The Centre for Chiropractic Health

2340 S. Highland Avenue, Suite 360 Lombard, IL 60148
Tel: (630) 268 - 2680 Email: info@cch4you.com
Fax: (630) 268 - 2689 Web: www.cch4you.com

CONFIDENTIAL PATIENT INFORMATION

Patient #_____

Today's Date_____ Social Security #_____
First Name_____ M.I._____ Last Name_____
Address_____ Unit #_____ City_____
State_____ Zip_____ Birth Date (mm/dd/yyyy)_____ Age_____ Sex: ☐M ☐F
Home # (_____)_____ Work # (_____)_____ Ext._____
Cell # (_____)_____ E-mail_____
Which phone # would you prefer us to contact you with? ☐Home ☐Work ☐Cell ☐Other # (_____)_____

Marital Status: ☐Single ☐Married ☐Other Spouse Name_____ # of Children_____
Occupation (optional)_____ Employer (optional)_____
Spouse Occupation (optional)_____ Spouse Employer (optional)_____
Name of Family Doctor_____ Family Doctor # (_____)_____
When doctors work together it benefits you. May we have your permission to update your medical doctor regarding your care at this office? ☐Y ☐N

How did you hear about our office?
☐Friend / Family (name)_____ ☐Clinic Location
☐Website (name web site?)_____ ☐Postcard
☐Advertisement (which ad?)_____ ☐Insurance Directory
☐At the gym (which gym?)_____ ☐Other (describe)_____

INSURANCE INFORMATION

How will you be paying for today's visit? ☐Cash ☐Check ☐Credit Card

Please ✓ all insurance coverage that may be applicable in this case**:**
☐Major Medical ☐Auto Accident ☐Worker's Compensation ☐Medicare ☐Flex Plans ☐Other_____

Health Insurance Patients: *We will file insurance for our patients. Our policy is to collect full payment from the patient until insurance is verified. **If we have a copy of your insurance card, you may skip this section.

Insurance Carrier Name_____
Group #_____ Policy #_____
Is the insurance policy in your name? ☐Y ☐N (**If No**, please fill out the following for the insured)
Insured's First Name_____ M.I._____ Last Name_____
Insured's Address_____ Unit #_____ City_____
State_____ Zip_____ Insured's Birth Date (mm/dd/yyyy)_____ Sex: ☐M ☐F
Insured's Social Security #_____ Your relation to the Insured_____

Auto Accident & Worker's Compensation Patients: Type: ☐Auto Accident ☐Worker's Compensation
Insurance Carrier Name_____
Insurance Carrier Address_____
Insurance Carrier City, State, Zip_____
Date of Injury_____ Claim Number_____
Adjuster's Name_____ Adjuster's Telephone (_____)_____

PRESENT MEDICAL HISTORY

Purpose of today's visit:_____
Date symptoms appeared or accident happened:_____
Is present illness due to: ☐Auto ☐Work ☐Illness ☐Unknown ☐Other (describe)_____
Have you ever had the same or a similar condition? ☐Y ☐N If yes, when:_____
Days lost from work:_____ Last physical exam (date):_____

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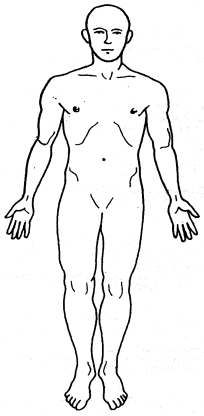
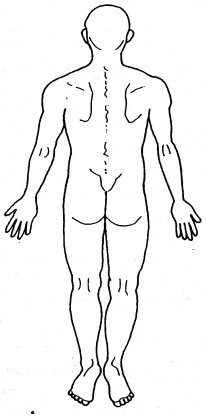
Patient #_____

Describe each PAIN or SYMPTOM that you are having and **place ✓ on the SEVERITY OF PAIN SCALE** to indicate the level of discomfort that the pain/symptom creates. **1 = No pain** and **10 = Worst pain ever.**

PAIN or SYMPTOM DESCRIPTION:	**SEVERITY OF PAIN SCALE:**
1._____	☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10
2._____	☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10
3._____	☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10

PAIN DRAWING: Mark your painful spots on the picture. If your pain radiates, draw an arrow from where it starts to where it stops. Use the appropriate symbols to describe the pain.

Ache > > > **Burning x x x** **Numbness = = =** **Pins/Needles o o o** **Stabbing / / /** **Throbbing ~ ~ ~**

R  L  R

Symptoms occur in: ☐Morning ☐Afternoon ☐Night ☐Consistently ☐Come & Go ☐Other
Symptoms have persisted for (number): ____Hours ____Days ____Weeks ____Months ___Years

Check the following activities that **AGGRAVATE YOUR CONDITION:**
☐Bending ☐Coughing ☐Lifting ☐Lying ☐Reaching ☐Sitting ☐Sneezing
☐Standing ☐Turning Head ☐Walking ☐Straining at Stool ☐Other_____

Check the following activities that **RELIEVE YOUR CONDITION:**
☐Bending ☐Lifting ☐Lying ☐Reaching ☐Sitting ☐Standing ☐Turning Head
☐Walking ☐Stretching ☐Self Massage ☐Cold Pack ☐Hot Pack ☐Other_____

PAST MEDICAL HISTORY

Have you ever been diagnosed as having or have suffered from: (Place ✓ by the conditions that apply to you)

☐Alcoholism	☐Depression	☐Fractured Bones	☐Rheumatoid Arthritis
☐Cancer	☐Drug Addiction	☐High/Low Blood Pressure	☐Seizures/Convulsions
☐Circulatory Problems	☐Eating Disorder	☐HIV Positive	☐Shortness of Breath
☐Congenital Disease	☐Epilepsy	☐Osteoarthritis	☐Strokes
☐Coughing Blood	☐Excessive Bleeding	☐Pace Maker	☐Ulcers
☐Blurred Vision	☐Constipation	☐Headaches	☐Loss of Concentration
☐Buzzing in Ears	☐Diarrhea	☐Insomnia	☐Muscle Jerking
☐Chronic Fatigue	☐Dizziness	☐Light Bothers Eyes	☐Stiff Neck
☐Cold Hands/Feet	☐Fainting	☐Loss of Balance	☐Other_____

Do you have a history of Stroke or Hypertension? ☐Y ☐N Describe_____
Have you had any major illnesses, injuries, car accidents, surgeries, or hospitalizations (include dates)? **Women,** include information about childbirths_____
_____

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Patient #_____

_____

♀**Women:** Any menstrual difficulties? ☐Y ☐N Describe_____
Are you pregnant? ☐Y ☐N Last Period (date)_____
Last Pap (date)_____ Last Mammogram (date)_____
Are you taking any medications/drugs? ☐Y ☐N Describe_____
Do you have any allergies? ☐Y ☐N Describe_____
Have you been treated by a physician for any health condition in the last year? ☐Y ☐N
Describe condition(s)_____
Please list any other health problems you have, no matter how insignificant they may be:
_____

SOCIAL HISTORY

Do you drink alcohol? ☐Y ☐N Drinks per week_____
Do you smoke? ☐Y ☐N Packs per day_____
Do you drink caffeine? ☐Y ☐N Drinks per day_____
Do you take vitamin supplements? ☐Y ☐N Describe_____
Do you exercise? ☐Y ☐N Frequency and type of activity_____
List personal hobbies:_____
What percentage of time during the day (at home or at work) do you spend:
At computer____ Bending____ Lifting____ Pulling____ Pushing____ Sitting____ Standing____

FAMILY HISTORY

Father: Living____ Age____ Cause of death & age, if deceased_____ (✓below)
Mother: Living____ Age____ Cause of death & age, if deceased:_____ (✓ below)
Self: As an adopted child, little is known of birth parents or family. Place ✓ if applicable to you:____

FAMILY DISEASES Indicate whether **F**ather, **M**other, **S**ister, **B**rother, if applicable:

_____Arthritis	_____Chest Pain	_____Liver Disease	_____Reproductive Disorders
_____Asthma	_____Diabetes	_____Lung Disease	_____Stroke
_____Back Pain	_____Heart Disease	_____Mental Illness	_____Thyroid Disease
_____Cancer	_____Kidney Disease	_____Muscular Dystrophy	_____Tuberculosis

Other Diseases_____

AUTHORIZATION AND RELEASE

I authorize payment of insurance benefits directly to this chiropractic office. I authorize the doctor to release all information necessary to communicate with personal healthcare providers, payors and to secure the payment of benefits. I understand that I am responsible for all costs of chiropractic care, regardless of insurance coverage. I also understand that if I terminate my schedule of care as determined by my treating doctor, any fees for professional services will be immediately due and payable.

MISSED APPOINTMENT / CANCELLATION POLICY: We make every effort to accommodate your scheduling needs. In return we ask that you keep your scheduled appointments or notify us in advance if for any reason you are unable to keep your appointment. We request a 24 hour notice in order to reschedule or cancel your appointment. A $25 fee will be charged if you miss or cancel your appointment without a 24 hour notice. The missed appointment fee is NOT covered by insurance and is your responsibility to pay.

Patient Name (Print):_____ Date:_____

Patient Signature:_____

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INFORMED CONSENT AND AUTHORIZATION TO TREAT

Patient #_____

Please read and sign the informed consent. This must be read and signed prior to the doctor performing an examination. If you have any questions or concerns, please address them to the doctor.

CHIROPRACTIC:

Doctors of Chiropractic (D.C.) who use manual therapy techniques such as spinal adjustments are required to advise patients that there may be some risks associated with such treatment.

a) While rare, some patients have experienced rib fractures, or muscle and ligament strains or sprains following spinal adjustments.

b) Some types of spinal adjustments of the neck have been associated with injuries to the arteries in the neck leading to or contributing to serious complications including stroke. Stroke has been the subject of tremendous disagreement within and without the profession, with prominent authority saying that there is at most a one-in-a-million chance of such an outcome. We employ tests in our examination which are designed to identify if you may be susceptible to that kind of injury.

c) There have been rare reported cases of disc injuries following neck or low back adjustments although no scientific study has ever demonstrated such injuries are caused, or may be caused, by spinal adjustments or chiropractic treatment.

Chiropractic treatment, including spinal adjustments, has been the subject of government reports and multidisciplinary studies conducted over many years and have been demonstrated to be highly effective in treating spinal pain, headaches and other symptoms. Chiropractic care contributes to your overall well being. The risk of injuries or complications from chiropractic treatment is substantially lower than that associated with many medical or other treatments, medications, and procedures given for the same symptoms.

☐ **PLEASE INITIAL AFTER READING**

ACUPUNCTURE:

I understand and am informed that in the practice of acupuncture there are some risks to treatment, including but not limited to, minor bleeding or bruising, minor pain or soreness, nausea, fainting, infection, shock, convulsions, and stuck or bent needles. I have been advised that only sterilized needles will be used. All acupuncture needles are properly disposed of after each and every treatment**.**

☐ **PLEASE INITIAL AFTER READING**

I do not expect the doctor to be able to anticipate and explain all possible risks and complications. I wish to rely on the doctor to exercise judgment during the course of treatment which the doctor feels at the time, based upon the facts then known, are in my best interests. I understand that the results are not guaranteed. I acknowledge I have discussed, or have had the opportunity to discuss, with my chiropractor the nature and purpose of the chiropractic treatment (may include spinal adjustments &/or acupuncture) as well as the contents of this Consent. I consent to the treatments recommended to me by my chiropractor.

Patient Name (Print):_____ Date:_____

Patient Signature:_____

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FINANCIAL POLICY FOR PATIENTS WITH HEALTH INSURANCE

The Centre for Chiropractic Health, Ltd. is "In-Network" with Blue Cross/Blue Shield PPO, Cigna, Medicare, MultiPlan, Private Health Care System (PHCS) and United Healthcare plans only. All other insurance plans are considered "Out-of-Network".

"In-Network" Insurance Plans: All co-payments, co-insurance, deductibles and non-covered services are due at the time of service. We will submit a claim one time on the patient's behalf. You are responsible for payment of all services your insurance company may deny or fail to pay.

"Out-of-Network" Insurance Plans: Payments for all services are due in full at the time services are provided. The Centre for Chiropractic Health, Ltd. is under no obligation to pursue reimbursement on the patient's behalf.

CREDIT GUARANTEE FOR "IN-NETWORK" INSURANCE PLANS ONLY

As the recipient of services from The Centre for Chiropractic Health, Ltd. you are ultimately responsible for payment for all services provided. In order for our office to bill your Insurance Plan, as a prerequisite, we ask that you provide a credit card on our security file to guarantee payment of your bill. Our office will submit a claim one time to your listed Health Insurance Provider. It is your responsibility to ensure that your health insurance pays your bill. If payment is not received in full within forty five (45) days after submission, by providing your credit card to be stored on our security file and by receiving provided services, you are authorizing The Centre for Chiropractic Health, Ltd. to charge your credit card for any unpaid bills or claims. Any claims paid after your credit card has been billed will be refunded to the patient. If your credit card becomes expired or is replaced due to fraudulent activity, it is your responsibility to inform us of your new card number immediately. If you choose not to leave a credit card on file, payment is due IN FULL AT THE TIME ALL SERVICES ARE PROVIDED.

☐PLEASE INITIAL AFTER READING

AUTHORIZATION (to release information & settle appeals or disputes) and ASSIGNMENT (of benefits to doctor)

I hereby authorize the doctor to release all medical information necessary to process any insurance claims. I authorize the use of this signature on all my insurance and/or employee health benefits claim submissions. I hereby convey to the above named doctor and clinic to the full extent permissible under the law and under any applicable insurance policies and/or employee health care plan any claim, chose in action, or other right I may have to such insurance and/or employee health care benefits coverage under any applicable insurance policies and/or employee health care plan with respect to medical expenses incurred as a result of the medical services I received from the above named doctor and clinic and to the extent permissible under the law to claim such medical benefits, insurance reimbursement and any applicable remedies. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original. I have read and fully understand this agreement.

In considering the amount of medical expenses to be incurred, I, the undersigned, have insurance and/or employee health care benefits coverage with the listed Health Insurance Provider, and hereby assign and convey directly to The Centre for Chiropractic Health, LTD. all medical benefits and/or insurance reimbursement, if any, otherwise payable to me for services rendered from such doctor and clinic. I understand that I am financially responsible for all charges regardless of any applicable insurance or benefit payments.

☐PLEASE INITIAL AFTER READING

Patient Name (Print): _____ Date: _____

Patient Signature: _____

Neck Pain and Disability Index (Vernon-Minor)

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 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 in my neck.
- ❑ 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.

SECTIONS 5 HEADACHES
- ❑ I have no headaches at all.
- ❑ I have slight headaches which come infrequently.
- ❑ I have moderate headaches which come infrequently.
- ❑ I have moderate headaches which come frequently.
- ❑ 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 can 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 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 mildly disturbed (1-2 hrs. sleepless).
- ❑ My sleep is moderately disturbed (2-3 hrs. sleepless).
- ❑ My sleep is greatly disturbed (3-5 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.

Pain Severity Scale:

Rate the Severity of your pain by checking one box on the following scale:

No pain	0	1	2	3	4	5	6	7	8	9	10	Excruciating Pain

Disabilities of the Arm, Shoulder and Hand

Please rate your ability to do the following activities in the last week by circling the number below the appropriate response.

	NO DIFFICULTY	MILD DIFFICULTY	MODERATE DIFFICULTY	SEVERE DIFFICULTY	UNABLE
1. Open a tight or new jar.	1	2	3	4	5
2. Write.	1	2	3	4	5
3. Turn a key.	1	2	3	4	5
4. Prepare a meal.	1	2	3	4	5
5. Push open a heavy door.	1	2	3	4	5
6. Place an object on a shelf above your head.	1	2	3	4	5
7. Do heavy household chores (e.g., wash walls, wash floors).	1	2	3	4	5
8. Garden or do yard work.	1	2	3	4	5
9. Make a bed.	1	2	3	4	5
10. Carry a shopping bag or briefcase.	1	2	3	4	5
11. Carry a heavy object (over 10 lbs).	1	2	3	4	5
12. Change a lightbulb overhead.	1	2	3	4	5
13. Wash or blow dry your hair.	1	2	3	4	5
14. Wash your back.	1	2	3	4	5
15. Put on a pullover sweater.	1	2	3	4	5
16. Use a knife to cut food.	1	2	3	4	5
17. Recreational activities which require little effort (e.g., cardplaying, knitting, etc.).	1	2	3	4	5
18. Recreational activities in which you take some force or impact through your arm, shoulder or hand (e.g., golf, hammering, tennis, etc.).	1	2	3	4	5
19. Recreational activities in which you move your arm freely (e.g., playing frisbee, badminton, etc.).	1	2	3	4	5
20. Manage transportation needs (getting from one place to another).	1	2	3	4	5
21. Sexual activities.	1	2	3	4	5

Disabilities of the Arm, Shoulder and Hand

	NOT AT ALL	SLIGHTLY	MODERATELY	QUITE A BIT	EXTREMELY
22. During the past week, *to what extent* has your arm, shoulder or hand problem interfered with your normal social activities with family, friends, neighbours or groups? *(circle number)*	1	2	3	4	5

	NOT LIMITED AT ALL	SLIGHTLY LIMITED	MODERATELY LIMITED	VERY LIMITED	UNABLE
23. During the past week, were you limited in your work or other regular daily activities as a result of your arm, shoulder or hand problem? *(circle number)*	1	2	3	4	5

Please rate the severity of the following symptoms in the last week. *(circle number)*

	NONE	MILD	MODERATE	SEVERE	EXTREME
24. Arm, shoulder or hand pain.	1	2	3	4	5
25. Arm, shoulder or hand pain when you performed any specific activity.	1	2	3	4	5
26. Tingling (pins and needles) in your arm, shoulder or hand.	1	2	3	4	5
27. Weakness in your arm, shoulder or hand.	1	2	3	4	5
28. Stiffness in your arm, shoulder or hand.	1	2	3	4	5

	NO DIFFICULTY	MILD DIFFICULTY	MODERATE DIFFICULTY	SEVERE DIFFICULTY	SO MUCH DIFFICULTY THAT I CAN'T SLEEP
29. During the past week, how much difficulty have you had sleeping because of the pain in your arm, shoulder or hand? *(circle number)*	1	2	3	4	5

	STRONGLY DISAGREE	DISAGREE	NEITHER AGREE NOR DISAGREE	AGREE	STRONGLY AGREE
30. I feel less capable, less confident or less useful because of my arm, shoulder or hand problem. *(circle number)*	1	2	3	4	5

DASH DISABILITY/SYMPTOM SCORE = _____ ([(sum of n responses / n) - 1] x 25, where n is the number of completed responses.)

A DASH score may <u>not</u> be calculated if there are greater than 3 missing items.

Low Back Pain and Disability Questionnaire (Revised Oswestry)

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 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
- ❑ 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 increase the pain but I manage not to change my way of doing it.
- ❑ Washing and dressing increase the pain and I find it necessary to change my way of doing it.
- ❑ Because of the pain lam 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.
- ❑ 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 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 half hour.
- ❑ Pain prevents me from sitting more than 10 minutes.
- ❑ I avoid sitting because it increases pain straight 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 straight away.

SECT ION 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 whilst traveling.
- ❑ I get some pain whilst traveling but none of my usual forms of travel make it any worse.
- ❑ I get extra pain whilst traveling but it does not compel me to seek alternative forms of travel.
- ❑ I get extra pain whilst traveling 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 overall is definitely 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.

Pain Severity Scale:

Rate the Severity of your pain by checking one box on the following scale

No pain	0	1	2	3	4	5	6	7	8	9	10	Excruciating Pain

THE LOWER EXTREMITY FUNCTIONAL SCALE

We are interested in knowing whether you are having any difficulty at all with the activities listed below because of your lower limb problem for which you are currently seeking attention. Please provide an answer for **each** activity.

Today, do you or would you have any difficulty at all with:

	Activities	Extreme Difficulty or Unable to Perform Activity	Quite a Bit of Difficulty	Moderate Difficulty	A Little Bit of Difficulty	No Difficulty
1	Any of your usual work, housework, or school activities.	0	1	2	3	4
2	Your usual hobbies, re creational or sporting activities.	0	1	2	3	4
3	Getting into or out of the bath.	0	1	2	3	4
4	Walking between rooms.	0	1	2	3	4
5	Putting on your shoes or socks.	0	1	2	3	4
6	Squatting.	0	1	2	3	4
7	Lifting an object, like a bag of groceries from the floor.	0	1	2	3	4
8	Performing light activities around your home.	0	1	2	3	4
9	Performing heavy activities around your home.	0	1	2	3	4
10	Getting into or out of a car.	0	1	2	3	4
11	Walking 2 blocks.	0	1	2	3	4
12	Walking a mile.	0	1	2	3	4
13	Going up or down 10 stairs (about 1 flight of stairs).	0	1	2	3	4
14	Standing for 1 hour.	0	1	2	3	4
15	Sitting for 1 hour.	0	1	2	3	4
16	Running on even ground.	0	1	2	3	4
17	Running on uneven ground.	0	1	2	3	4
18	Making sharp turns while running fast.	0	1	2	3	4
19	Hopping.	0	1	2	3	4
20	Rolling over in bed.	0	1	2	3	4
	Column Totals:					

Minimum Level of Detectable Change (90% Confidence): 9 points

SCORE: _____/ 80

Please submit the sum of responses to ASH

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