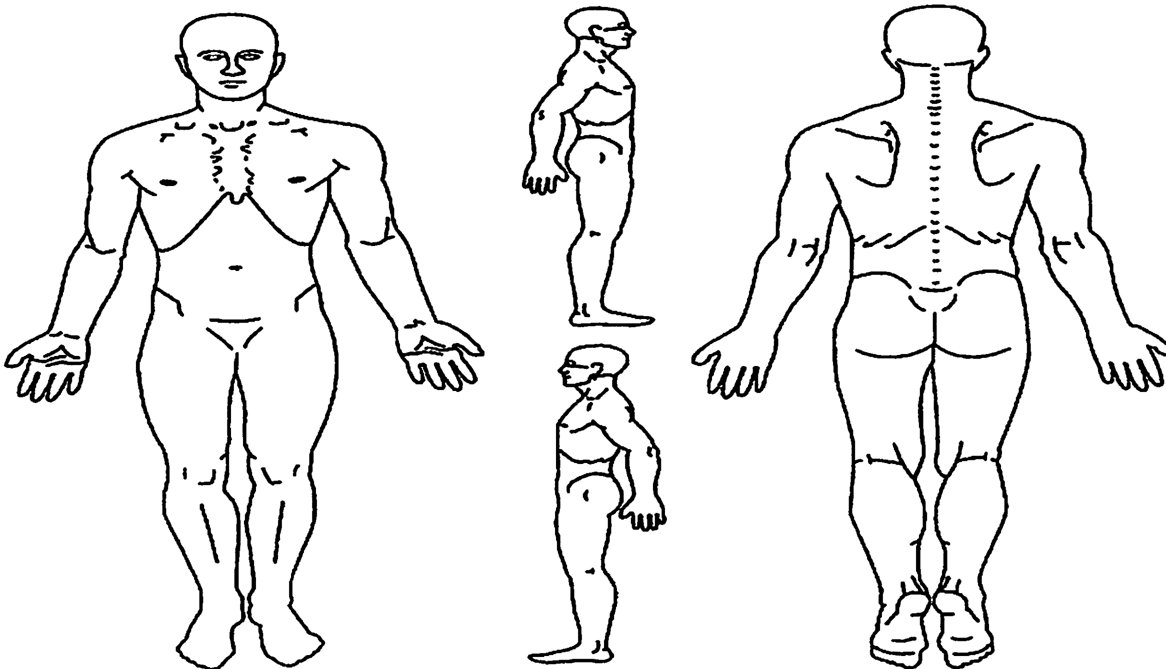
Do you exercise: ☐ Yes ☐ No If yes, how often ____________________

Nutrition History (continued)

Check all the factors that apply to your current lifestyle and eating habits:

- ☐ Fast Eater
- ☐ Erratic eating pattern
- ☐ Eat too much
- ☐ Late night eating
- ☐ Dislike healthy food
- ☐ Time constraints
- ☐ Eat more than 50% of meals away from home
- ☐ Travel frequently
- ☐ Non-availability of healthy foods
- ☐ Do not plan meals or menus
- ☐ Reliance on convenience items
- ☐ Emotional eater (eat when sad, lonely, depressed, bored)
- ☐ Significant other or family members don't like healthy foods
- ☐ Significant other or family members have special dietary needs or food preferences
- ☐ Love to eat
- ☐ Eat because I have to
- ☐ Have a negative relationship to food
- ☐ Struggle with eating issues
- ☐ Poor snack choices
- ☐ Eat too much under stress
- ☐ Eat too little under stress
- ☐ Don't care to cook
- ☐ Eating in the middle of the night
- ☐ Confused about nutrition advice

Indicate on the body diagram where you are experiencing symptoms:



Please describe, in detail, any issues that you wish to discuss with the Doctor today

____

____

____

When did your symptoms begin? **Month**__________ **Day**________ **Year** __________

How did your symptoms begin? ______________________________

How often do you experience symptoms? Check the one that best describes your symptoms

- ◻ Intermittently (0-25% of the time)
- ◻ Occasionally (25-50% of the time)
- ◻ Frequently (51-75% of the time)
- ◻ Constantly (76-100% of the time)

What describes your symptoms? Check the one that best describes your symptoms

- ◻ Sharp
- ◻ Dull ache
- ◻ Numb
- ◻ Shooting
- ◻ Burning
- ◻ Tingling
- ◻ Stabbing
- ◻ Other _______

How are your symptoms changing?

- ◻ Getting better
- ◻ Not changing
- ◻ Getting worse

Employment Status: Employed Unemployed Student Other_______________

Employer Name ____

Address ____

City ______________________________ **State** _________ **Zip Code** ___________

Occupational Activities: (Check the one that best describes your job description)

- ◻ Administration
- ◻ Business Owner
- ◻ Clerical/Secretary
- ◻ Computer User
- ◻ Heavy Equipment operator
- ◻ Daycare/Childcare
- ◻ Construction
- ◻ Health Care
- ◻ Food Service Industry
- ◻ Medium Manual Labor
- ◻ Manufacturing
- ◻ Home Services
- ◻ Heavy Manual Labor
- ◻ Light Manual Labor
- ◻ Executive/Legal
- ◻ Housekeeper
- ◻ Other _______________

Condition's Effect on Job Performance:

No effect
Mild (painful, can do)
Moderate/Severe (limited duty)
Moderate (painful, limited ability)
Severe (no/limited duty)
Extremely Severe (can't do limited duty)

Daily Activities: Effects of Current Condition on Performance – Please check applicable box

Bending	◻ No Effect	◻ Mild	◻ Moderate	◻ Severe	◻ Extremely Severe
Carrying Groceries	◻ No Effect	◻ Mild	◻ Moderate	◻ Severe	◻ Extremely Severe
Sit to Stand	◻ No Effect	◻ Mild	◻ Moderate	◻ Severe	◻ Extremely Severe
Climb Stairs	◻ No Effect	◻ Mild	◻ Moderate	◻ Severe	◻ Extremely Severe
Driving	◻ No Effect	◻ Mild	◻ Moderate	◻ Severe	◻ Extremely Severe
Computer Use	◻ No Effect	◻ Mild	◻ Moderate	◻ Severe	◻ Extremely Severe
Household Chores	◻ No Effect	◻ Mild	◻ Moderate	◻ Severe	◻ Extremely Severe
Kneeling	◻ No Effect	◻ Mild	◻ Moderate	◻ Severe	◻ Extremely Severe
Lift Children	◻ No Effect	◻ Mild	◻ Moderate	◻ Severe	◻ Extremely Severe
Pet Care	◻ No Effect	◻ Mild	◻ Moderate	◻ Severe	◻ Extremely Severe
Concentration	◻ No Effect	◻ Mild	◻ Moderate	◻ Severe	◻ Extremely Severe
Self-care	◻ No Effect	◻ Mild	◻ Moderate	◻ Severe	◻ Extremely Severe
Sexual Activities	◻ No Effect	◻ Mild	◻ Moderate	◻ Severe	◻ Extremely Severe
Sleep	◻ No Effect	◻ Mild	◻ Moderate	◻ Severe	◻ Extremely Severe
Sitting	◻ No Effect	◻ Mild	◻ Moderate	◻ Severe	◻ Extremely Severe
Standing	◻ No Effect	◻ Mild	◻ Moderate	◻ Severe	◻ Extremely Severe
Walking	◻ No Effect	◻ Mild	◻ Moderate	◻ Severe	◻ Extremely Severe
Yard Work	◻ No Effect	◻ Mild	◻ Moderate	◻ Severe	◻ Extremely Severe

Recreational Activity: Effects of Current Condition on Performance

______________	□ No Effect	□ Mild	□ Moderate	□ Severe	□ Extremely Severe
______________	□ No Effect	□ Mild	□ Moderate	□ Severe	□ Extremely Severe
______________	□ No Effect	□ Mild	□ Moderate	□ Severe	□ Extremely Severe

HIPAA Privacy Practices

I acknowledge that I have received and /or have been given the opportunity to review this Chiropractic Office's Notice of HIPAA Privacy Practices for protected health information. **Initials** _________

Please Carefully Read the Following and Initial Each Statement

Office Policies:

_____ **Sign In:** When you arrive for your appointment please sign in with the front desk. This is required by law. If you have any changes in your condition, we ask that you please inform us at this time so that we can ensure proper treatment.

_____ **Payment of Bills:** Payment is required at the time services are rendered. You will be expected to honor your financial agreements with our office. If you find that you cannot fulfill your financial agreement with our office, please immediately speak with our Office Manager to make new arrangements.

_____ **Cell Phones:** We ask that you refrain from using your cell phone while in the treatment areas. Please respect that there are other patients in the office.

_____ **Arbitration:** By my initials I consent to Arbitration rather than going to court as a way of resolving any future claim about my chiropractic care. This agreement applies only to the care that I receive in this office or out call service from Dr. Ryan Hatch or any associate doctor (past, present or future) working with Dr. Ryan Hatch and/or Hatch Chiropractic & Wellness, LLC.

_____ **Collections:** By my initials, I hereby waive my statute of limitations to any outstanding balance with this office. I understand that should my account become delinquent Hatch Chiropractic & Wellness will give me reasonable opportunities to satisfy my financial obligations. I understand that should my account be sent to an independent collection agency I will incur further charges.

_____ **Informed Consent:** I understand and am informed that, in the practice of chiropractic and acupuncture care there are some risks involved. To exam and treat including, but not limited to, fractures, disc injuries, stroke, dislocations, sprains, increased symptoms of pain, no improvement of symptoms or pain and in extreme rare instances death can occur. I do not expect the doctor to be able to anticipate and explain all the risks and complications, however I wish to rely on the doctor to exercise judgment during the procedure(s) which the doctor feels at the time, based on information I have given him, is in my best interest. I further acknowledge that no guarantees or assurances have been made to me concerning the results intended from the treatment.

I have read or have read to me the above policies and consents. By my signature below, I agree to all the above policies and statements.

Consent to Treat a Minor: (Minor's Printed Name) ____________________________________

Parent/Guardian Signature Authorizing Care ____________________________________

Patient Signature: ____________________________________ Date: ______________

Printed Patient Name: ____________________________________

Signature of Legal Parent or Guardian: ________________________ Date: ______________

Appointment Cancellation and No-Show Policy

At Hatch Chiropractic we strive to render excellent chiropractic care to you and the rest of our patients. We understand that there are times when you must miss an appointment due to emergencies or obligations for work or family. However, when you do not call to cancel an appointment, you may be preventing another patient from getting much needed treatment.

Our policy is as follows:

In the event you need to reschedule your appointment we require that you give our office 24-hour notice. This allows for other patients to be scheduled into that appointment.

If you miss an appointment without contacting our office within 24 hours of your scheduled time, it will be considered a missed appointment. A fee of $50 will be charged to you; if the scheduled appointment is for acupuncture or massage you will be charged $79; this fee cannot be billed to your insurance company and will be your direct responsibility.

Additionally, if a patient is more than 15 minutes past their scheduled time their appointment will have to be rescheduled. This will be considered a missed appointment.

If you have any questions regarding this policy, please let our staff know and we will be glad to clarify any questions you have.

A valid credit card is required to be on file. In the event you fail to show for an appointment your card will be charged accordingly.

By signing below, I acknowledge that I have received, reviewed, understand, and will comply with the policies outlined above.

______________________________ ______________________

Signature of Patient Date

____

Printed Name

Massage Intake Form

Name	DOB
Address	City/State/Zip
Medications	
Cell Phone	Occupation
Email (internal use only)	

You are here today for:

_______ Relaxation

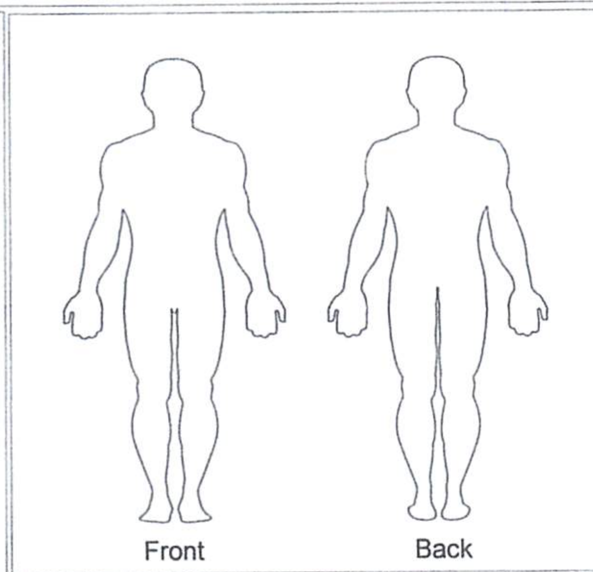
_______ Injury/Accident

_______ Specific Complaint

Describe: ____

____

____



Do you have any of the following? Please circle.

Cancer If yes:	High Blood Pressure	Heart Problems
Type	Chronic Bowel Issues	Blood Clots
Year Diagnosed	Diabetes	Herniated Discs
In Remission ☐ Yes ☐ No	Liver Disease	Where ______________
Currently Receiving:	Muscle Spasms	Disectomy
Radiation ☐ Yes ☐ No	Osteoporosis	Where ______________
Chemo ☐ Yes ☐ No	Recent Surgery ______________	Fused Discs
Oncologist ______________	Type ______________	Where ______________
Phone ______________	Broken Bones ______________	Allergies
	Where ______________	What ______________
	Numbness ______________	Recent Accident or Fall

Do you have any of the following? Please circle.

I acknowledge that I have listed all known medical conditions. I release all providers of Hatch Chiropractic from any and all liability if I fail to inform them of any health changes or of any known health conditions or diagnoses.

Signature	Date

Massaged Cancellation and No-Show Policy

In consideration of our patients and therapists, a minimum 24-hour notice is required to reschedule or cancel an appointment. If your appointment is on a Monday, notice must be given the Friday before. Weekends and holidays do not count toward the 24 hr notice policy.

Cancellations, No Shows, or appointments rescheduled with less than 24-hour notice will be charged full price for their service.

Exceptions to this policy are as follows:

- We care able to fill your appointment time with another patient
- A true emergency – which will be reviewed on a case-by-case basis
- Illness excused by a doctor's note

Please note: Cancellations left on voicemail, email, or text while the office is closed will be considered less than 24 hour notice No-shows will be treated as a cancellation without notice.

A valid credit card is required to be on file in order to book your massage, no matter the payment method used to purchase the services.

By signing below I acknowledge that I have received, reviewed, understand, and will comply with the policies outlined above.

________________________________   ________________

Patient Signature   Date

____

Printed Name

REQUIRED DISCLOSURES PURSUANT TO C.R.S. §38-27.5-104

Patient/Guardian: ______________________________

Health-care provider: ___________________________

Date of Injury: ________________________________

Pursuant to Colorado law, Patient/injured person is provided with the following disclosures and advisements:

(1) Before a health-care provider lien is created, a health-care provider or its assignee must make the following disclosures and advisements to the injured person:

(a) The following are potential methods for payment of a health-care provider's billed charges:

I. The creation of a health-care provider lien;
II. The use of benefits available from any payer of benefits as defined in section 38-27-101(9) to which the injured person is a beneficiary, including that the injured party can obtain information about the payer of benefits' network from the payer of benefits or the health-care provider;
III. Any other payment method or arrangement agreed to in writing by both the health-care provider or its assignee and the injured person; or
IV. A combination of the payment methods specified in subsections (1)(a)(I) to (1)(a)(III) of C.R.S. 28-27.5-104, as set forth above.

(b) That the health-care provider or its assignee is not a heath insurer or payer of benefits;

(c) That, except in the event of fraud or misrepresentation by the injured person:

I. If the injured person does not receive a judgment, settlement, or payment on the injured person's claim against third parties or under an uninsured or underinsured motorist policy, the injured person is not liable to the holder of the health-care provider lien for any portion of the health-care provider lien;

II. If the injured person receives a net judgment, settlement, or payment that is less than the full amount of the health-care provider lien, the injured person is not liable to the holder of the health-care provider lien for any amount beyond the net judgment, settlement, or payment, and the holder of the health-care provider lien may not file a complaint or counterclaim against the injured person directly to be reimbursed for any amount beyond the net judgment, settlement, or payment. Nothing in this section prevents a health-care provider or its assignee from initiating a declaratory judgment action or participating in an interpleader action or claim pursuant to the Colorado Rules of Civil Procedure, or any other similar action or claim, to determine the health-care provider's or its assignee's share of the injured person's net judgment, settlement, or payment;

III. The health-care provider or its assignee may not assign a heath-care provider lien to a collection agency or debt collector.

(d) That a health-care provider's assignee's compensation from the injured person is based on the difference between the health-care provider's usual and customary billed charge and the amount that the assignee pays to purchase the health-care provider lien;

(e) Of any common ownership interest between the holder of the health-care provider lien and the injured person's legal counsel. No such relationship exists;

(f) Of any common ownership interest between the assignee of a health-care provider lien and any health-care provider who is providing treatment or who may provide treatment to the injured person under the terms of the health-care provider lien; and

(g) That if the injured person has obtained health insurance even after a health-care provider lien has been created, and the injured person or the injured person's legal counsel so informs the holder of the health-care provider lien, all future care may be billed to the health insurance carrier at the injured person's discretion.

(2) Nothing in C.R.S. 38-27.5-101, *et. seq.* changes any obligation of the health-care provider or its agents under the "Colorado Medical Assistant Act", Articles 4 to 6 of Title 25.5

(3) Upon request by the injured person or the injured person's legal counsel, the holder of a health-care provider lien shall provide in writing to the injured person an itemized statement of all the billed charges for treatment comprising the total value of the health-care provider lien as the billed charges are accrued, to the extent practicable, and when the health-care provider lien is final. The final itemized statement must include a summary of all treatments provided, the total amounts billed for each treatment, and the total amount of the health-care provider lien due and owning.

I acknowledge receipt of the foregoing disclosures and advisements as required by Colorado law.

Dated this ____ day of _______, 20____.

______________________________	______________________________
Signature of Patient/Guardian	Printed Name

Irrevocable Lien, Assignment of Benefits, and Security Interest

Patient/Guardian: ___________________________ (hereafter "patient")

Date of Injury: ______________________________

Provider: __________________________________

Patient, in order to receive care, treatment, products, and services (collectively referred to hereafter as "Services") from Provider or Provider's Assignee (hereafter collectively referred to as Provider), hereby executes this Irrevocable Lien, Assignment of Benefits, and Security Interest (hereafter "Document") in favor of Provider, and any Assignee designated at Provider's discretion. Patient agrees as follows:

1. Provider, shall have an irrevocable lien against, and a security interest in, any settlement, award, judgment, verdict, or recovery arising out of the injury sustained by patient on the above-referenced Date of Injury. Patient assigns, to Provider, the proceeds from any such settlement, award, judgment, verdict, or recovery in an amount equivalent to Patient's outstanding balance for Services with Provider.

2. Patient assigns to Provider, in an amount equivalent to Services provided, any benefits available, or to which Patient may be entitled, and any legal or contractual rights patient may have under health insurance, uninsured/underinsured motorist coverage, and medical payment coverage. On Patient's behalf, Patient authorizes Provider to receive a complete copy of Patient's, or any third-party's insurance policy, including declarations sheets, endorsements, conditions, limitations, benefits, exclusions, and policy limits.

3. Patient understands and agrees that this Document is valid, secured, and enforceable upon execution and shall remain valid even if Provider's rights hereunder are assigned. Patient consents to any assignment at the discretion of Provider. Patient agrees that Provider may file this, and any other Document, with the appropriate court, any insurance carrier, with Patient's attorney, or the Colorado Secretary of State, as Provider so desires. Patient further authorizes Provider to provide copies of Patient's medical records to Patient's attorney and any insurance carrier who may be responsible for payment of Services, either through contract or due to a third-party's liability. Patient acknowledges receipt of Disclosures/Advisements pursuant to C.R.S. 38-27.5-104, *et. seq.*

4. Patient directs any attorney representing Patient to acknowledge and honor this Document, even if not signed by the attorney, and to make payment to Provider pursuant to the same. This document is intended to be valid and enforceable, even if not signed by Patient's attorney. Patient's attorney is advised, that by execution of this Document, that Patient recognizes that Provider is a third party with an undisputed interest in Patient's claim/case as anticipated by Colorado Formal Ethics Opinion 94.

5. Patient authorizes and directs Patient's attorney, Patient's insurance company, or any third-party insurance company to disclose all insurance benefits, offers, status of negotiations, and any final settlement or judgment amount, along with date of settlement, all provider or insurer lien reductions, and disbursement amounts to others (actual or proposed).

6. Provider shall not be responsible, either in part or in whole, for payment of attorney's fees, expenses, or costs which Patient may incur for the collection of funds due from third parties or insurance benefits.

Patient understands that Provider is not subject to either the "made-whole rule" or the "common fund doctrine."

7. This agreement does not create a continuing obligation to provide Services for Patient. Should Patient or Patient's representative request that Provider bill services to health or other insurance, such request shall be made in writing. In the event Provider is asked to bill health or other insurance, Patient shall be responsible for payment of all co-payments or deductibles at the time of service, unless another method of payment is agreed to between Patient and Provider, in writing.

8. This Document applies to amounts currently owed by Patient to Provider and to amounts which may be incurred in the future. Patient agrees that this Document shall apply to any balances owed by patient for past or future treatment, whether or not such Services are related to the Date of Injury as set forth above.

9. Patient agrees that this document shall be governed by the laws of Colorado and any dispute under this document, or for Services provided, shall be brought in the county where Patient received Services.

10. In the event patient has made any misrepresentations or committed fraud, Patient shall be responsible for Provider's reasonable attorney's fees and costs should collection efforts be undertaken by Provider, whether or not a lawsuit is undertaken.

11. If any provision of this agreement is deemed to be unenforceable for any reason, the remaining portions shall still be enforceable and have binding effect.

Dated this ____ day of _______, 20____.

______________________________	______________________________
Signature of Patient/Guardian	Printed Name
	______________________________
	Address
	______________________________
	City, State, Zip

ACKNOWLEDGEMENT

I, the undersigned attorney, am the attorney of record for Patient named above. I hereby acknowledge receipt of the foregoing Irrevocable Lien, Assignment of Benefits, and Security Interest and hereby agreed to honor and observe the terms herein. **I provide this acknowledgement with the understanding that attorneys' fees and costs shall be deducted BEFORE payment of any Services pursuant to this Lien**.

______________________________	______________________________
Attorney Signature	Attorney Printed Name
	______________________________
	Firm Name

Hatch Chiropractic Informed Consent

I understand that I am the decision maker for my health care. Part of this office's role is to provide me with information to assist me in making informed choices. The purpose of the informed consent is for my understanding and agreement regarding the care recommended, the benefits and risks associated with the care, alternatives and the potential effect on my health if I choose not to receive the care.

Chiropractic Treatment – the doctor will use his/her hands or a mechanical device to move your joints. You may feel a click or pop, you may also feel movement of the joint. Various therapies, such as hot or cold packs, electric muscle stimulation, and therapeutic ultrasound may be used. **Possible risks:** As with any health care procedure, complications are possible following a chiropractic manipulation. Complications could include fractures of bone, muscular strain, ligaments sprain, dislocations of joints, or injury to intervertebral discs, nerves, or spinal cord. Cerebrovascular injury or stroke could occur upon severe injury to arteries of the neck, although this is a rare occurrence. A minority of patients may notice stiffness or soreness after the first few days of treatment.

Acupuncture Treatment – I understand that methods of treatment may vary, but are not limited to, acupuncture, cupping, and Chinese massage. I have been informed that acupuncture is a generally safe method of treatment, but, as with all types of healthcare interventions, there are some risks of care. **Possible risks:** Bruising, numbness or tingling near the needling sites that may last a few days; and dizziness or fainting. Bruising is a common side effect of cupping. Unusual risks of acupuncture include nerve damage and organ puncture, including lung puncture (pneumothorax). Infection is another possible risk, although the clinic uses sterile disposable needles and maintains a clean and safe environment.

Physical Therapy – Response to physical therapy intervention varies from person to person; hence, it is not possible to accurately predict your response to a specific modality, procedure, or exercise protocol. Hatch Chiropractic does not guarantee what your reaction will be to a specific treatment, nor does it guarantee that the treatment will help resolve the condition that you are seeking treatment for. **Possible risks:** It is possible that the physical therapy treatment may result in aggravation of existing symptoms and may cause discomfort, pain, or injury.

Dry Needling – Functional Dry Needling (FDN) involves inserting a monofilament needle into a muscle or tissue to reset the tissue to an improved homeostasis. This can help to resolve pain and muscle tension, as well as promote healing. This is not traditional Chinese acupuncture, it is a medical treatment that relies on a medical diagnosis to be effective. **Possible risks:** FDN may cause injury to a blood vessel causing a bruise, infection, and/or nerve injury. The most serious risk with FDN is accidental puncture of a lung (pneumothorax), this is a rare complication.

While I do not expect the clinical staff to be able to anticipate and explain all possible risks and complications of treatment, I wish to rely on the doctor to exercise judgment during the course of treatment, based upon the facts then known to be in my best interest. I understand that, as with all healthcare approaches, results are not guaranteed, and there is no promise to cure.

I understand that I must inform, and continue to fully inform, this office of any medical history, family history, medications, and/or supplements being taken (prescription and over-the-counter drugs). I understand the clinical and administrative staff may review my patient records and lab reports, all which are kept confidential and will not be released without my written consent.

My signature below confirms that I have read and fully understand the consent to treatment. I understand the risks and benefits of the procedures and have had an opportunity to ask questions.

Pregnancy Release: I certify that to the best of my knowledge I am not pregnant, and the clinical staff has my permission to perform x-rays. I have been advised that x-ray can be hazardous to an unborn child.

Date of last menstrual cycle: ______________________________ Initials __________

Patient Printed Name: ______________________________ Date: ____________________

Patient Signature: ______________________________

Primary Auto Insurance Information

Date of Injury: ______________________ What state was the accident in? ________

Insurance Company: ____

Claim Number: ____________________ Has accident been reported: Y N

Insured's Policy Number: _________________ Adjuster's Name: ____________________

Adjuster's Phone Number (include extension): ________________________________

Third Party Insurance Information

Date of Injury: ______________________ What state was the accident in? ________

Insurance Company: ____

Claim Number: ____________________ Has accident been reported: Y N

Insured's Policy Number: _________________ Adjuster's Name: ____________________

Adjuster's Phone Number (include extension): ________________________________

Have you retained an attorney? Y N

Name: ____________________________ Phone Number: ____________________

Address: ____

City: ________________________________ State: _________ Zip: ____________

Who was the at-fault? You Other Driver

Did you go to the hospital? Y N

Name	Dat e	Date
Max Foramin Comp	+ - L R	+ - L R
Jackson Comp	+ - L R	+ - L R
Cervical Distraction	+ - L R	+ - L R
Shoulder Depression	+ - L R	+ - L R
George's Test	+ - L R	+ - L R
Allens	+ - L R	+ - L R
Adson's	+ - L R	+ - L R
Wright's	+ - L R	+ - L R
Soto Hall	+ - L R	+ - L R
Bechterew Sitting	+ - L R	+ - L R
Minor's	+ - L R	+ - L R
Kemps	+ - L R	+ - L R
Braggard Test	+ - L R	+ - L R
Laseque	+ - L R	+ - L R
Fabre Patrick	+ - L R	+ - L R
Hibb's Test	+ - L R	+ - L R
Nachlas' Test	+ - L R	+ - L R
Ely's Test	+ - L R	+ - L R
Yeoman's Test	+ - L R	+ - L R
Heel Walk Test	+ - L R	+ - L R
Toe Walk Test	+ - L R	+ - L R
Rhomberg	+ - L R	+ - L R
Heel-Toe Walk	N AB	N AB
Rapid Hand	N AB	N AB
Finger to Nose	N AB	N AB
Finger to finger	N AB	N AB
Check Reflex	N AB	N AB

	Trigger	Spasm	Trigger	Spasm
Cervical Flexors	L R	L R	L R	L R
Cervical Extensors	L R	L R	L R	L R
Trapezius	L R	L R	L R	L R
Rhomboids	L R	L R	L R	L R
Thoracic M	L R	L R	L R	L R
Lumbar Extensors	L R	L R	L R	L R
Gluteus M	L R	L R	L R	L R
Hamstrings	L R	L R	L R	L R

Motion Dysfunction		
TMJ		
Cervical Spine		
Upper Thoracic		
Thoracic Spine		
Lumbar Spine		
Lumbo Sacral		
Left SI		
Right SI		
Bi Lateral SI		

Dermatomes	Left	Right	Left	Right
C3	N	N	N	N
C4	N	N	N	N
C5	N	N	N	N
C6	N	N	N	N
C7	N	N	N	N
C8	N	N	N	N
T1	N	N	N	N
L1	N	N	N	N
L2	N	N	N	N
L3	N	N	N	N
L4	N	N	N	N
L5	N	N	N	N
S1	N	N	N	N
Vibratory sense				
Reflexes				
Jaw	N		N	
Pectoral	N	N	N	N
Biceps	N	N	N	N
Triceps	N	N	N	N
Brachioradialis	N	N	N	N
Patella	N	N	N	N
Medial Hamstring	N	N	N	N
Achilles	N	N	N	N
Muscle Weakness				
Circle Dominate hand	LEFT	RIGHT	LEFT	RIGHT
C Lat Flexors				
Deltoids				
Biceps Brachii				
Triceps				
Wrist extensors				
Wrist Flexors				
Finger Abductors				
Finger Flexors				
Lower				
Lumbar Extensors				
Gluteus				
Hamstring				
Biceps Femoris				
Tensor Fascia Lata				
Gastroc/Soleus				
Tibialis Anterior				
Extensor Halucis Longus				

Cervical	Normal		psi	Pain	Normal		psi	Pain
Flexion	50				50			
Extension	60				60			
Left Lat Flex	45				45			
Right Lat Flex	45				45			
Left Rotation	80				80			
Right Rotation	80				80			
Lumbar								
Flexion	60				60			
Extension	25				25			
Left Lat Flex	25				25			
Right Lat Flex	25				25			

CROFT WHIPLASH TREATMENT GUIDELINES

It is important to stress that guidelines are merely guides to care - not prescriptions for treatment schedules. The patient is always the ultimate guide to the need for care. Guidelines can alert the clinician to possibly missed or occult injuries, in the case where his treatment appears outside the guidelines, or to the possibility that his approach to care needs to be reevaluated.

THE STAGES OF INJURY

Stage I (acute inflammatory stage), 0 - 72 hours;

Stage II (repair stage), 72 hours - 14 weeks;

Stage III (remodeling stage), 14 weeks - 12 months or more; and

Stage IV (chronic; permanent).

THE FIVE GRADES OF SEVERITY OF CAD TRAUMA

Grade I: minimal; no limitation of range of motion, no ligamentous injury, no neurological symptoms;

Grade II: slight; limitation of range of motion, no ligamentous injury, no neurological findings;

Grade III: moderate; limitation of range of motion, some ligamentous injury, neurological findings present;

Grade IV: moderate to severe; limitation of range of motion, ligamentous instability, neurological findings present, fracture or disc derangement; and

Grade V: severe, requires surgical treatment and stabilization.

PLACING THE GRADED PATIENT WITHIN THE FREQUENCY/DURATION TABLE

The table below details these treatment recommendations in tabular form. In the two right hand columns are listed the approximate maximum treatment duration and the approximate maximum number of visits expected to be necessary over that period. Patients not at high risk for poor outcome should not require treatment approaching these maxima. This guideline is based on analysis of approximately 2,000 randomly selected cases from a number of treating practitioners' files.

Grade	Daily	3x/wk	2x/wk	1x/wk	1x/mo	TD	TN
Grade I	1 wk	1-2 wk	2-3 wk	> 4 wk	—*	> 10 wk	> 21
Grade II	1 wk	> 4 wk	> 4 wk	> 4 wk	> 4 mo	> 29 wk	> 33
Grade III	1-2 wk	> 10 wk	> 10 wk	> 10 wk	> 6 mo	> 56 wk	> 76
Grade IV	2-3 wk	> 16 wk	> 12 wk	> 20 wk	**	**	**
Grade V	Surgical stabilization necessary - chiropractic care is post surgical						

TD = treatment duration	*possible follow-up at one month
TN = treatment number	**may require permanent monthly or prn care

POTENTIALLY COMPLICATING FACTORS THAT MAY PROLONG CARE

Advance Age
Metabolic disorders
Congenital anomalies of the spine
Development anomalies of the spine
Degenerative disc disease

Disc protrusion/herniation
Spondylosis and/or facet arthrosis
Arthritis of the spine
AS or other spondylarthropathy
Prior cervical or lumbar spine surgery

Prior vertebral facture
Osteoporosis or bone disease
Spinal or foraminal stenosis
Paraplegia/tetraplegia
Prior spinal injury; scoliosis

Concussion Symptoms

	None	Mild		Moderate		Severe	
Headache	0	1	2	3	4	5	6
"Pressure in head"	0	1	2	3	4	5	6
Neck pain	0	1	2	3	4	5	6
Nausea or vomiting	0	1	2	3	4	5	6
Dizziness	0	1	2	3	4	5	6
Blurred vision	0	1	2	3	4	5	6
Balance problems	0	1	2	3	4	5	6
Sensitivity to light	0	1	2	3	4	5	6
Sensitivity to noise	0	1	2	3	4	5	6
Feeling slowed down	0	1	2	3	4	5	6
Feeling like "in a fog"	0	1	2	3	4	5	6
"Don't feel right"	0	1	2	3	4	5	6
Difficulty concentrating	0	1	2	3	4	5	6
Difficulty remembering	0	1	2	3	4	5	6
Fatigue or low energy	0	1	2	3	4	5	6
Confusion	0	1	2	3	4	5	6
Drowsiness	0	1	2	3	4	5	6
More emotional	0	1	2	3	4	5	6
Irritability	0	1	2	3	4	5	6
Sadness	0	1	2	3	4	5	6
Nervous or anxious	0	1	2	3	4	5	6
Trouble falling asleep (if applicable)	0	1	2	3	4	5	6

Total Number of symptoms ________ of 22

Symptom severity score ________ of 132

Do your symptoms get worse with ph ysical activity? Y N

Do your symptoms getw orse with mental activity? Y N

If 100% is feeling perfectly normal, what percent of normal do you feel? ________ %

If not 100%, why?

____

____

____

NECK BOURNEMOUTH QUESTIONNAIRE

Patient Name ______________________________ Date ____________________

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

1. Over the past week, on average, how would you rate your 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 you been feeling?

Not at all anxious — Extremely anxious

0 1 2 3 4 5 6 7 8 9 10

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

Not at all depressed — Extremely depressed

0 1 2 3 4 5 6 7 8 9 10

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

____
Examiner

OTHER COMMENTS: ____

With Permission from: Bolton JE, Humphreys BK: The Bournemouth Questionnaire: A Short-form Comprehensive Outcome Measure. II. Psychometric Properties in Neck Pain Patients *JMPT* 2002; 25 (3): 141-148.

CAD Injury History Form

General information:

Patient' name: ______________________
Today's date: ______________________
Date of injury: ______________________
Marital status: ☐ M ☐ S ☐ W ☐ D
Habits:
Smoke: ☐ None Pk/day _____ Years _____
Alcohol: ☐ Never ☐ Social ☐ Light ☐ Mod. ☐ Heavy
Employment:
At time of crash: ______________________
☐ Unemployed
Currently: ______________________
☐ Unemplyed
Due to crash? ☐ Yes ☐ No
Type of work: ☐ Office/clerical ☐ Light labor ☐ Moderate labor ☐ Heavy labor

Past medical history:

Surgeries (dates and residuals): ______________________

Fractures (dates and residuals): ______________________

Serious illness (dates and residuals): ______________________

Workers' comp. injuries (date, TX, awards, residuals): ______________________

Personal Injuries (date, TX, awards, residuals): ______________________

Sports or other injuries to head, neck, or back: ______________________

Past medical history (cont'd)

Any prior HX of current complaints:
1. ______________________
2. ______________________
3. ______________________

Prior TX by DC for these:
1. ______________________
2. ______________________
3. ______________________

Current Medical history:

Current health problems: ☐ None
____

Current medications taken: ☐ None
____

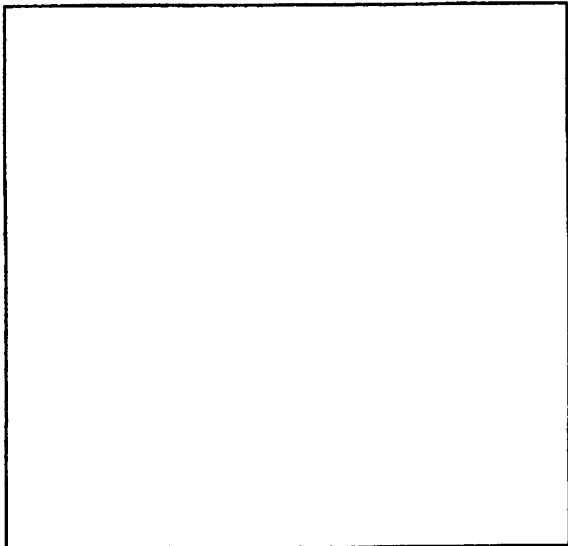
Injury history. General:

Was the crash on-the-job? ☐ Yes ☐ No
You were: ☐ Driver ☐ Front seat passenger ☐ Rear seat passenger ☐ Motorcycle operator ☐ Motorcycle passenger ☐ Other _____
Vehicle driven by: ______________________
Your vehicle (year, make, model): ______________________
Your estimated speed at moment of crash: _____
☐ Stopped ☐ Slowing ☐ Accelerating
Other vehicle (year, make, model): ______________________
Time of day: ☐ Daylight ☐ Dawn ☐ Dusk ☐ Dark
Road conditions: ☐ Dry ☐ Damp ☐ Wet ☐ Snow ☐ Ice ☐ Other _____
Head restraints: ☐ None ☐ Integral type ☐ Adjustable type: ☐ Up ☐ Down ☐ Don't know
If adjustable, was the position altered by the crash? ☐ Yes ☐ No
Was the seat back adjustment altered by the crash? ☐ Yes ☐ No
Was the seat broken? ☐ Yes ☐ No
Lap belt: ☐ Wearing ☐ Not wearing ☐ Don't know
Shoulder belt: ☐ None ☐ Wearing ☐ Not wearing ☐ Don't know
Did air bag deploy? ☐ Yes ☐ No
If yes, were you struck? ☐ Yes ☐ No
Body position: ☐ Good ☐ Forward lean
Other ______________________
Head position: ☐ Forward ☐ Left ___° ☐ Right ___° ☐ Up ___° ☐ Down ___°

Injury history. General: (cont'd)

Hands: ☐ One on wheel ☐ Two on wheel
☐ N/A
Brakes applied? ☐ Yes ☐ No
Crash description: ____________________
____
____
____
____
____
____
____
____

Crash diagram:



Aware of impending crash? ☐ Yes ☐ No

During the crash:

Did you strike any parts of the vehicle? ☐ Y ☐ N
If yes, describe____________________
Did vehicle strike any objects after crash?
If yes, describe____________________
Wearing hat or glasses? ☐ Yes ☐ No
If yes, still on after crash? ☐ Yes ☐ No
Did you lose consciousness? ☐ Yes ☐ No
If yes, for how long?____________________
Estimated property damage to your vehicle:
$ ____________________
Estimated damage to other vehicle(s): ☐ None
☐ Minimal ☐ Moderate ☐ Major
Were the police on-scene? ☐Yes ☐No
If yes, was a report made? ☐Yes ☐No

After the crash:

Symptoms: ☐ Headache ☐ Dizziness ☐ Nausea
☐ Confusion/disorientation ☐ Neck pain
☐ Paresthesia(s)
If yes, where?____________________
☐ Extremity pain. If yes, where?____________________
☐ Back pain
When did SX first appear? ☐ Immediately
(describe which SX)____________________ hr afterward
Where did you go after crash? ☐ Home
☐ Work ☐ Hospital:
Mode of transportation ____________________
Pvt. doctor:____________________

Emergency department:

Radiographs: ☐ Yes ☐ No
Body parts imaged____________________
Results____________________
Lab work ☐ Yes ☐ No ____________________
☐ Cervical collar ☐ Ice
Medications:____________________
Other: ____________________
Follow-up instructions: ☐ None____________________

Treatment history:

1. Dr.: ____________________
Specialty:__________ Date first seen: __________
Referred by:__________TX type: __________
TX frequency:__________TX duration: __________
Currently treating? ☐ Yes ☐ No
Any disability? ☐ Yes ☐ No
If yes, describe:____________________
Special tests:____________________
Referred to:____________________
Did TX help? ☐ Yes ☐No
Notes: ____________________
____

2. Dr.: ____________________
Specialty:__________ Date first seen:__________
Referred by:__________TX type:__________
TX frequency:__________TX duration:__________
Currently treating? ☐ Yes ☐ No
Any disability? ☐ Yes ☐ No
If yes, describe:____________________
Special tests:____________________
Referred to:____________________
Did TX help? ☐ Yes ☐No
Notes: ____________________
____

Treatment history: (cont'd)

3. Dr.: ______
Specialty: ______ Date first seen: ______
Referred by: ______ TX type: ______
TX frequency: ______ TX duration: ______
Currently treating? ☐ Yes ☐ No
Any disability? ☐ Yes ☐ No
If yes, describe: ______
Special tests: ______
Referred to: ______
Did TX help? ☐ Yes ☐ No
Notes: ______
______

4. Dr.: ______
Specialty: ______ Date first seen: ______
Referred by: ______ TX type: ______
TX frequency: ______ TX duration: ______
Currently treating? ☐ Yes ☐ No
Any disability? ☐ Yes ☐ No
If yes, describe: ______
Special tests: ______
Referred to: ______
Did TX help? ☐ Yes ☐ No
Notes: ______
______

5. Dr.: ______
Specialty: ______ Date first seen: ______
Referred by: ______ TX type: ______
TX frequency: ______ TX duration: ______
Currently treating? ☐ Yes ☐ No
Any disability? ☐ Yes ☐ No
If yes, describe: ______
Special tests: ______
Referred to: ______
Did TX help? ☐ Yes ☐ No
Notes: ______
______

6. Dr.: ______
Specialty: ______ Date first seen: ______
Referred by: ______ TX type: ______
TX frequency: ______ TX duration: ______
Currently treating? ☐ Yes ☐ No
Any disability? ☐ Yes ☐ No
If yes, describe: ______
Special tests: ______
Referred to: ______
Did TX help? ☐ Yes ☐ No
Notes: ______
______
______
______

Original chief complaints (if injury was not recent):

1. Body part/system: ______
Onset: ______
Provocative: ______
Palliative: ______
Quality: ______
Radiation: ______
Severity (1-4): ______
Temporal: ______

2. Body part/system: ______
Onset: ______
Provocative: ______
Palliative: ______
Quality: ______
Radiation: ______
Severity (1-4): ______
Temporal: ______

3. Body part/system: ______
Onset: ______
Provocative: ______
Palliative: ______
Quality: ______
Radiation: ______
Severity (1-4): ______
Temporal: ______

4. Body part/system: ______
Onset: ______
Provocative: ______
Palliative: ______
Quality: ______
Radiation: ______
Severity (1-4): ______
Temporal: ______

5. Body part/system: ______
Onset: ______
Provocative: ______
Palliative: ______
Quality: ______
Radiation: ______
Severity (1-4): ______
Temporal: ______
______
______
______
______
______

Current chief complaints:

1. Body part/system: ______
Onset: ______
Provocative: ______
Palliative: ______
Quality: ______
Radiation: ______
Severity (1-4): ______
Temporal: ______

2. Body part/system: ______
Onset: ______
Provocative: ______
Palliative: ______
Quality: ______
Radiation: ______
Severity (1-4): ______
Temporal: ______

3. Body part/system: ______
Onset: ______
Provocative: ______
Palliative: ______
Quality: ______
Radiation: ______
Severity (1-4): ______
Temporal: ______

4. Body part/system: ______
Onset: ______
Provocative: ______
Palliative: ______
Quality: ______
Radiation: ______
Severity (1-4): ______
Temporal: ______

5. Body part/system: ______
Onset: ______
Provocative: ______
Palliative: ______
Quality: ______
Radiation: ______
Severity (1-4): ______
Temporal: ______

Self assessment as of today: % improved (list for separate areas)

______

Request records:

- ☐ 1. Request radiographs from: ______
- ☐ 2. Request records from: ______
- ☐ 3. Request copy of police report.

Referral:

- ☐ For: ______
- ☐ To: ______

Tests to order:

- ☐ Radiographs: ______
- ☐ Tomograms: ______
- ☐ CT: ______
  Area(s): ______
- ☐ MRI: ______
  Area(s): ______
- ☐ MRA: ______
  Area(s): ______
- ☐ Scintigraphy/SPECT: ______
  Area(s): ______
- ☐ Videofluoroscopy: ______
  Area(s): ______
- ☐ EMG/NCV: ______
  Root level/nerve(s): ______
- ☐ SEP: ______
  Root level/nerve(s): ______
- ☐ Other electrodiagnostic test(s): ______
- ☐ Ultrasound: ______
  Area(s): ______

Action taken on this visit:

- ☐ Exam/TX: ______
- ☐ Place on disability: ______
- ☐ Work restriction: ______
- ☐ Referral: ______
- ☐ Brace/collar: ______
- ☐ Home traction device: ______
- ☐ NEXERCICER: ______
- ☐ Supplements: ______
- ☐ Other: ______

The Revised Oswestry Disability Index (for low back pain/dysfunction)

Patient name: ______________________ **File #**__________ **Date:**__________

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

SECTION 1-PAIN INTENSITY

- ☐ The pain comes and goes and is very mild.
- ☐ The pain is mild and does not vary much.
- ☐ The pain comes and goes and is moderate.
- ☐ The pain is moderate and does not vary much.
- ☐ The pain comes and goes and is very severe.
- ☐ The pain is severe and does not vary much.

SECTION 2-PERSONAL CARE

- ☐ I would not have to change my way of washing or dressing in order to avoid pain.
- ☐ I do not normally change my way of washing or dressing even though it causes some pain.
- ☐ Washing and dressing increases the pain, but I manage not to change my way of doing it.
- ☐ Washing and dressing increases the pain and I find it necessary to change my way of doing it.
- ☐ Because of the pain, I am unable to do some washing and dressing without help.
- ☐ Because of the pain, I am unable to do any washing and dressing without help.

SECTION 3-LIFTING

- ☐ I can lift heavy weights without extra pain.
- ☐ I can lift heavy weights, but it causes extra pain.
- ☐ Pain prevents me from lifting heavy weights off the floor, but I manage if they are conveniently positioned (e.g., on a table).
- ☐ Pain prevents me from lifting heavy weights off the floor.
- ☐ Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
- ☐ I can only lift very light weights at the most.

SECTION 4-WALKING

- ☐ I have no pain on walking.
- ☐ I have some pain on walking, but it does not increase with distance.
- ☐ I cannot walk more than one mile without increasing pain.
- ☐ I cannot walk more than 1/2 mile without increasing pain.
- ☐ I cannot walk more than 1/4 mile without increasing pain.
- ☐ I cannot walk at all without increasing pain.

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 1/2 hour.
- ☐ Pain prevents me from sitting more 10 minutes.
- ☐ I avoid sitting because it increases pain right away.

SECTION 6-STANDING

- ☐ I can stand as long as I want without pain.
- ☐ I have some pain on standing, but it does not increase with time.
- ☐ I cannot stand for longer than one hour without increasing pain.
- ☐ I cannot stand for longer than 1/2 hour without increasing pain.
- ☐ I cannot stand for longer than 10 minutes without increasing pain.
- ☐ I avoid standing because it increases the pain right away.

SECTION 7-SLEEPING

- ☐ I get no pain in bed.
- ☐ I get pain in bed, but it does not prevent me from sleeping well.
- ☐ Because of pain, my normal night's sleep is reduced by less than 1/4.
- ☐ Because of pain, my normal night's sleep is reduced by less than 1/2.
- ☐ Because of pain, my normal night's sleep is reduced by less than 3/4.
- ☐ Pain prevents me from sleeping at all.

SECTION 8-SOCIAL LIFE

- ☐ My social life is normal and gives me no 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, etc.
- ☐ Pain has restricted my social life and I do not go out very often.
- ☐ Pain has restricted my social life to my home.
- ☐ I have hardly any social life because of the pain.

SECTION 9-TRAVELLING

- ☐ I get no pain while travelling.
- ☐ I get some pain while travelling, but none of my usual forms of travel makes it any worse.
- ☐ I get extra pain while travelling, but it does not compel me to seek alternative forms of travel.
- ☐ I get extra pain while travelling, which compels me to seek alternative forms of travel.
- ☐ Pain restricts all forms of travel.
- ☐ Pain prevents all forms of travel except that done lying down.

SECTION 10-CHANGING DEGREE OF PAIN

- ☐ My pain is rapidly getting better.
- ☐ My pain fluctuates, but is definitively getting better.
- ☐ My pain seems to be getting better, but improvement is slow at present.
- ☐ My pain is neither getting better nor worse.
- ☐ My pain is gradually worsening.
- ☐ My pain is rapidly worsening.