ADVANCED
SPINE & POSTURE

**ALIANTE:** 6592 N. Decatur Blvd. Suite 115 North Las Vegas, Nv 89131
Ph: 702.396.4993 Fax: 702.636.4990
**MIDTOWN:** 3061 S. Maryland Pkwy Suite 201 Las Vegas, Nv 89109
Ph: 702.478.9594 Fax: 702.478.9509
**PAHRUMP:** 2100 E. Calvada Blvd. Pahrump, NV 89048
Ph: 775.727.7959 Fax: 775.727.7960

# PATIENT APPLICATION

## WELCOME

We specialize in helping our patients achieve a higher level of health through the use of a customized spinal, postural, and/or functional corrective care. Our approach is very unique and different from other physical medicine, traditional physical therapy or chiropractic offices. Our integrated approach allows our patients to achieve far superior results compared to most other systems. Please fill out the following information thoroughly so the doctor can let you know if you are a case we can accept. We do not accept all cases.

**Please feel free to ask any questions if you need assistance. We look forward to serving you!**

## MEET THE TEAM

**David R. Golan, MD**

**Jason O. Jaeger, DC fCBP**

**John Brown, DC**

**Creig Christensen, DC**

**Mike Jonak, MD**

Patient Signature:_____ Date: __ / __ / ____

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## PATIENT APPLICATION SURVEY

Full Name: _____ Preferred Name:_____ Age ____ Gender: ☐ M ☐ F

Home Street Address: _____ Home Phone: ( ) _____

City, State, Zip: _____ Work Phone: ( ) _____

Email Address: _____ Birth Date: ___ / ___ / _____ Cell Phone: ( ) _____

Social Security #: _____ - ___ - _____ Marital Status: S M D W Height: ____ Weight: ____

Race/Ethnicity: ☐ African American ☐ Arabic ☐ Asian ☐ Caucasian ☐ Hispanic ☐ Native American ☐ Other

Occupation: _____ Employer Name: _____

Primary Spoken Language:_____ How were you referred to this office? _____

### IN CASE OF EMERGENCY

Name_____ Relationship_____ Phone: ( ) _____

### PURPOSE OF VISIT

*(*please list in order of importance)*

| Major symptom/reason for appointment: | Date condition(s) began: | Have you had this before? | Injury related? |
|---|---|---|---|
| 1. _____ | __ / __ / ____ | ☐ Yes ☐ No | ☐ Yes ☐ No |
| 2. _____ | __ / __ / ____ | ☐ Yes ☐ No | ☐ Yes ☐ No |
| 3. _____ | __ / __ / ____ | ☐ Yes ☐ No | ☐ Yes ☐ No |

### EXPERIENCE WITH PHYSICAL MEDICINE

Have you been seen at a physical medicine center before? ☐ Yes ☐ No Who? _____

When? _____ Reason for visits? _____ How did you respond?_____

Have you seen a Chiropractor before? ☐ Yes ☐ No Who? _____

When? _____ Reason for visits? _____ How did you respond?_____

Have you seen a physical therapist before? ☐ Yes ☐ No Who? _____

When? _____ Reason for visits? _____ How did you respond?_____

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## GENERAL HEALTHCARE PROVIDER

Name of Primary Care Provider: _____ Date of last visit: __ / __ / ____

## OTHER HEALTHCARE PROVIDERS

Name: _____ Specialty: _____ Date of last visit: __ / __ / ____

Name: _____ Specialty: _____ Date of last visit: __ / __ / ____

Allergies and reactions: _____

Previous major injuries/trauma and dates: _____

_____

Previous surgeries and dates: _____

_____

Previous hospitalizations and dates: _____

What other testing/treatments have you tried to date for present condition: _____

_____

Current prescription medications: _____

_____

Current over-the-counter medications & supplements (vitamins, herbs, etc.): _____

_____

## SOCIAL HISTORY AND LIFESTYLE

Do you exercise? ☐ Yes ☐ No Times per week: 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ other: _____

What activities? ☐ Running ☐ Jogging ☐ Weight Training ☐ Cycling ☐ Yoga ☐ Pilates ☐ Swimming
☐ Other _____

Do you consider yourself to be: ☐ Underweight ☐ Normal weight ☐ Overweight ☐ Obese ☐ Severely obese

Smoking History? ☐ Never ☐ Former ☐ Current How many? _____ per ☐ day ☐ week ☐ month ☐ year

Do you use recreational drugs?

☐ Yes ☐ No Type: _____ How much? _____ per ☐ day ☐ week ☐ month ☐ year

Do you drink alcohol? ☐ Yes ☐ No How much? _____ per ☐ day ☐ week ☐ month ☐ year

Do you drink coffee? ☐ Yes ☐ No How much? _____ per ☐ day ☐ week ☐ month ☐ year

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## HEALTH CONDITIONS

*(Please check any problems you are currently experiencing)*

**GENERAL:** ☐ Low Energy or Fatigue ☐ Muscle Spasm ☐ Nausea ☐ Dizziness ☐ Headaches ☐ Jaw Pain

☐ Sleep Disturbance ☐ Depression ☐ Anxiety ☐ Irritability ☐ Snoring ☐ Unexplained Weight Loss

**BLADDER & BOWEL FUNCTION:**

*If you have had any change in your bowel or bladder function, do you:*

☐ Urinate more often ☐ Have loss of control or accidents ☐ Have a sense of urgency

☐ Have problems with sexual function ☐ Have a loss of sensation around the groin or buttocks

☐ Constipation ☐ Diarrhea ☐ Recurrent bladder/urinary tract infections

**NEUROLOGIC/ORTHOPEDIC:** ☐ Neck pain ☐ Upper back pain ☐ Shoulder pain ☐ Mid-back pain

☐ Low back pain ☐ Pain into ribs/chest ☐ Scoliosis ☐ Muscle cramps/spasms

☐ Pain into shoulders/arms/hands ☐ Weakness into arms/hands ☐ Numbness/tingling into arms/hands

☐ Pain into hips/legs/feet ☐ Weakness into legs ☐ Numbness/tingling into legs/feet ☐ Osteoporosis

☐ *Arthritis ☐ *Seizures

**OTHER:** ☐ *Immune problems ☐ *Infectious disease (e.g, HIV/AIDS, Hep C) ☐ Dizziness/fainting

☐ Cold hands/feet ☐ *Visual disturbances ☐ *Hearing disturbances ☐ *Thyroid conditions

☐ Pain with breathing ☐ Sinusitis ☐ Heart palpitations ☐ Shortness of breath ☐ High blood pressure

☐ *Heart murmurs ☐ Asthma ☐ High cholesterol ☐ *Kidney disease ☐ Diabetes ☐ Ulcers/gastritis

☐ Indigestion/Heartburn ☐ Hypoglycemia ☐ Gallbladder problems ☐ Acid reflux ☐ *Liver disease

☐ *Bleeding Disorder ☐ Sleep apnea ☐ *Lung disease

*Please explain any health conditions mentioned above as necessary: _____

_____

_____

Please list any health conditions not mentioned: _____

_____

Have you ever been diagnosed with cancer? ☐ Yes ☐ No If yes, explain: _____

_____

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## FUNCTIONAL IMPACT

Which activities in your life have been most affected by your present condition? _____

_____

_____

If you were to describe how this condition limits your ability to complete these activities (0% being completely unable to do, 100% being completely unaffected), what percentage would you describe your function? _____%

## FAMILY HEALTH HISTORY

Please indicate if any of your immediate family members ever had the following:

☐ Mental Health Disease ☐ Neurological Problems ☐ Lung Disease ☐ Thyroid ☐ Arthritis

☐ Circulatory Problems ☐ Immune System Problems ☐ Back Pain ☐ Cancer ☐ Scoliosis

☐ Heart Disease ☐ Stroke ☐ Kidney Disease ☐ Diabetes ☐ Osteoporosis ☐ Migraine Headaches

☐ Digestive Disorders ☐ Infectious Disease ☐ Seizures ☐ Liver Disease

☐ Other: _____

## HISTORY OF YOUR PRIMARY COMPLAINT(S)

Is this the first time you have had these symptoms? ☐ Yes ☐ No If No, when was the FIRST time you had these same symptoms? _____

How did the CURRENT episode of pain/discomfort occur? _____

How did the FIRST episode of pain/discomfort occur? _____

**HOW WOULD YOU DESCRIBE YOUR PAIN?** *Please describe your pain over the last 2 weeks in each painful area*

Pain Location: _____ ☐ Constant ☐ Frequent ☐ Occasional ☐ Seldom

RIGHT NOW: _____ / 10 (Pain severity: If 10 is the worst pain imaginable, and 0 is no pain)

Pain Quality: ☐ Dull ☐ Achy ☐ Stiff ☐ Intense ☐ Throbbing ☐ Sharp ☐ Stabbing

☐ Sharp with movement ☐ Burning ☐ Constricting ☐ Pressure ☐ Annoying ☐ Tight ☐ Unbearable

☐ Other: _____


History Of Your Primary Complaint(s) Cont. Pg. 6 →

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**Continued from page Pg. 5**

Pain Location: _____ ☐ Constant ☐ Frequent ☐ Occasional ☐ Seldom

RIGHT NOW: _____ / 10 (Pain severity: If 10 is the worst pain imaginable, and 0 is no pain)

Pain Quality: ☐ Dull ☐ Achy ☐ Stiff ☐ Intense ☐ Throbbing ☐ Sharp ☐ Stabbing

☐ Sharp with movement ☐ Burning ☐ Constricting ☐ Pressure ☐ Annoying ☐ Tight ☐ Unbearable

☐ Other: _____

Pain Location: _____ ☐ Constant ☐ Frequent ☐ Occasional ☐ Seldom

RIGHT NOW: _____ / 10 (Pain severity: If 10 is the worst pain imaginable, and 0 is no pain)

Pain Quality: ☐ Dull ☐ Achy ☐ Stiff ☐ Intense ☐ Throbbing ☐ Sharp ☐ Stabbing

☐ Sharp with movement ☐ Burning ☐ Constricting ☐ Pressure ☐ Annoying ☐ Tight ☐ Unbearable

☐ Other: _____

**RADIATING:** Does your pain seem to radiate from the primary area: ☐ Yes ☐ No If Yes, where does the pain radiate to? _____

**NUMBNESS/TINGLING (PINS AND NEEDLES):** Do you currently experience numbness and or tingling anywhere?

☐ Yes ☐ No Please describe where and when you feel these symptoms: _____

_____

**WHEN IS YOUR PAIN/DISCOMFORT WORSE:**

☐ It does not seem to be affected by the time of day

☐ In the morning ☐ While awake

☐ In the afternoon ☐ While sleeping

☐ In the evening

**WHEN YOUR PAIN/DISCOMFORT BETTER:**

☐ It does not seem to be affected by the time of day

☐ In the morning ☐ While awake

☐ In the afternoon ☐ While sleeping

☐ In the evening

**WHAT DECREASES YOUR PAIN/SYMPTOMS? (CHECK ALL THAT APPLY):**

☐ Nothing ☐ Traction ☐ Electrical stimulation ☐ Ice ☐ Heat ☐ Massage/Rubbing ☐ Exercise/Activity

☐ Sitting ☐ "Popping" the Joints ☐ Standing ☐ Rest ☐ Stretching ☐ Laying ☐ Bracing/Taping

☐ TPI Therapy ☐ Other: _____ ☐ Medications:_____

**WHAT INCREASES YOUR PAIN/SYMPTOMS? (CHECK ALL THAT APPLY):**

☐ Coughing ☐ Sneezing ☐ Bearing Down ☐ Sexual Intercourse ☐ Running ☐ Standing ☐ Lifting

☐ Bending ☐ Pushing ☐ Pulling ☐ Driving ☐ Sitting ☐ Walking ☐ Laying down ☐ Head movement

☐ Low back movement ☐ Other: _____

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## INSURANCE AND FINANCIAL OBLIGATION INFORMATION

Do you have insurance? ☐ Yes ☐ No Policy#: _____ Group#: _____

Insurance Company Name: _____ Phone: (  ) _____

Address: _____

Insured's Name_____ Birth Date: __ / __ / ____ Relationship: _____

Do you have secondary insurance? ☐ Yes ☐ No Policy#: _____ Group#: _____

Insurance Company Name: _____ Phone: (  ) _____

Address: _____

Insured's Name: _____ Birth Date: __ / __ / ____ Relationship: _____

For Automobile Collision, what is the name of your Insurance Carrier?

Phone: (  ) _____ Policy Claim Number: _____

For Work Injury, what is your Employer Contact Name: _____

Phone: (  ) _____ Claim#: _____ If known, Insurance Carrier? _____

Other than yourself, who else should receive charges on your account? (check all that apply)

☐ Spouse ☐ Parent/Guardian ☐ Workers Comp ☐ Auto Insurance ☐ Medicare ☐ Personal Health Insurance

By signing below, I verify that, I clearly understand that all insurance coverage, whether accident, auto, work related, or general coverage is an arrangement between my insurance carrier and myself. If this office **chooses** to bill any services to my insurance carrier this is done strictly as a **convenience** and **courtesy** for me. This office may provide any necessary reports subject to reasonable service fees to aid in insurance reimbursement of services, but I understand that insurance carriers may deny my claims and that I am ultimately responsible for any unpaid balances. Any money received will be credited to my account. I understand there could be some services that my insurance company does not cover, if this is the case I am willing to pay for these services.

I also understand that I will be charged $25 for any and all scheduled appointments that are missed without contacting the office in advance. This missed visit fee WILL NOT be covered by insurance and must be paid prior to the next scheduled visit.

Signature of Patient/or Guardian: _____ Date: __ / __ / ____

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## FOR PATIENT'S USING MEDICAL LIEN

I _____ authorize my attorney _____, to pay Advanced Spine and Posture charges/bill in full without reduction or request for reduction.

Signature of Patient/or Guardian: _____ Date: __ / __ / ____

## HEALTHCARE AUTHORIZATION FORM (HIPAA)

THE FOLLOWING AUTHORIZES *Advanced Spine & Posture* TO USE AND/OR DISCLOSE PROTECTED HEALTH CARE INFORMATION IN ACCORDANCE WITH THE FOLLOWING SPECIFIC AUTHORIZATIONS:
I give permission to Advanced Spine and Posture to use my name, address, phone numbers and clinical records to contact me with birthday cards, holiday related cards, health related e-mails messages and information about treatment alternatives or other health related information as well as any advertisements, newsletters or patient of the week/month postings.
I give permission to Advanced Spine and Posture to treat me in an open room where other patients are also being treated. I am aware that other persons in the office may overhear some of my protective health care information during the course of my treatment. Should I need to speak with a doctor or assistant in private, the doctor or assistant will provide a private room for these conversations BY APPOINTMENT ONLY.
By signing the following you are giving Advanced Spine and Posture permission to use and disclose your protected health information in accordance with the directives listed above.

Signature of Patient/or Guardian: _____ Date: __ / __ / ____

## CONSENT TO RECEIVE TEXT MESSAGES OR EMAILS ABOUT APPOINTMENT REMINDERS

*Patients in our practice may be contacted via email or text messaging to remind you or an appointment.*

I _____ consent to receive text messages from the practice at my cell phone and any number forwarded or transferred to that number or emails to receive appointment reminders. I understand that this request to receive text messages will apply to all future appointment reminders unless I request a change in writing. The cell phone number phone number that I authorize to receive text messages for appointment reminders is: (  ) _____

The email that I authorize to receive text messages for appointment reminders is: _____
The practice does not charge for this service, but standard text messaging rates may apply as provided in your wireless plan (contact your carrier for pricing plans and details).

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## ACKNOWLEDGEMENT OF RECIEPT & NOTICE OF PRIVACY PRACTICES

I understand and maybe provided upon request with a notice of information practices that provides me a more complete description of information uses and disclosures; I understand that I have the following rights and privileges:

- The right to review the notice prior to signing this consent.
- The right to object to the use of my health care information for directory purpose.
- The right to request restrictions as to how my health care information may be used or disclosed in this office to carry out treatment, payment, or health care operations.

Signature of Patient/or Guardian: _____ Date: __ / __ / ____

## INFORMED CONSENT FORM ADVANCED SPINE & POSTURE

Please read this entire document and discuss any questions or concerns prior to signing it. It is important that you understand the information contained in this document.

### AUTHORIZATION OF CARE

I authorize and agree to allow the physician, physician assistant, physical therapist, chiropractic intern, and/or assistants(s) to the use of physical examination, x-ray & MRI, structural and/or functional physiotherapy, spinal adjustments, rehabilitative exercises (in office & at home), traction, injections and other methods for the sole purpose of postural and structural improvement in biomechanical and related neurological function. I understand that I am responsible for all fees incurred for the services provided, and agree to ensure full payment of all charges. The healthcare providers and/or assistants will not be held responsible for any health conditions or diagnoses which are pre-existing, given by another health care practitioner, or are not related to the spinal structural conditions diagnosed at this clinic. I also clearly understand that if I do not follow the healthcare providers and/or assistants specific recommendations at this clinic that I will not receive the full benefit from this program, and that if I terminate my care prematurely that all fees incurred will be due and payable at that time. Any discounts are at the discretion of Advanced Spine and Posture and failure to keep your treatment plan agreement may result in full fees being applied. I authorize the assignment of all insurance benefits be directed to Advanced Spine and Posture for all services rendered.

Patient's Name Printed: _____ Date: __ / __ / ____

Patient's Signature: _____ Date: __ / __ / ____

Guardian/Spouse's Signature (Authorizing Care of Minor): _____ Date: __ / __ / ____

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## RADIOGRAPH CONSENT

In order to best determine the cause and extent of my underlying spinal problems, I hereby give my consent to Advanced Spine and Posture and assistants to take spine or other relevant radiographs as deemed clinically necessary through a medical and chiropractic history/examination and in accordance with clinical usage indications as published in the PCCRP Clinical Practice (2009).

Signature of Patient/or Guardian: _____ Date: __ / __ / ____

**ALL FEMALES:** I also hereby declare to my knowledge that I am not pregnant: _____ (Initial)

## ANALYSIS, EXAMINATION AND TREATMENT

As a part of the analysis, examination and treatment of your condition you are consenting to the following procedures. *Please initial each area below:*

Spinal Adjustment/Manipulative Therapy _____
Range of motion testing _____
Muscle strength testing _____
Radiographic Study/ X-ray _____
Orthopedic examination _____
Postural Analysis _____
Cryotherapy (ice) _____
Physical examination _____
Vital signs _____
Neurological Examination _____
Electrical Stimulation, muscle and/or joint _____
Palpation (examining the body using touch) _____

## THE NATURE OF THE ADJUSTMENT/MANIPULATION

One of the primary treatments used by a Doctor of Chiropractic is the spinal adjustment or spinal manipulative therapy. We will use this type of procedure with you. We may use our hands or a mechanical instrument upon your body in such a way as to move your joints. This may cause an audible “pop” or “click” much like one experiences from “popping” knuckles. You may feel a sense of movement.

## THE MATERIAL RISKS INHERENT IN SPINAL AND/OR JOINT ADJUSTMENT

As with any healthcare procedure, there are certain complications which may arise with adjustment/ manipulation and therapy. These complications include but are not limited to: fracture, disc injury, dislocation, muscle strain, cervical myelopathy, costovertebral strains and separations. Some types of adjustment/manipulation of the neck have been associated with injuries to the arteries of the neck leading to or contributing to serious complications including stroke. Some patients will feel some stiffness and

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soreness following the first few days of treatment. This is similar to the soreness associated with working out and the "lactic acid "response. We will make every reasonable effort during the examination to screen for contradictions to care; however, if you have a condition that would otherwise not come to our attention, it is your responsibility to inform us.

## THE PROBABILITY OF THOSE RISKS OCCURRING

Fractures are rare occurrences and generally the result of an underlying weakness of the bone which will be checked for during your history, examination and on x-ray. Stroke has been the subject of tremendous disagreement. The incidences of stroke are exceedingly rare and are estimated to occur between one in one million to one in five million cervical adjustments. The other complications are also described as generally rare.

## THE AVAILABILITY AND NATURE OF OTHER TREATMENT OPTIONS

Other treatment options for your condition may include: Self administered, OTC treatments/medications, Medications and prescription drugs, Hospitalization and Surgical procedures

## THE RISKS AND DANGERS ATTENDANT TO REMAINING UNTREATED

Remaining untreated may allow the formation of joint adhesions, and reduced mobility which may lead to a pain reaction and further reduced mobility. Over time this process may complicate treatment making it more difficult and less effective the longer care is postponed.

## DO NOT SIGN UNTIL YOU HAVE READ AND UNDERSTAND THE ABOVE.

I have read or have had read to me the aforementioned explanation of the adjustment/manipulation and related treatment. I may choose to discuss any questions with the examining provider (MD, physician assistant, chiropractor, or chiropractic intern) and have 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 is in my best interest to undergo the treatment recommended. Having been informed of the risks, I hereby give my consent for treatment.

Patients Name: _____

Patient Signature: _____

Signature of parent or guardian (if a minor)

_____

Date: __ / __ / ____

Providers Name: _____

Providers Signature: _____

Date: __ / __ / ____

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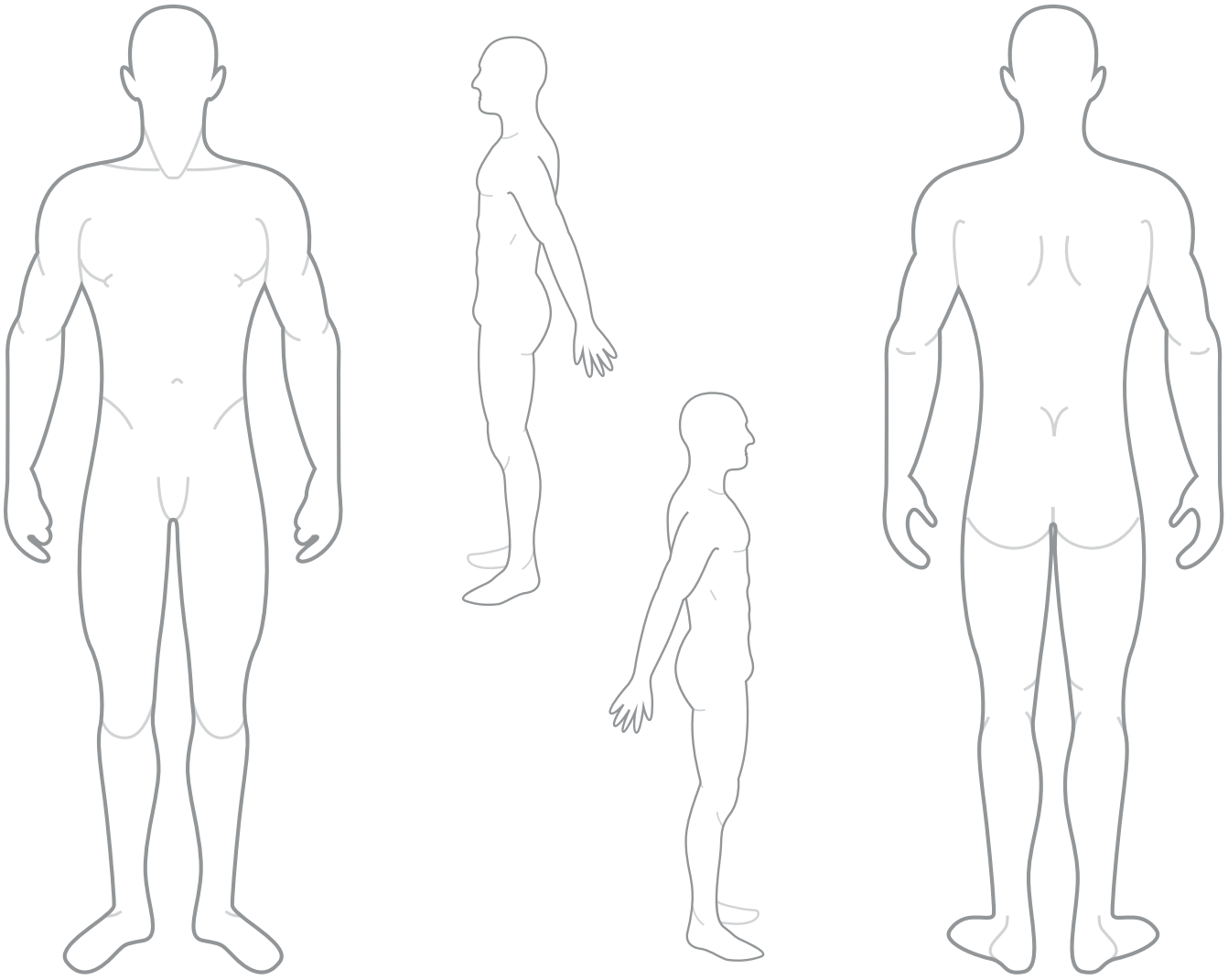
## THE DISABILITY INDEX QUESTIONNAIRE

How long have you had spine or extremity pain? Years _____ Months _____ Weeks _____

**ON THE DIAGRAM BELOW, PLEASE INDICATE WHERE YOU ARE EXPERIENCING PAIN AND OTHER SYMPTOMS.**



**A = ACHE** **P = PINS & NEEDLES** **B = BURNING**
**S = STABBING** **N = NUMBNESS** **O = OTHER**

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## GENERAL PAIN DISABILITY INDEX QUESTIONNAIRE

**PLEASE READ:** This rating scales below are designed to measure the degree to which several aspects of your life are presently disrupted by chronic pain. In other words, we would like to know how much pain is preventing you from doing what you would normally do, or from doing it as you normally would. Respond to each category by indicating the *overall* impact of pain in your life, not just when the pain is at its worse.

For each of the six categories of daily living listed. **PLEASE CIRCLE THE NUMBER WHICH BEST DESCRIBES YOUR TYPICAL LEVEL OF ACTIVITIES.** A score of 0 means no disability at all and a score of 10 signifies that all of the activities in which you would normally be involved have been totally disrupted or prevented by your pain.

**1. Family/Home Responsiblities.** This category refers to activities related to the home or family. It includes chores and duties performed around the house (e.g., yard work) and errands or favors for other family members (e.g., driving the children to school)

0 1 2 3 4 5 6 7 8 9 10

Completely able to function — Totally unable to function

**2. Recreation.** This category includes hobbies, sports, and other similar leisure time activities.

0 1 2 3 4 5 6 7 8 9 10

Completely able to function — Totally unable to function

**3. Social Activities.** This category refers to activities which involve participation with friends and acquaintances other than family members. It includes parties, theater, concerts, dining out, and other social functions.

0 1 2 3 4 5 6 7 8 9 10

Completely able to function — Totally unable to function

**4. Occupation.** This category refers to activities that are a part of or directly related to one's job. This includes nonpaying jobs as well, such as that of a homemaker or volunteer worker.

0 1 2 3 4 5 6 7 8 9 10

Completely able to function — Totally unable to function

**5. Self Care.** This category includes activities which involve personal maintenance and independent daily living (e.g., taking a shower, driving, getting dressed, etc.)

0 1 2 3 4 5 6 7 8 9 10

Completely able to function — Totally unable to function

**6. Life-Support Activity.** This category refers to basic life-supporting behaviors such as eating, sleeping, and breathing.

0 1 2 3 4 5 6 7 8 9 10

Patient Signature: _____ Date: ____ H.C.P Signature: _____ Score: ___

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# OSWESTRY NECK DISABILITY QUESTIONNAIRE

**PLEASE READ:** This questionnaire is designed to enable us to understand how much your neck pain has affected your ability to manage everyday activities. Please answer by checking ONE box in each section for the statement which best applies to you. We realize you may consider that two or more statements in any one section apply but please just shade out the spot that indicates the statement which most clearly describes your problem RIGHT NOW.

## 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 placed 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 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 cannot read as much as I want because of moderate pain in my neck.
- ☐ I can hardly read at all because of severe pain in my neck.
- ☐ I cannot read at all.

## SECTION 5 – HEADACHES

- ☐ I have no headaches at all.
- ☐ I have slight headaches that 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 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 cannot 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 cannot 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 cannot drive my car at all.

## SECTION 9 – SLEEPING

- ☐ I have no trouble sleeping.
- ☐ My sleep is slightly disturbed (less than 1 hour sleepless).
- ☐ My sleep is mildly disturbed (1-2 hours sleepless).
- ☐ My sleep is moderately disturbed (2-3 hours sleepless).
- ☐ My sleep is greatly disturbed (3-5 hours sleepless).
- ☐ My sleep is completely disturbed (5-7 hours 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 cannot do any recreation activities at all.

Patient Signature: _____ Date: ____ H.C.P Signature: _____ Score: ___

**SCORE:** 0-4 no disability | 5-14 mild disability | 15-24 moderate disability | 25-34 severe disability | 34+ complete disability

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# OSWESTRY LOW BACK PAIN DISABILITY QUESTIONNAIRE

**PLEASE READ:** This questionnaire is designed to enable us to understand how much your lower back has affected your ability to manage everyday activities. Please answer by checking ONE box in each section for the statement which best applies to you. We realize you may consider that two or more statements in any one section apply but please just shade out the spot that indicates the statement which most clearly describes your problem RIGHT NOW.

## 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 placed 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 lift very light weights.
- ☐ I cannot lift or carry anything at all.

## SECTION 4 – WALKING*

- ☐ Pain does not prevent me walking any distance.
- ☐ Pain prevents me from walking more than one mile.
- ☐ Pain prevents me from walking more than 1/2 mile.
- ☐ Pain prevents me from walking more than 100 yards.
- ☐ I can only walk using a stick or crutches.
- ☐ I am in bed most of the time.

## 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 sitting more than one hour.
- ☐ Pain prevents me from sitting more than 30 minutes.
- ☐ Pain prevents me from sitting more than 10 minutes.
- ☐ Pain prevents me from sitting at all.

## SECTION 6 – STANDING

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

## SECTION 7 – SLEEPING

- ☐ My sleep is never disturbed by pain.
- ☐ My sleep is occasionally disturbed by pain.
- ☐ Because of pain I have less than 6 hours sleep.
- ☐ Because of pain I have less than 4 hours sleep.
- ☐ Because of pain I have less than 2 hours sleep.
- ☐ Pain prevents me from sleeping at all.

## SECTION 8 – SEX LIFE (IF APPLICABLE)

- ☐ My sex life is normal and causes no extra pain.
- ☐ My sex life is normal but causes some extra pain.
- ☐ My sex life is nearly normal but is very painful.
- ☐ My sex life is severely restricted by pain.
- ☐ My sex life is nearly absent because of pain.
- ☐ Pain prevents any sex life at all.

## SECTION 9 – SOCIAL LIFE

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

## SECTION 10 – TRAVELING

- ☐ I can travel anywhere without pain.
- ☐ I can travel anywhere but it gives me extra pain.
- ☐ Pain is bad but I manage journeys over two hours.
- ☐ Pain restricts me to journeys of less than one hour.
- ☐ Pain restricts me to short necessary journeys under 30 minutes.
- ☐ Pain prevents me from traveling except to receive treatment.

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Patient Signature: _____ Date: ____ H.C.P Signature: _____ Score: ___

**SCORE:** 0-4 no disability | 5-14 mild disability | 15-24 moderate disability | 25-34 severe disability | 34+ complete disability