Knight Family Chiropractic ▪ Chiropractic Case History/Patient Information

Date: _____

Name _____ Social Security # ☐☐☐ ☐☐ ☐☐☐☐

Home Phone _____ Cell Phone _____ Cell Carrier: _____

Address _____

City: _____ State: _____ Zip: _____

E-mail address: _____ Fax # _____

Age:_____ Birth Date:_____ Race:_____ Marital: M S W D

Occupation:_____ Employer: _____

Employer's Address:_____ Office Phone: _____

Spouse:_____ Occupation:_____ Employer: _____

How many children?_____Names & Ages of Children: _____

_____

Nearest Relative: _____ Phone: _____

How were you referred to our office? _____

Family Medical Doctor: _____ Last Physical: _____ Last Lab Work: _____

May we have your permission to update your medical doctor regarding your care at this office? ☐ Yes ☐ No

HISTORY OF PRESENT ILLNESS:

Chief Complaint: Purpose of this appointment: _____

Date symptoms appeared or accident happened: _____

Is this due to: Auto___ Work____ Other _____

Have you ever had the same or a similar condition? ☐ Yes ☐ No If yes, when and describe: _____

_____

Days lost from work:_____ Date of last physical examination:_____

How frequent is the condition? Constant _____ Daily ____ Intermittent ____ Night Only ____

How long does it last? All Day _____ Few Hours _____ Minutes _____

Are there any other conditions or symptoms that may be related to your major symptom?

Yes _____ No _____. If yes, describe _____

Are there other unrelated health problems? Yes _____ No _____. If yes, describe _____

Describe the pain: Sharp _____ Dull_____ Numbness _____ Tingling _____ Aching _____

Burning _____ Stabbing _____ Other _____

Is there anything you can do to relieve the problem? Yes ___ No ___.

If yes, describe _____

If no, what have you tried to do that has not helped? _____

What makes the problem worse? Standing ____ Sitting _____ Lying _____ Bending _____

Lifting _____ Twisting _____ Other _____

WOMEN ONLY: Are you pregnant or any possibility you may be pregnant? ☐ Yes ☐ No ☐ Uncertain **LMP** _____

PAST MEDICAL HISTORY: Have you ever been diagnosed as having or have suffered from? (Place a check mark by conditions that apply to you)

__Broken or Fractured Bones	__Osteoarthritis	__Eating Disorder	__Ulcers
__Circulatory Problems	__Epilepsy	__Alcoholism	__Coughing Blood
__Rheumatoid Arthritis	__Pace Maker	__Drug Addiction	__High/Low Blood Pressure
__Seizures/Convulsions	__Strokes	__HIV Positive	__Excessive Bleeding
__A Congenital Disease	__Cancer	__Gall Bladder	__Ruptures
__Depression	__ Diabetes	__Tuberculosis	__ Asthma
__Kidney Disease	__Liver Disease	__Mental Illness	__Heart Disease
__Lung Disease			

Do you have a history of stroke or hypertension? _____

Have you had any major illnesses, injuries, falls, auto accidents or **surgeries**? Women, please include information about childbirth (include dates): _____

Have you been treated for any health condition by a physician in the last year? □ Yes □ No

If yes, describe: _____

What medications or drugs are you taking?_____

_____

Do you have any allergies to any medications, nutritional products or food? □ Yes □ No

If yes, describe: _____

Do you have any allergies of any kind? □ Yes □ No

If yes, describe: _____

Please list any other health problems you have, no matter how insignificant they may be: _____

_____

SOCIAL HISTORY:

Do you drink alcoholic beverages?___ If so, how much per week? _____
Do you use any tobacco products?_____Do you smoke?____ If so, packs per day: _____
Do you take vitamin supplements?_____ If so, please list: _____
Do you consume caffeine?____ If so, how much per day: _____
Do you exercise?_____ If yes, what is the frequency and type of exercise? _____
What are your hobbies? _____
What percentage of time during the day (at home or at your job away from home) do you spend:
lifting_____ sitting_____ bending_____working at a computer_____

FAMILY HISTORY:

Parents: Father: living___ deceased____ Current age if still living:_____ Cause of death and age at death if deceased:_____ (check one) Mother: living___ deceased____ Current age if still living:_____
Cause of death and age at death if deceased:_____ (check one)

Check if applicable to you: _____ As an adopted child, little is known of birth parents or family.

Do you have any family members who suffer from the same condition you do? If so, please list: _____

_____

FAMILY DISEASES: (check if applicable and indicate whether family member is **F**ather, **M**other, **S**ister, **B**rother):

Tuberculosis____	Cancer____	Mental Illness____
Diabetes ____	Asthma____	Heart Disease ____
Stroke ____	Kidney Disease____	Lung Disease____
Arthritis_____	Liver Disease ____	Other _____

Remarks: _____

_____

Patient's Signature:_____ Date: _____

Guardian's Signature Authorizing Care:_____ Date: _____

KNIGHT FAMILY CHIROPRACTIC

www.DrKnight.net

Patient Name: _____

Advance Beneficiary Notice of Non-coverage (ABN)

NOTE: If your health insurance doesn't pay for the service listed below, you may have to pay.

Your insurance company does not pay for everything, even some care that you or your health care provider have good reason to think you need. We expect your insurance company may not pay for the following items below.

Non-covered Services	Reason Insurance Company May Not Pay	Estimated Cost
1. New or Established Patient Exam	1. Non-Covered Service General Insurance	1. $64 - $160
2. Intersegmental Traction (IST)	2. Non-Covered Service	2. $24.00
3. Rehab	3. Non-Covered Service	3. $9.60
4. Decompressive Therapy (DTS)	4. Cash Only Service	4. $40.00

What you need to do now:

- Read this notice, so you can make an informed decision about your care.
- Ask us any questions that you may have after you finish reading.
- Choose an option below about whether to receive the non-covered services listed above.

Note: If you choose Option 1 or 2, we may help you with other financing options.

Options: Check only one box.

❑ OPTION 1. I want the non-covered services listed above. You may ask to be paid now, but I also want my insurance billed for an official decision on payment, which is sent to me on an Explanation of Benefits (EOB). I understand that if my insurance doesn't pay, I am responsible for payment, but I can appeal to my insurance company by following the directions on the MSN. If my insurance does pay, you will refund any payments I made to you, less co-pays or deductibles.

❑ OPTION 2. I want the non-covered services listed above, but do not bill my insurance. You may ask to be paid now as I am responsible for payment. I cannot appeal if my insurance is not billed.

❑ OPTION 3. I don't want the non-covered services listed above. I understand with this choice I am not responsible for payment, and I cannot appeal to see if my insurance would pay.

Signing below means that you have received and understand this notice. You also receive a copy.

Patient Signature:	Date:
Staff Signature:	Date:

Knight Family Chiropractic
FINANCIAL POLICY

Our recommendations are based on a desire to see you get well and stay well. Chiropractic care is covered under many insurance plans. Most of our patients that have health or accident insurance will fall under one of the plans discussed in this policy. Regardless of your coverage, we'll suggest the chiropractic care we think you need. We ask that you read and understand our policy as it applies to your particular situation.

PATIENTS WITHOUT INSURANCE
We request that 100% of the first visit be paid at the time of the visit. On other visits, payment may be made at the end of the week if you sign a credit guarantee form. We are happy to accept your check, Master Card, Visa, Discover & American Express.

GROUP OR INDIVIDUAL INSURANCE
Your insurance is an agreement between you and your insurance company, not between your insurance company and our office. We cannot be certain if your insurance covers Chiropractic, although most policies do provide coverage. The amount they pay varies from one policy to another. When possible, we will call to verify benefits on your insurance; however, the benefits quoted to us by your insurance company are not a guarantee of payment. As a courtesy to you, our office will complete any necessary insurance forms at no additional charge, and file them with your insurance company to help you collect. It is to be understood and agreed that any services rendered are charged to you directly and you are personally responsible for payment of any non-covered services, deductibles or co-pays. You may also pay the full amount due each day thereby qualifying for our Time of Service Reduction in fees. You may then submit the bill to your insurance carrier for reimbursement.

PERSONAL INJURY OR AUTOMOBILE ACCIDENTS
Please present your auto insurance card, your health insurance card, and tell us if you have retained an attorney. There are four options available to the PI patient:

1. Pay cash for your care and we will submit reports whenever necessary.
2. We will bill (accept assignment) from the Med Pay/Personal Injury Protection portion of your auto insurance.
3. We will accept a Letter of Protection from an Approved attorney and await payment at the time of settlement as long as you remain an active patient.
4. We will bill your standard health insurance plan and you will be responsible for all co-pays and deductibles as they are incurred.

Although you are ultimately responsible for your bill, we will wait for settlement of your claim for up to six months after your care is completed. Once the claim is settled or if you suspend or terminate care, any fees for services are due immediately.

MEDICARE
We do accept assignment from Medicare. The check is usually sent directly to our office in payment of the services that Medicare will cover which for Chiropractors is ONLY manual manipulation of the spine. Medicare pays 80% of the allowable fee once the deductible has been met. You are required to pay the deductible and the remaining 20%. All other services we provide are NON-COVERED. These services include, but are not limited to, x-rays, examinations, therapies, orthotics, supports, and/or nutritional supplements. Medicare patients are fully responsible for charges of non-covered services. Secondary insurance may or may not pay for these non-covered services. Our office completes and files the forms for Medicare at no charge.

SECONDARY INSURANCE
Please inform us of any secondary insurance you may have. We will assist you if you need help in filing.

MANAGED CARE PLANS
We are preferred providers for the most insurance companies. Some plans require you to pay a co-pay at the time of service. Other plans may have a deductible amount to be met first. After the deductible is satisfied, you and your insurance company will share a percentage of the cost that varies from plan to plan. A referral from your primary care physician may also be necessary. Out of network benefits are usually available if a referral is not obtained.

Please see below for a summary of your personal benefits that were quoted to us by your insurance company.

FLEX PLANS/MEDICAL SAVINGS ACCOUNTS
Please inform us if you have a medical savings account, sometimes known as a 'flex plan'. We will be happy to provide you with a statement of your charges for reimbursement.

CREDIT CARD GUARANTEE/ELECTRONIC DEBIT
ALL patients with ALL types of cases (Patients without Insurance, Group or Individual Insurance, Personal Injury & Medicare) are required to have a Credit Card Guarantee and/or an Authorization for Electronic Debit on file.

FINANCING OPTIONS
Our clinic works hard to give you affordable care that has been recommended to you. We offer the following financing options: *Care Credit*, *HealthCare Payment Solutions*

INSURANCE FORMS/PAYMENT
If you receive any correspondence from your insurance carrier pertaining to the care you have received at this office or a request of more information regarding your care, please bring it in as soon as possible. It is very important that we keep your file as up to date as possible. Occasionally, either by mistake, or due to provisions in your policy, the check issued by the insurance company for payment of services rendered in our office, may come to you instead of our office. If you should receive any unexpected check in the mail, please contact us to see if it does represent payment of your bill here.

I have read and understand the payment policy of Knight Family Chiropractic. I understand that my insurance is an arrangement between me and my insurance company, and NOT between Knight Family Chiropractic and my insurance company. I request that Knight Family Chiropractic prepare the customary forms at no charge so that I may obtain insurance benefits. I also understand that if my insurance does not respond within 60 days, or if I suspend or terminate my schedule of care as prescribed by the doctors at Knight Family Chiropractic that fees will be due and payable immediately.

_____ _____
Patient's signature (or guardian if patient is a minor) Date

_____
Witness

SPECIAL PAYMENT INSTRUCTIONS

Patient's Name: _____

☐ We have verified your benefits and while your insurance company did <u>not</u> guarantee payment, they stated that you have a $_____deductible, $_____of which has been met. Additionally, your insurance will pay _____% of covered charges, leaving _____%. _____ limit per ____ yr.

☐ We have verified your benefits and while your insurance company did <u>not</u> guarantee payment, they stated that you have a $_____ co-pay of each visit due by you. _____ limit per ____ yr.

Revised May 2016

ASSIGNMENT AND INSTRUCTION FOR DIRECT PAYMENT TO DOCTOR
PRIVATE/GROUP ACCIDENT AND HEALTH INSURANCE

Patient:_____

Insured
SS#/ID#_____

Claim/Group
#:_____

I hereby instruct and direct the payment of all professional or medical expense benefits allowable and otherwise payable to me under my current insurance policy to:

Knight Family Chiropractic

as payment for professional services rendered. THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY. This payment will not exceed my indebtedness to the above mentioned assignee, and I have agreed to pay, in a current manner, any balance of said professional service charges over and above this insurance payment.

If my current policy prohibits direct payment to doctor, then I hereby also instruct and direct you to make out the check to me and mail it as follows:

Ryan L. Knight, D.C.
Knight Family Chiropractic

A photocopy of this Assignment shall be considered as effective and valid as the original.

I also authorize the release of any information pertinent to my case to any insurance company, adjuster or attorney involved in this case.

Dated at _____ this _____ day of

_____ _____
Insured Witness

KNIGHT FAMILY CHIROPRACTIC
INFORMED CONSENT DOCUMENT

PATIENT NAME: _____

TO THE PATIENT: PLEASE READ THIS ENTIRE DOCUMENT PRIOR TO SIGNING IT.
IT IS IMPORTANT THAT YOU UNDERSTAND THE INFORMATION CONTAINED IN THIS DOCUMENT.
PLEASE ASK QUESTIONS BEFORE YOU SIGN IF THERE IS ANYTHING THAT IS UNCLEAR.

The Nature of the Chiropractic Adjustment

The primary treatment used by Doctors of Chiropractic is spinal manipulative therapy. I will use that procedure when I treat you. I may use my hands or a mechanical instrument upon your body in such a way as to move your joints. That may cause an audible "pop" or "click", much as you have experienced with you "crack" your knuckles. You may feel a sense of movement.

Analysis/Examination/Treatment

As part of the analysis, examination, and therapy, you are consenting to the following procedures:

Spinal manipulative therapy	Palpation	Vital signs
Range of motion testing	Orthopedic testing	Basic neurological testing
Muscle strength testing	Postural analysis testing	Hot/cold therapy
Radiographic studies	Other:	

The material risks inherent in a chiropractic adjustment

As with any healthcare procedure, there are certain complications which may arise during chiropractic manipulation and therapy. These complications include but are not limited to: fractures, disc injuries, dislocations, muscle strain, cervical myelopathy, costovertebral strains and separations, and burns. Some types of manipulation of the neck have been associated with injuries to the arteries in the neck leading to or contributing to serious complications including stroke. Some patients will feel some stiffness and soreness following the first few days of treatment. The Doctor will make every reasonable effort during the examination to screen for contraindications to care; however, if you feel you have a condition that would otherwise not come to the Doctor's attention, it is your responsibility to inform the Doctor.

The probability of those risks occurring

Fractures are rare occurrences and generally result from some underlying weakness of the bone which we check for during the taking of your history and during examination and x-ray. Stroke and/or arterial dissection caused by chiropractic manipulation of the neck has been the subject of ongoing medical research and debate. The most current research topic is inconclusive as to a specific incident of this complication occurring. If there is a casual relationship at all it is extremely rare and remote. Unfortunately, there is no recognized screening procedure to identify patients with neck pain who are at risk of arterial stroke.

The availability and nature of other treatment options

- Other treatment options for your condition may include:
- Self-administered, over-the-counter analgesics and rest
- Medical care and prescription drugs such as anti-inflammatory, muscle relaxants & pain-killers
- Hospitalization
- Surgery

If you chose to use one of the above noted "other treatment" options, you should be aware that there are risks and benefits of such options and you may wish to discuss these with your primary medical physician.

The risks and dangers attendant to remaining untreated

Remaining untreated may allow the formation of adhesions and reduce mobility which may set up a pain reaction further reducing mobility. Over time this process may complicate treatment making it more difficult and less effective the longer it is postponed.

Consent to treatment of minor

I hereby request and authorize Knight Family Chiropractic to perform diagnostic tests and render chiropractic adjustments and other treatments to my: _____
(indicate relationship to child)

This authorization also extends to all other doctors and office staff members and is intended to include radiographic examination at the doctor's discretion.

This authorization also extends to all other doctors and office staff members and is intended to include radiographic examination at the doctor's discretion.

As of this date, I have the legal right to select and authorize health care services for the minor child named above. Under the terms and conditions of my divorce, separation or other legal authorization, the consent of a spouse/former spouse or other parent is not required. If my authority to so select and authorize this care should be revoked or modified in anyway, I will immediately notify this office.

DO NOT SIGN UNTIL YOU HAVE READ AND UNDERSTAND THE ABOVE.
PLEASE CHECK THE APPROPRIATE BLOCK AND SIGN BELOW

I have read [ ] or have had read to me [ ] the above explanation of the chiropractic adjustment and related treatment. I have discussed it with Knight Family Chiropractic and have had my questions answered to my satisfaction. By signing below, I state that I have weighed the risks involved in undergoing treatment and have decided that it is in my best interest to undergo the treatment recommended. Having been informed of the risks, I hereby give my consent to that treatment.

_____ _____
Date Patient's Printed Name

_____ _____
Patient's Signature Signature of Parent or Guardian (if a minor)

_____
Doctor's Signature

_____
Date

Knight Family Chiropractic | HIPAA Medical Information Release Form

Patient Name: _____ Date of Birth: _____/____/_____

Release of Information

CHECK ONE:

[ ] Information is not to be released to anyone.

[ ] I authorize the release of information including the diagnosis, records; examination rendered to me and claims information. This information may be released to:

[ ] Spouse_____

[ ] Child(ren)_____

[ ] Other_____

This Release of Information will remain in effect until terminated by me in writing.

Messages

Please call [ ] my home [ ] my work [ ] my cell

If unable to reach me:

[ ] you may leave a detailed message

[ ] please leave a message asking me to return your call

[ ] _____

I have read and understand how my Patient Health Information will be used and I agree to these policies and procedures established at Knight Family Chiropractic.

_____

Signature of Patient Date

_____

Witness Date

Ryan L. Knight, D.C | Knight Family Chiropractic
Patient Health Information Consent Form

We want you to know how your Patient Health Information (**PHI**) is going to be used in this office and your rights concerning those records. Before we will begin any health care operations we must require you to read and sign this consent form stating that you understand and agree with how your records will be used. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your Patient Health Information we encourage you to read the HIPAA NOTICE that is available to you at the front desk before signing this consent.

1. The patient understands and agrees to allow this chiropractic office to use their Patient Health Information (**PHI**) for the purpose of treatment, payment, healthcare operations, and coordination of care. As an example, the patient agrees to allow this chiropractic office to submit requested PHI to the Health Insurance Company (or companies) provided to us by the patient for the purpose of payment. Be assured that this office will limit the release of all PHI to the minimum needed for what the insurance companies require for payment.
2. The patient has the right to examine and obtain a copy of his or her own health records at any time and request corrections. The patient may request to know what disclosures have been made and submit in writing any further restrictions on the use of their PHI. Our office is not obligated to agree to those restrictions.
3. A patient's written consent need only be obtained one time for all subsequent care given the patient in this office.
4. The patient may provide a written request to revoke consent at any time during care. This would not effect the use of those records for the care given prior to the written request to revoke consent but would apply to any care given after the request has been presented.
5. For your security and right to privacy, all staff has been trained in the area of patient record privacy and a privacy official has been designated to enforce those procedures in our office. We have taken all precautions that are known by this office to assure that your records are not readily available to those who do not need them.
6. Patients have the right to file a formal complaint with our privacy official about any possible violations of these policies and procedures.
7. If the patient refuses to sign this consent for the purpose of treatment, payment and health care operations, the chiropractic physician has the right to refuse to give care.

KNIGHT *Family* CHIROPRACTIC

X-RAY RELEASE

I hereby acknowledge that Drs. Knight, Davis, Lackey, Turner, Williams, Wilson of Knight Family Chiropractic has informed me of the advisability of, risk, inherent in, and the probable consequences of not receiving X-rays. He/She has explained to me the reasons and need for such X-rays.

Notwithstanding these recommendations that _____(name of person to be treated) receives X-rays, I have decided on my own volition to refuse such X-rays, and do hereby release and hold harmless from any legal action or responsibility whatsoever for unfavorable or untoward results caused by my refusal to permit the use of this procedure, or from any and all problems rising from subsequent treatments I will receive from Drs. Knight, Davis, Lackey, Turner, Williams, Wilson, licensed Doctors of Chiropractic.

Dated this _____day of _____, 20___.

_____
Signature of Patient/Authorized Representative of Patient

_____
Witness

PREGNANCY WAIVER

I hereby acknowledge that Drs. Knight, Davis, Lackey, Turner, Williams, Wilson of Knight Family Chiropractic have informed me prior to being x-rayed of the advisability of risk and the probable consequences of receiving x-rays during pregnancy. I have stated on my own violation that I was **not** pregnant at the time and do hereby release and hold harmless from any legal action or responsibility caused by the use of this procedure.

_____
Printed Name of Patient

_____
Signature of Patient/Authorized Representative of Patient

_____
Witness

_____
Date

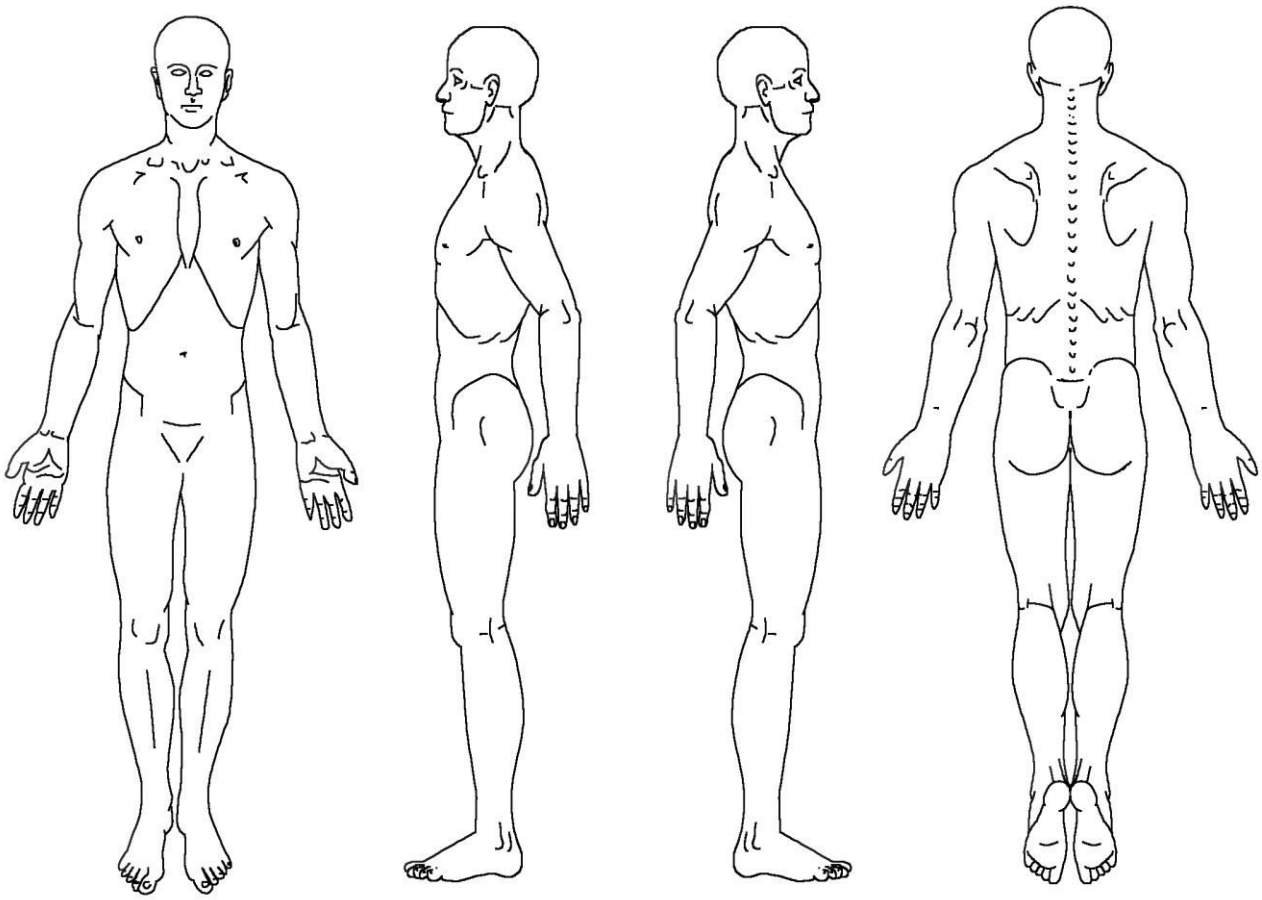
RYAN L. KNIGHT, D.C., C.C.S.P.
KNIGHT FAMILY CHIROPRACTIC
WWW.DRKNIGHT.NET

PAIN DRAWING

Name_____**Date**_____

Using the following descriptive symbols, draw the location of your pain on body outlines below. In addition, mark the level of your pain on the pain line at the bottom of the page.

ACHE	BURNING	NUMBNESS	PINS & NEEDLES	STABBING	OTHER
≋	====	OOOO	……	//////////	XXX



No Pain 1_____10 Worst Possible Pain

Please make a slash through this line to indicate the level of your pain.

Patient Signature

_____

Ryan L. Knight, D.C.
Knight Family Chiropractic

Patient Name: Date:

NECK 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 everyday life. Please answer every section and mark in each section only ONE sentence that 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 one that most closely describes your problem.

SECTION 1 - Pain Intensity **A I have no pain at the moment.** **B The pain is very mild at the moment.** **C The pain is moderate at the moment.** **D The pain is fairly severe at the moment.** **E The pain is very severe at the moment.** **F The pain is the worst imaginable at the moment.**	***SECTION 6 - Concentration/*** **A I can concentrate fully when I want to with no difficulty.** **B I can concentrate fully when I want to with slight difficulty.** **C I have a fair degree of difficulty in concentrating when I want to.** **D I have a lot of difficulty in concentrating when I want to.** **E I have a great deal of difficulty in concentrating when I want to.** **F I cannot concentrate at all.**
SECTION 2 -Personal Care (Washing,Dressing,etc.) **A I can look after myself normally without causing extra pain.** **B I can look after myself normally, but it causes extra pain.** **C It is painful to look after myself and I am slow and careful.** **D I need some help, but manage most of my personal care.** **E I need help every day in most aspects of self care.** **F I do not get dressed, I wash with difficulty and stay in bed.**	***SECTION 7 - Work*** **A I can do as much work as I want to.** **B I can only do my usual work, but no more.** **C I can do most of my usual work, but no more.** **D I cannot do my usual work.** **E I can hardly do any work at all.** **F I cannot do any work at all.**
SECTION 3 - Lifting **A I can lift heavy weights without extra pain.** **B I can lift heavy weights, but it gives extra pain.** **C Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned, for example, on a table.** **D Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.** **E I can lift very light weights.** **F I cannot lift or carry anything at all.**	***SECTION 8 - Driving*** **A I can drive my car without any neck pain.** **B I can drive my car as long as I want with slight pain in my neck.** **C I can drive my car as long as I want with moderate pain in my neck.** **D I cannot drive my car as long as I want because of moderate pain in my neck.** **E I can hardly drive at all because of severe pain in my neck.** **F I cannot drive my car at all.**
SECTION 4 - Reading **A I can read as much as I want to with no pain in my neck.** **B I can read as much as I want to with slight pain in my neck.** **C I can read as much as I want to with moderate pain in my neck.** **D I cannot read as much as I want because of moderate pain in my neck.** **E I cannot read as much as I want because of severe pain in my neck.** **F I cannot read at all.**	***SECTION 9 - Sleeping*** **A I have no trouble sleeping.** **B My sleep is slightly disturbed (less than 1 hour sleepless).** **C My sleep is mildly disturbed (1-2 hours sleepless).** **D My sleep is moderately disturbed (2-3 hours sleepless).** **E My sleep is greatly disturbed (3-5 hours sleepless).** **F My sleep is completely disturbed (5-7 hours)**
SECTION 5 - Headaches **A I have no headaches at all.** **B I have slight headaches which come infrequently.** **C I have moderate headaches which come infrequently.** **D I have moderate headaches which come frequently.** **E I have severe headaches which come frequently.** **F I have headaches almost all the time.**	***SECTION 10 - Recreation*** **A I am able to engage in all of my recreational activities with no neck pain at all.** **B I am able to engage in all of my recreational activities with some pain in my neck.** **C I am able to engage in most, but not all of my recreational activities because of pain in my neck.** **D I am able to engage in a few of my recreational activities because of pain in my neck.** **E I can hardly do any recreational activities because of pain in my neck.** **F I cannot do any recreational activities at all.**

NECK DISABILITY QUESTIONNAIRE

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

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

Ryan L. Knight, D.C.
Knight Family Chiropractic

Patient Name: 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 everyday life. Please answer every section and mark in each section only ONE sentence that 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 one that most closely describes your problem.

SECTION 1 - Pain Intensity **A The pain comes and goes and is very mild.** **B The pain is mild and does not vary much.** **C The pain comes and goes and is moderate.** **D The pain is moderate and does not vary much.** **E The pain comes and goes and is severe.** **F The pain is severe and does not vary much.**	***SECTION 6 - Standing*** **A I can stand as long as I want without pain.** **B I have some pain while standing, but it does not increase with time.** **C I cannot stand for longer than one hour without increasing pain.** **D I cannot stand for longer than 1/2 hour without increasing pain.** **E I cannot stand for longer than ten minute without increasing pain.** **F I avoid standing, because it increases the pain straight away.**
SECTION 2 - Personal Care **A I would not have to change my way of washing or dressing in order to avoid pain.** **B I do not normally change my way of washing or dressing even though it causes some pain.** **C Washing and dressing increases the pain, but I manage not to change my way of doing it.** **D Washing and dressing increases the pain and I find it necessary to change my way of doing it.** **E Because of the pain, I am unable to do some washing and dressing without help.** **F Because of the pain, I am unable to do any washing or dressing without help.**	***SECTION 7 - Sleeping*** **A I get no pain in bed.** **B I get pain in bed, but it does not prevent me from sleeping well.** **C Because of pain, my normal night's sleep is reduced by less than one than one quarter.** **D Because of pain, my normal night's sleep is reduced by less than one-half.** **E Because of pain, my normal night's sleep is reduced by less than three-quarters.** **F Pain prevents me from sleeping at all.**
SECTION 3 - Lifting **A I can lift heavy weights without extra pain.** **B I can lift heavy weights, but it causes extra pain.** **C Pain prevents me from lifting heavy weights off the floor.** **D Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned, eg. on a table.** **E Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.** **F I can only lift very light weights, at the most.**	***SECTION 8 - Social Life*** **A My social life is normal and gives me no pain.** **B My social life is normal, but increases the degree of my pain.** **C Pain has no significant effect on my social life apart from limiting my more energetic interests, My e.g., dancing, etc.** **D Pain has restricted my social life and I do not go out very often.** **E Pain has restricted my social life to my home.** **F I have hardly any social life because of the pain.**
SECTION 4 - Walking **A Pain does not prevent me from walking any distance.** **B Pain prevents me from walking more than one mile.** **C Pain prevents me from walking more than 1/2 mile.** **D Pain prevents me from walking more than 1/4 mile.** **E I can only walk while using a cane or on crutches.** **F I am in bed most of the time and have to crawl to the toilet.**	***SECTION 9 - Traveling*** **A I get no pain while traveling.** **B I get some pain while traveling, but none of my usual forms of travel make it any worse.** **C I get extra pain while traveling, but it does not compel me to seek alternative forms of travel.** **D I get extra pain while traveling which compels me to seek alternative forms of travel.** **E Pain restricts all forms of travel.** **F Pain prevents all forms of travel except that done lying down.**
SECTION 5 - Sitting **A I can sit in any chair as long as I like without pain.** **B I can only sit in my favorite chair as long as I like.** **C Pain prevents me from sitting more than one hour.** **D Pain prevents me from sitting more than 1/2 hour.** **E Pain prevents me from sitting more than ten minutes.** **F Pain prevents me from sitting at all.**	***SECTION 10 - Changing Degree of Pain*** **A My pain is rapidly getting better.** **B My pain fluctuates, but overall is definitely getting better.** **C My pain seems to be getting better, but improvement is slow at present.** **D My pain is neither getting better nor worse.** **E My pain is gradually worsening.** **F My pain is rapidly worsening.**

LOW BACK DISABILITY QUESTIONNAIRE

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

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