



# Decker Chiropractic Walk-In-Care, PA

13025 S Mur-Len Road Suite 100 Olathe KS 66062

Phone Number: 913-829-5111

Fax: 913-829-5179

## Patient Information

Date:			Birthday:		
First Name:			Middle Name:		
Sex:	<input type="radio"/> M	<input type="radio"/> F	Height:		
Marital Status:	<input type="radio"/> Yes	<input type="radio"/> No	Spouse Name:		
Home #:			Cell #:		
Address:					
City:			State:		
Emergency Contact:			Emergency Relation:		
Email:			Zip:		
			Work #:		
			# of Children:		
			Weight:		
			Emergency Phone:		

## Referral Information

Referring Physician:			Referred by:		
Advertisement:	<input type="radio"/> Yes	<input type="radio"/> No	Advertisement:		

## Employer Information

Employer Title:			Job Title:		
Employer Address:			City, State, Zip:		
Supervisor Name:					

## Complaint Information

Injury Occurred:	<input type="radio"/> Automobile	<input type="radio"/> Work	<input type="radio"/> Third-Party	Other:			Injury Date:		
Injury Origin:									
Describe Discomfort:									
Frequency:	<input type="radio"/> Always	<input type="radio"/> Hourly	<input type="radio"/> Daily	<input type="radio"/> Occasionally					
Interfere w/ Activities:	<input type="radio"/> Yes	<input type="radio"/> No	Affected Sleep:	<input type="radio"/> Yes	<input type="radio"/> No				
Missed Work:	<input type="radio"/> Yes	<input type="radio"/> No	Unable to Work from:			Unable to Work until:			
Affected Appetite:	<input type="radio"/> Yes	<input type="radio"/> No	Explain:						
Reduced Work:	<input type="radio"/> Yes	<input type="radio"/> No	Explain:						
Does it Worsen:	<input type="radio"/> Yes	<input type="radio"/> No	Explain:						
Weather Affects it:	<input type="radio"/> Yes	<input type="radio"/> No	Explain:						
Aggravates Condition:									
Improves Condition:									
Received Treatment:	<input type="radio"/> Yes	<input type="radio"/> No	Explain:						
X-Rays Taken:	<input type="radio"/> Yes	<input type="radio"/> No	Explain:						
Same Condition Before:	<input type="radio"/> Yes	<input type="radio"/> No	Date:			Practitioner:			

## History

Last Physical Exam: _____	Primary Physician: _____	Phys Phone # _____
Phys City: _____	Phys State: _____	Phys Zip: _____
<b>Health Conditions</b>		
Previous Chiro Care: <input type="radio"/> Yes <input type="radio"/> No	Date: _____	Explain: _____
Chance Pregnant: <input type="radio"/> Yes <input type="radio"/> No	Planning: <input type="radio"/> Yes <input type="radio"/> No	
Medications: _____		
Supplements: _____		
Broken Bones: <input type="radio"/> Yes <input type="radio"/> No	Treatment: <input type="radio"/> Yes <input type="radio"/> No	Explain: _____
Sprains/Strains: <input type="radio"/> Yes <input type="radio"/> No	Treatment: <input type="radio"/> Yes <input type="radio"/> No	Explain: _____
Hospitalized: <input type="radio"/> Yes <input type="radio"/> No	Explain: _____	
Surgery: <input type="radio"/> Yes <input type="radio"/> No	Explain: _____	
Auto Accident: <input type="radio"/> Yes <input type="radio"/> No	Treatment: <input type="radio"/> Yes <input type="radio"/> No	Explain: _____
Struck Unconscious: <input type="radio"/> Yes <input type="radio"/> No	Treatment: <input type="radio"/> Yes <input type="radio"/> No	Explain: _____
Eating Disorder: <input type="radio"/> Yes <input type="radio"/> No	Explain: _____	
Stroke: <input type="radio"/> Yes <input type="radio"/> No	Explain: _____	
Family Health History: _____		

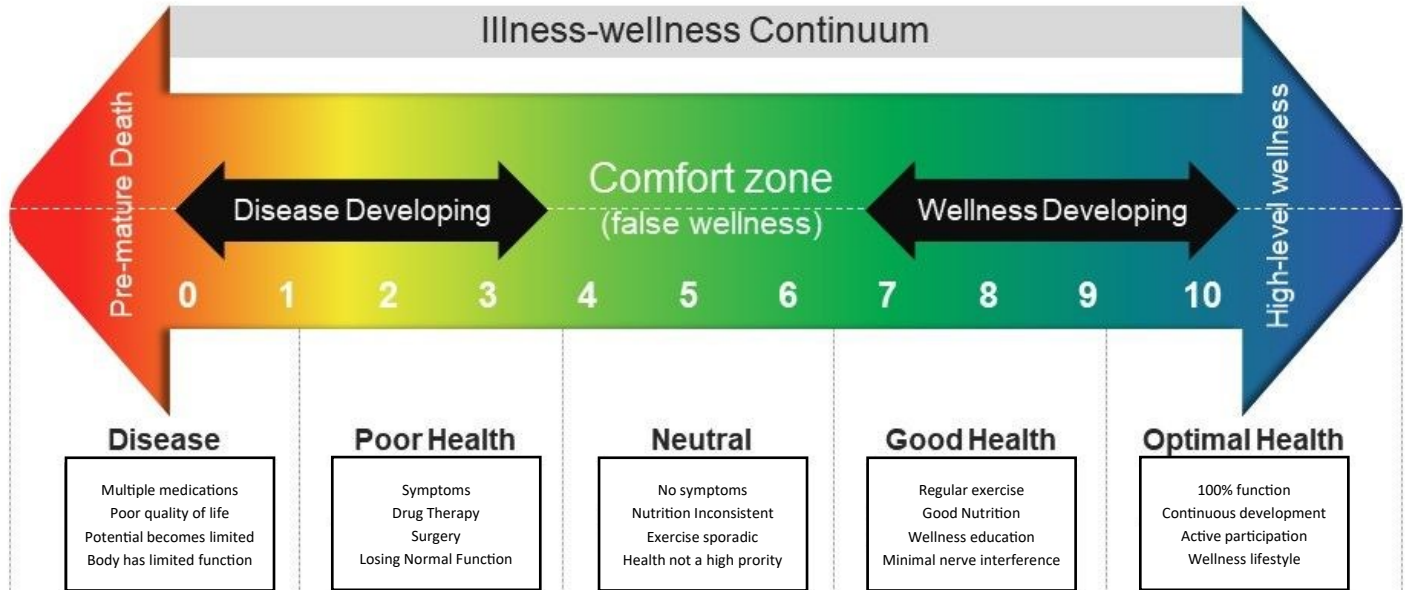
## Patient Social

Alcohol	<input type="radio"/> Daily	<input type="radio"/> Weekly	<input type="radio"/> Occasionally	<input type="radio"/> Never
Diet Food Products	<input type="radio"/> Daily	<input type="radio"/> Weekly	<input type="radio"/> Occasionally	<input type="radio"/> Never
OTC Stimulants	<input type="radio"/> Daily	<input type="radio"/> Weekly	<input type="radio"/> Occasionally	<input type="radio"/> Never
Homemade Food	<input type="radio"/> Daily	<input type="radio"/> Weekly	<input type="radio"/> Occasionally	<input type="radio"/> Never
Soft Drinks	<input type="radio"/> Daily	<input type="radio"/> Weekly	<input type="radio"/> Occasionally	<input type="radio"/> Never
Water	<input type="radio"/> Daily	<input type="radio"/> Weekly	<input type="radio"/> Occasionally	<input type="radio"/> Never
Caffeine	<input type="radio"/> Daily	<input type="radio"/> Weekly	<input type="radio"/> Occasionally	<input type="radio"/> Never
Drugs	<input type="radio"/> Daily	<input type="radio"/> Weekly	<input type="radio"/> Occasionally	<input type="radio"/> Never
Exercise	<input type="radio"/> Daily	<input type="radio"/> Weekly	<input type="radio"/> Occasionally	<input type="radio"/> Never
Processed Food	<input type="radio"/> Daily	<input type="radio"/> Weekly	<input type="radio"/> Occasionally	<input type="radio"/> Never
Tobacco/Vaping	<input type="radio"/> Daily	<input type="radio"/> Weekly	<input type="radio"/> Occasionally	<input type="radio"/> Never

## Health Checklist

<input type="checkbox"/> Allergies	<input type="checkbox"/> Cramps	<input type="checkbox"/> Irregular Menstrual Cycle	<input type="checkbox"/> Sinus Infection
<input type="checkbox"/> Alcoholism	<input type="checkbox"/> Depression	<input type="checkbox"/> Kidney Infection	<input type="checkbox"/> Insomnia
<input type="checkbox"/> Anemia	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Kidney Stones	<input type="checkbox"/> Spinal Curvatures
<input type="checkbox"/> Arteriosclerosis	<input type="checkbox"/> Digestion Problems	<input type="checkbox"/> Loss of Memory	<input type="checkbox"/> Stroke
<input type="checkbox"/> Arthritis	<input type="checkbox"/> Dizziness	<input type="checkbox"/> Loss of Balance	<input type="checkbox"/> Swelling of Ankles
<input type="checkbox"/> Asthma	<input type="checkbox"/> Excessive Menstruation	<input type="checkbox"/> Loss of Smell	<input type="checkbox"/> Swollen Joints
<input type="checkbox"/> Back Pain	<input type="checkbox"/> Eye Pain or Difficulties	<input type="checkbox"/> Loss of Taste	<input type="checkbox"/> Thyroid Condition
<input type="checkbox"/> Breast Lump	<input type="checkbox"/> Fatigue	<input type="checkbox"/> Nosebleeds	<input type="checkbox"/> Tuberculosis
<input type="checkbox"/> Bronchitis	<input type="checkbox"/> Frequent Urination	<input type="checkbox"/> Pacemaker	<input type="checkbox"/> Ulcers
<input type="checkbox"/> Bruise Easily	<input type="checkbox"/> Headache	<input type="checkbox"/> Polio	<input type="checkbox"/> Varicose Veins
<input type="checkbox"/> Cancer	<input type="checkbox"/> Hemorrhoids	<input type="checkbox"/> Poor Posture	<input type="checkbox"/> Venereal Disease
<input type="checkbox"/> Chest Pain	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Prostate Trouble	Other: _____
<input type="checkbox"/> Cold Extremities	<input type="checkbox"/> Hot Flashes	<input type="checkbox"/> Sciatica	
<input type="checkbox"/> Constipation	<input type="checkbox"/> Irregular Heart Beat	<input type="checkbox"/> Shortness of Breath	

# Health Goals



**On the arrow diagram above:**

What number do you think represents your health today?

In what direction is your health currently headed?

**What are your health goals?**

Immediate:

Short term:

Long term:

**Goals for Your Care**

People see a chiropractor for a variety of reasons. Some go for relief of pain, some to correct the cause of pain and others for correction of whatever is malfunctioning in their body. Your doctor will weigh your needs and desires when recommending your care program. Please check the type of care desired so that we may be guided by your wishes whenever possible.

- I want the Doctor to select the type of care appropriate for my condition.**
- Relief Care:** Symptomatic relief of pain or discomfort.
- Corrective Care:** Correcting and relieving the cause of the problem as well as the symptoms.
- Comprehensive Care:** Bring whatever is malfunctioning in the body to the highest state of health possible with chiropractic care.



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## Financial Policy

### 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 cash, check or credit card.

### 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.

### "ON THE JOB" INJURY (Worker's Compensation)

If you are injured on the job, your care should be paid for under your employer's Worker's Compensation insurance. You will need to inform your employer of the accident and obtain the name and address of the carrier of their insurance. If your employer does not provide us with this information, if a settlement has not been made within 3 months, or if you suspend or terminate care, any fees and services are due immediately.

### 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 portion of your auto insurance.
3. We will accept a Letter of Protection or Doctor's Lien from an 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 3 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.

### 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 Decker Chiropractic, I understand that my insurance is an arrangement between myself and my insurance company, NOT between Decker Chiropractic and my insurance company, I request that Decker 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 Decker Chiropractic that fees will be due and payable immediately.*

Patient's Signature (or guardian if patient is a minor)

Date



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## Addendum to Notice of Privacy Practices • HIPAA

I give permission to release information to the following person or persons. He and/or she may inquire in person, by phone, or mail about my account or records and speak with the doctor on my behalf.

None

Name	Relationship
_____	_____
Name	Relationship
_____	_____
Name	Relationship
_____	_____
Name	Relationship
_____	_____

I give permission to release information about my chiropractic care and my progress to the medical doctor listed below:

Doctor's name	_____
Office Address	City, Zip
_____	_____
Office Phone	_____
_____	

**Signature:** \_\_\_\_\_

**Date:** \_\_\_\_\_



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## HIPAA Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW CAREFULLY.

If you have any questions about the above notice, please contact our Office at 913-829-5111

### Our Obligations

We are required by law to:

- Maintain the privacy of protected health information
- Give you the notice of your legal duties and privacy practices regarding health information about you
- Follow the terms of our notice that is currently in effect

### How We May Use and Disclose Health Information

Described as follows are the ways we may use and disclose health information that identifies you ("Health Information"). Except for the following purposes, we will use and disclose health information only with your written permission. You may revoke such permissions at any time by writing to our practice's privacy officer.

**Treatment.** We may use and disclose Health Information for your treatment and to provide you with treatment-related health care services. For example, we may disclose Health Information to doctors, nurses, technicians, or other personnel, including people outside our office, who are involved in your medical care and need the information to provide you with medical care.

**Payment.** We may use and disclose Health Information so that we or others may bill and receive payment from you, an insurance company, or a third party for treatment and services you receive. For example, we may give your health plan information so that they will pay for your treatment.

**Health Care Operations.** We may use and disclose Health Information for health care operation purposes. These uses and disclosures are necessary to make sure that all of our patients receive quality care to operate and manage our office. For example, we may use and disclose information to make sure the obstetric or gynecologic care you receive is of the highest quality. We also may share information with our entities that have a relationship with you (for example, your health plan) for their health care operation activities.

**Appointment Reminders, Treatment Alternatives, and Health Related Benefits and Services.** We may use and disclose Health Information to contact you and remind you that you have an appointment with us. We also may use and disclose Health Information to tell you about treatment alternatives or health related benefits and services that may be of interest to you.

**Individuals Involved in Your Care or Payment for Your Care.** When appropriate, we may share Health Information with a person who is involved in your medical care or payment for your care, such as your family or a close friend. We also may notify your family about your location or general condition or disclose such information to an entity assisting in a disaster relief effort.

**Research.** Under certain circumstances, we may use and disclose Health Information for research. For example, a research project may involve comparing the health of patients who receive one treatment to those who receive another for the same condition. Before we use or disclose Health Information for research, the project will go through a special approval process. Even without special approval, we may permit researchers to look at records to help them identify patients who may be included in their research project or for other similar purposes.

### Special Situations

As required by law. We will disclose Health Information when required to do so by international, federal, state, or local law.

**To Avert a Serious Threat to Health or Safety.** We will disclose Health Information when necessary to prevent a serious threat to your health and safety or the public, or another person. Disclosure, however, will be made only to someone who may be able to help provide treatment.

## HIPAA Notice of Privacy Practices (continued)

**Business Associates.** We may disclose Health Information to our business associates that perform functions on our behalf or to provide us with services if the information is necessary for such functions or services. For example, we may use another company to perform billing services on our behalf. All of our business associates are obligated to protect the privacy of your information and are not allowed to use or disclose any information other than that as specific in our contract.

**Organ and Tissue Donation.** If you are an organ donor, we may use or release Health Information to organizations that handle organ procurement or other entities engaged in procurement; banking or transportation of organs, eyes, or tissues to facilitate organ, eye, or tissue donation, and transplantation.

**Military and Veterans.** If you are a member of the army forces, we may use or release Health Information as required by military command authorities. We also may release Health Information to the appropriate foreign military authority if you are a member of a foreign military.

**Worker's Compensation.** We may release Health Information for worker's compensation or similar programs. These programs provide benefits for work-related injuries or illness.

**Public Health Risks.** We may disclose Health Information for public health activities. These activities generally include disclosure to prevent or control disease, injury, or disability; report child abuse or neglect; report reactions to medications or problems with products; notify people of recalls of products they may be using; inform a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition; and report to the appropriate government authority if we believe a patient has been a victim of abuse, neglect, or domestic violence. We will only make this disclosure if you agree or when required by law.

**Health Oversight Activities.** We may disclose Health Information to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.

**Lawsuits and Disputes.** If you are involved in a lawsuit or a dispute, we may disclose Health Information in response to a court or a court administrator order. We also may disclose Health Information in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.

**Law Enforcement.** We may release Health Information if asked by a law enforcement official if the information is: 1) in response to a court order, subpoena, warrant, summons, or similar process; 2) limited information to identify or locate a suspect, fugitive, material witness, or missing person; 3) about the victim of crime even if, under certain circumstances, we are unable to obtain the person's agreement; 4) about a death we believe may be the result of criminal conduct; 5) about criminal conduct on our premises and; 6) in an emergency to report a crime to the location of the crime if victims, or the identity, description, or location of the person who committed the crime.

**Coroners, Medical Examiners, Funeral Directors.** We may release Health Information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We may also release Health Information to funeral directors as necessary for their duties.

**National Security and Intelligence Activities.** We may release Health Information to authorized federal officials so they may provide protection to the President, other authorized persons, or foreign heads of state, or to conduct special investigations.

**Protective Services and Intelligence Activities.** We may release Health Information to authorized federal officials so they may provide protection to the President, other authorized persons, or foreign heads of state, or to conduct special investigations.

**Inmates or Individuals in Custody.** If you are an inmate of a correctional institution or other custody of a law enforcement official, we may release Health Information to the correctional institution or law enforcement official. This release would be made if necessary 1) for the institution to provide you with health care; 2) to protect your health and safety or the health and safety of others, or; 3) for the safety and security of the correctional institution.

## HIPAA Notice of Privacy Practices (continued)

### Your Rights

You have the following rights regarding Health Information we have about you:

**Right to Inspect and Copy.** You have the right to inspect and copy Health Information that we may have used to make decisions about your care or payment for your care. This includes medical and billing records, other than psychotherapy notes. To inspect and copy this information, you must make your request in writing, to our Privacy Officer.

**Right to Amend.** If you feel that Health Information we have is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for our office. To request an amendment, you must make your request, in writing, to our Privacy Officer.

**Right to an Accounting of Disclosures.** You have the right to request a list of certain disclosures we made of Health Information for purposes other than treatment, payment, and health care operations or for which you provided written authorization. To request an accounting of disclosures, you must make your request, in writing, to our Privacy Officer.

**Right to Request Restrictions.** You have the right to request a restriction or limitation on the Health Information we use or disclose for treatment, payment, or health care operation. You also have a right to request a limit on the Health Information we disclose to someone involved in your care or the payment for your care, like a family member or friend. For example, you can ask that we not share information about your particular diagnosis or treatment with your spouse. To request a restriction, you must make your request, in writing, to our Privacy Officer. **We are not required to agree with your request.** If we agree, we will comply with your request unless the information is needed to provide you with emergency treatment.

**Right to Request Confidential Communication.** You have the right to request that we communicate with you about your medical matters in a certain way or at a certain location. For example, you can ask that we contact you only by mail or at work. To request confidential communications, you must make your request, in writing, to our Privacy Officer. Your request must specify how or where you wish to be contacted. We will accommodate reasonable requests.

**Right to a Paper Copy of This Notice.** You have the right to a paper copy of this notice. You must ask us to give you a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice. You may obtain a copy of this notice by contacting our office.

### Changes to This Notice

We reserve the right to change this notice and make the new notice apply to Health Information we already have as well as any information we receive in the future. We will post a current copy of our notice at our office. The notice will contain the effective date on the first page, in the top right hand corner.

### Complaints

If you believe your privacy has been violated, you may file a complaint with our office or with the Secretary of the Department of Health and Human Services. To file a complaint with our office, contact our Privacy Officer. All complaints must be made in writing. **You will not be penalized for filing a complaint.**

By Subscribing my name below, I acknowledge receipt of a copy of this notice, and my understanding and my agreement to its terms.

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Patient Signature

Date





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## Patient Messaging Consent

By supplying my home phone number, mobile phone number, email address, and any other personal contact information, I authorize my health care provider to use my personal information, the name of my care provider, the time and place of my scheduled appointment (s), and other limited information, for the purpose of notifying me of a pending appointment, a missed appointment, overdue wellness exam, balances due, lab results, or other communications via an automated outreach and messaging system. I also authorize my healthcare provider to disclose to third parties who may intercept these messages (individuals you have provided with access to your digital devices or email accounts) limited protected health information (PHI) regarding my healthcare events. I consent to the receiving multiple messages per day from the automated outreach and messaging system, when necessary.

Patient Name

Date

Patient Signature



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## INFORMED CONSENT TO CHIROPRACTIC ADJUSTMENTS AND CARE

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy and diagnostic x-rays, on me (or the patient named below, for whom I am legally responsible) by the doctor of chiropractic named below and/or other licensed doctors of chiropractic who now or in the future treat me while employed by, working or associated with or serving as back-up for the doctor of chiropractic named below, including those working at the clinic or office listed below or any other office or clinic.

I have had the opportunity to discuss with the doctor of chiropractic named below and/or with other office or clinic personnel the nature and purpose of chiropractic adjustments and other procedures.

I understand and I am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment, including but not limited to: fractures, disc injuries, strokes, dislocations and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely on the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts known, is in my best interest.

I have read, and or have had read to me, the above consent. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above-named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition (s) for which I seek treatment.

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### To be completed by patient:

---

Print Patient's Name

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Patient Signature (or legal guardian if under 18)

Date Signed

---

### To be completed by doctor or staff:

Name and Address of clinic/office:

Decker Chiropractic Walk-In-Care, PA  
13025 S Mur-Len Road, Suite 100 Olathe, KS 66062  
913-829-5111

Print name (s) doctor (s) treating this patient:

George D Decker, D.C.

## Neck Disability Index

This questionnaire is designed to help us better understand how your **neck pain** affects your ability to manage everyday-life activities. Please mark the **one circle** that applies to you.

Although you may consider that two of the statements in any one section relate to you, please mark the box that **most closely** describes your present-day situation.

### Section 1– Pain Intensity

- I have no neck 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

- I can look after myself normally without causing extra neck pain.
- I can look after myself normally, but it causes extra neck 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 causing extra neck pain.
- I can lift heavy weights, but it gives me extra neck pain.
- Neck pain prevents me from lifting heavy weights off the floor but I can manage if items are conveniently positioned, ie on a table.
- Neck pain prevents me from lifting heavy weights, but I can manage light weights if they are conveniently positioned.
- I can lift only very light weights.
- I cannot lift or carry anything at all.

### Section 4– Reading

- I can read as much as I want with no neck pain.
- I can read as much as I want with slight neck pain.
- I can read as much as I want with moderate neck pain.
- I can't read as much as I want because of moderate neck pain.
- I can't read as much as I want because of severe neck pain.
- I can't read at all.

### Section 5– Headaches

- I have no headaches at all.
- I have slight headaches that come infrequently.
- I have moderate headaches that come infrequently.
- I have moderate headaches that come frequently.
- I have severe headaches that come frequently.
- I have headaches almost all the time.

### Section 6– Concentration

- I can concentrate fully without difficulty.
- I can concentrate fully with slight difficulty.
- I have a fair degree of difficulty concentrating.
- I have a lot of difficulty concentrating.
- I have a great deal of difficulty concentrating.
- I can't concentrate at all.

### Section 7– Work

- I can do as much work as I want.
- I can only do my usual work, but no more.
- I can do most of the usual work, but no more.
- I can't 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 neck pain.
- I can drive my car with only slight neck pain.
- I can drive as long as I want with moderate neck pain.
- I can't drive as long as I want because of moderate neck pain.
- I can hardly drive at all because of severe neck pain.
- I can't drive my car at all because of neck pain.

### Section 9– Sleeping

- I have no trouble sleeping.
- My sleep is slightly disturbed for less than 1 hour.
- My sleep is mildly disturbed for up to 1-2 hours.
- My sleep is moderately disturbed for up to 2-3 hours.
- My sleep is greatly disturbed for up to 3-5 hours.
- My sleep is completely disturbed for up to 5-7 hours.

### Section 10– Recreation

- I am able to engage in all my recreational activities with no neck pain at all.
- I am able to engage in all my recreational activities with some neck pain.
- I am able to engage in most, but not all of my recreational activities because of pain in my neck.
- I am able to engage in a few of my recreational activities because of neck pain.
- I can hardly do recreational activities due to neck pain.
- I can't do any recreational activities due to neck pain.

Patient Name

Date

## Oswestry Low Back Pain Scale

Please rate the severity of your pain by circling a number below:

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

Instructions: Please mark the circle in each section 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 severe.
- The pain is severe and does not vary much.

### Section 2 - Personal Care (Washing, Dressing, etc.)

- 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 I am unable to do some washing and dressing without help.
- Because of the pain I am unable to do any washing and dressing without help.

### Section 3 - Lifting

- I can lift heavy weights without extra pain.
- I can lift heavy weights but it gives extra pain.
- Pain prevents me lifting heavy weights off the floor.
- Pain prevents me lifting heavy weights off the floor, but I can manage if they are conveniently positioned, e.g., on a table.
- Pain prevents me lifting heavy weights but I can manage light to medium weights if they are conveniently positioned.
- I can only lift very light weights at 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 1 mile without increasing pain.
- I cannot walk more than ½ mile without increasing pain.
- I cannot walk more than ¼ 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 sit only in my favorite chair as long as I like.
- Pain prevents me from sitting more than 1 hour.
- Pain prevents me from sitting more than ½ hour.
- Pain prevents me from sitting more than 10 minutes.
- I avoid sitting because it increases pain immediately.

### 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 1 hour without increasing pain.
- I cannot stand for longer than ½ hour without increasing pain.
- I cannot stand for longer than 10 minutes without increasing pain.
- I avoid standing because it increases the pain immediately.

### Section 7 - Sleeping

- I get no pain in bed..
- I get pain in bed but it does not prevent me from sleeping well.
- Because of pain my normal nights sleep is reduced by less than one-quarter.
- Because of pain my normal nights sleep is reduced by less than one-half.
- Because of pain my normal nights sleep is reduced by less than three-quarters.
- 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 it 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 - Traveling

- I get no pain when traveling.
- I get some pain when traveling but none of my usual forms of travel make it any worse.
- I get extra pain while traveling but it does not compel me to seek alternate forms of travel.
- I get extra pain while traveling which compels to seek alternative forms of travel.
- Pain restricts me to short necessary journeys under ½ hour.
- Pain restricts all forms of travel.

### Section 10 - Changing Degree of Pain

- My pain is rapidly getting better.
- My pain fluctuates but is definitely getting better.
- My pain seems to be getting better but improvement is slow.
- My pain is neither getting better or worse.
- My pain is gradually worsening.
- My pain is rapidly worsening.

Patient Name

Date