Pregnancy
Wellness Profile

LIFE IN MOTION Chiropractic Center

lifeinmotionchirocenter.com

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Practice Member Information

File _____

Name: _____

Appointment Date M _____ D _____ 20 _____ Birth Date M _____ D _____ Y _____

Home Address: _____

City _____ State _____ Zip _____

Home Phone: _____ May we leave a message? ☐ Yes ☐ No

Cell Phone: _____ May we leave a message? ☐ Yes ☐ No

Work Phone: _____ May we leave a message? ☐ Yes ☐ No

Email: _____

May we add you to our email newsletter and calendar of events? ☐ Yes ☐ No (Your email will not be shared)

Spouse's name? _____

Name(s) and age(s) of children: _____ _____ _____ _____

Occupation: _____

Do you primarily: ☐ Sit ☐ Stand ☐ Perform repetitive tasks

How did you hear about us? _____

Healthcare History

Have you had previous chiropractic care? ☐ No ☐ Yes

Who was your previous Chiropractor? _____

Where? _____ When? _____

Were X-rays taken in the last 6 months? ☐ Yes ☐ No

What was the primary reason for consulting that office?

☐ Relief Care - Symptom relief of pain or discomfort

☐ Corrective Care - Correcting, relieving and stabilizing spinal, joint and postural issues

☐ Wellness Care - Maximizing the body's ability for optimal healing and function

Do you feel your previous chiropractic care was effective? ☐ No ☐ Yes

Please explain: _____

Are you wearing: ☐ Heel Lifts ☐ Custom Orthotics

Family Doctor: _____

Date and reason of last visit: _____

May we contact your family doctor regarding your care at our office if necessary? ☐ No ☐ Yes

Naturopathic Doctor: _____

Date and reason of last visit: _____

Other Specialists and healthcare professionals:

Name: _____

Professional Designation: _____

Date and reason of last visit: _____

Name: _____

Professional Designation: _____

Date and reason of last visit: _____

Pregnancy Profile

How far along in your pregnancy are you?_____ When is your baby's due date? D_____ M_____ Y_____
Have you taken any medications during this pregnancy? ☐No ☐Yes:
OTC and Reason: _____
Prescription and Reason: _____
Vaccines and Reason: _____
Have you experienced any physical trauma during this pregnancy? ☐No ☐Yes _____
Have you had any evaluation procedures (ultrasound, amniocentesis, chorionic villus sampling)? ☐No ☐Yes
Dates and Reasons: _____
_____
_____
Have there been any stressful events in your life during this pregnancy? ☐No ☐Yes _____
_____
_____
What type of birth care provider are you planning on using? ☐Midwife ☐OB/Gyn ☐Medical Doctor ☐Other
Where do you plan on delivering? _____
Is this your first pregnancy? ☐Yes ☐No:
If not, how many pregnancies previously? _____
How many children do you have? _____
Miscarriages? ☐No ☐Yes: ☐D&C ☐Natural Miscarriage
How many vaginal deliveries? _____
How many caesarean sections? _____
Have there been any complications during your previous deliveries? ☐No ☐Yes _____
Was labor induced/use of Pitocin? ☐No ☐Yes ☐Unknown
Did your care provider rupture your membranes? ☐No ☐Yes ☐Unknown
Was there any back or hip pain during labor? ☐No ☐Yes
Was baby in a suboptimal position during the pushing phase of any labor? ☐No ☐Yes ☐Unknown
Did you receive an epidural? ☐No ☐Yes
Were there any operative devices used? ☐No ☐Yes ☐Forceps ☐Vacuum
Any postpartum complications or long term consequences? ☐No ☐Yes _____
_____

Have you experienced any of the following symptoms during this pregnancy or a previous pregnancy?

CURRENT	PREVIOUS		CURRENT	PREVIOUS	
☐	☐	Headaches	☐	☐	Carpal Tunnel (numbness in hands/fingers)
☐	☐	Facial Paralysis	☐	☐	Low/Mid Back Pain
☐	☐	Chronic Fatigue	☐	☐	Breech or Sidelying Presentation
☐	☐	Nausea/"Morning Sickness"	☐	☐	Round Ligament Pain/Pulling (front of belly)
☐	☐	Heartburn/Indigestion	☐	☐	Pain in your Pubic Bone
☐	☐	Preeclampsia	☐	☐	Pins/Needles in the Front/Side of your Leg
☐	☐	Gestational Diabetes	☐	☐	Pain in Posterior Leg (Sciatica)
☐	☐	Constipation	☐	☐	Leg Cramps
☐	☐	Hemorrhoids	☐	☐	Swelling of Ankles, Legs and Feet

Wellness Profile

Do you have a specific concern that brings you in?

☐ No, I'm interested in having my spinal and pelvic alignment assessed to help achieve optimal growth and delivery for my baby

☐ Yes: _____

If yes, please answer the following questions:

What is your primary area of complaint today? _____

How long have you been aware of this? _____ days _____ weeks _____ months _____ years

Where else does this pain go in your body? _____

How often do you experience this? ☐ daily ☐ weekly ☐ monthly ☐ comes and goes ☐ constantly

On a scale of 1 to 10 (10 being the worst), how does it feel when it's at its worst? _____

How would you describe the pain/discomfort?

☐ Dull ☐ Achy ☐ Throbbing ☐ Stabbing ☐ Tight/Stiff ☐ Burning ☐ Sharp ☐ Other _____

What makes it feel worse? _____

What makes it feel better? _____

Do you notice any other problems in your body when you get this pain/discomfort? _____

Do you feel your condition getting progressively worse? ☐ No ☐ Yes

Do you feel your condition can be healed? ☐ No ☐ Yes

What have you tried that ***has*** helped? ☐ Ice ☐ Heat ☐ Medication ☐ Massage ☐ Physical Therapy ☐ Chiropractic ☐ Other _____

What have you tried that ***hasn't*** helped? ☐ Ice ☐ Heat ☐ Medication ☐ Massage ☐ Physical Therapy ☐ Chiropractic ☐ Other _____

See additional ***Spinal Nerve Function Form*** to provide further detail on your *Wellness Profile* (**Page6**)

Lifestyle Information

The human body is designed to be healthy. The primary system in the body which coordinates health and function is the nervous system. Your nervous system is surrounded and protected by the bones of the spine, called vertebrae. Physical, emotional, and chemical stresses, common to our contemporary lifestyle, can result in misalignment to the spinal column as well as damage the delicate nervous system. The result is a condition called a ***Vertebral Subluxation.*** The remainder of the intake form addresses the possible factors which may contribute to vertebral subluxation in your spine which may be impeding your body's ability to heal.

Physical

Height _____ Weight _____

Are you happy with your current physical appearance and abilities? ☐ Yes ☐ No

Frequency of exercise/week: Cardio? . . . . . ☐0 ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7

Weight bearing?. ☐0 ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7

Do you stretch after exercise or after other activities of poor posture? ☐ Yes ☐ Sometimes ☐ No

Hours of sleep/night? ☐ <6 ☐ 7-9 ☐ 10+

Do you feel refreshed upon waking? ☐ Always ☐ Sometimes ☐ Rarely

Age of mattress? _____ Do you feel your mattress is appropriate for your sleeping style? ☐ No ☐ Yes

Which position do you sleep? ☐ Back ☐ Belly Side: ☐ Right ☐ Left ☐ Both

Number of hours spent commuting/week? ☐ 0-2 ☐ 3-5 ☐ 6-8 ☐ 9-11 ☐ 12+

Number of hours spent at a desk or computer/week? ☐0 ☐1-5 ☐6-10 ☐11-20 ☐21-40 ☐41+

Number of hours spent on smart device/tablet/week? ☐0 ☐1-5 ☐6-10 ☐11-20 ☐21-40 ☐41+

Do you perform any repetitive tasks at home or at work? ☐ No ☐ Yes

Have you ever been hospitalized or had surgery? ☐ No ☐ Yes If yes why and when? _____

_____

Have you ever been in a motor vehicle accident (even if it was minor)? ☐ No ☐ Yes

If yes, what kind and when? _____

Were you evaluated and treated after each accident? ☐ No ☐ Yes

Have you had any non-vehicle accidents or falls? ☐ No ☐ Yes _____

Early Years

To your knowledge, was your delivery difficult? ☐No ☐Yes
☐If yes: ☐Forceps ☐Vacuum ☐Caesarean ☐Breech ☐Other_____
Were you breast fed? ☐No ☐Yes For how long? _____
Did you experience emotional trauma as a child? ☐No ☐Yes _____
Were you ever given antibiotics as a child? ☐No ☐Yes _____
Did you ever have ear infections as a child? ☐No ☐Yes _____
Any major childhood illness? ☐No ☐Yes _____

Emotional

Rate your current level of ***personal stress*** in your life: . . . . . ☐None ☐Low ☐Moderate ☐High
Rate your current level of ***relationship stress*** in your life: . . . . . ☐None ☐Low ☐Moderate ☐High
Rate your current level of ***financial stress*** in your life: . . . . . ☐None ☐Low ☐Moderate ☐High
Rate your current level of ***health stress*** in your life: . . . . . ☐None ☐Low ☐Moderate ☐High
Rate your current level of ***family stress*** in your life: . . . . . ☐None ☐Low ☐Moderate ☐High
Rate your current level of ***career stress*** in your life: . . . . . ☐None ☐Low ☐Moderate ☐High
Do you feel you have a supportive network of friends and family? . . . ☐Yes ☐No
Do you feel you have healthy coping strategies for life stress? . . . . . ☐Yes ☐No

Chemical

Were you vaccinated as a child? . . . . . ☐No ☐Yes
Any adverse reactions to vaccines? . . . . . ☐No ☐Yes _____
Do you choose to have annual flu shots? . . . . . ☐No ☐Yes
Do you take antibiotics? . . . . . ☐No ☐Yes, How often? _____
How many glasses of water/day:. . . . . ☐0 ☐1-3 ☐4-6 ☐7-9 ☐10+
How many glasses of caffeinated beverages/day: . . . . . ☐0 ☐1-3 ☐4-6 ☐7-9 ☐10+
How many glasses of cow's milk, juice and pop/day: . . . . . ☐0 ☐1-3 ☐4-6 ☐7-9 ☐10+
Do you eat gluten?. . . . . ☐No ☐Yes ☐Trying to eliminate from diet
Do you eat dairy? . . . . . ☐No ☐Yes ☐Trying to eliminate from diet
Do you eat refined sugars? (white sugar, white bread and pasta) . . . . . ☐No ☐Yes ☐Trying to eliminate from diet
Do you eat boxed/frozen foods?. . . . . ☐No ☐Yes ☐Trying to eliminate from diet
Do you choose organic foods?. . . . . ☐No ☐Yes, which: ☐Veggies ☐Fruits ☐Meats ☐Grains ☐All
Do you eat any artificial sweeteners? (Splenda, Aspartame, Diet Soda, etc) . ☐No ☐Yes
Any food/drink allergies, sensitivities intolerances?. . . . . ☐No ☐Yes _____
Do you smoke? . . . . . ☐No ☐Yes ☐I used to for__ years ☐I wish I didn't
Are you or have you been exposed to second hand smoke? . . . . ☐No ☐Yes
Do you drink alcohol? . . . . . ☐No ☐Yes ☐0-6/week ☐6-12/week ☐12+/week
Do you take a probiotic daily?. . . . . ☐No ☐Yes, _____ CFU's/day
Do you take vitamin D3 daily?. . . . . ☐No ☐Yes, _____ IU's/day
Do you take Omega 3 Fish Oils daily?. . . . . ☐No ☐Yes, _____ mg/day ☐Capsule ☐Liquid
Other supplements or homeopathics? _____
Any other daily medication and their purpose? _____

Do you have a plan in place with your medical doctor to wean yourself off of any long term medications? ☐No ☐Yes

Family Health

At our clinic we are not only interested in your health and wellness, but also the health and wellness of the important people in your life. Please mention below any health conditions or concerns you may have about your:

Children: _____

Spouse: _____

Mother: _____

Father: _____

Brothers/Sisters: _____

Are you seeking chiropractic care today for:

- ☐ Relief Care - Symptom relief of pain or discomfort
- ☐ Corrective Care - Correcting, relieving and stabilizing spinal, joint and postural issues
- ☐ Wellness Care - Maximizing the body's ability for optimal healing and function of the nervous system
- ☐ Pregancy Care: regular care throughout pregnancy to optimize the growth and development of my baby and prepare my body for a healthy delivery and fast recovery.

Do you have other concerns we should know about? _____

Goals & Consent

What is your primary goal for consulting our clinic? _____

Our goals are to provide a detailed assessment of your current health status and provide to you the resources for a highly engaged and healthy body which is functioning at its absolute peak potential. Essential to this is a healthy nervous system functioning free from interference called subluxations. You've taken an important step for your health through a chiropractic evaluation!

Consent to Evaluation

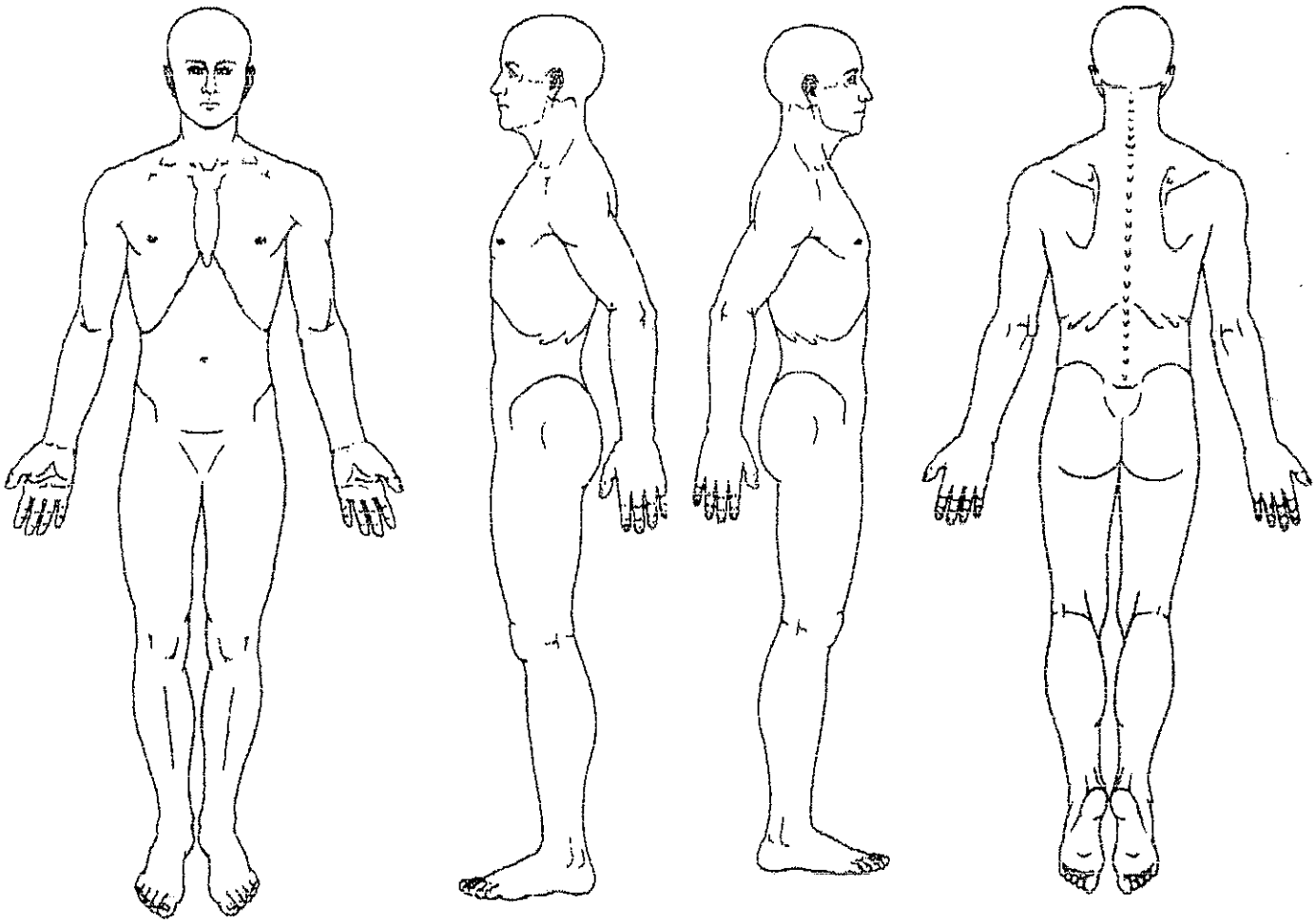
I _____ hereby grant permission to receive a chiropractic evaluation including history, spinal scan and examination. Any findings will be communicated before consenting to commencement of care, if appropriate.

_____ _____

Consenting Adult's Signature Date

PATIENT HISTORY

PAIN LOCATION



Please mark off the areas of your complaint on the diagram above. Please use the following symbols on the pain diagram to accurately describe your condition.

PPP	Where you experience **Pain**
NNN	Where you experience **Numbness**
TTT	Where you experience **Tingling**
BBB	Where you experience **Burning**
CCC	Where you experience **Cramping**

PATIENT SIGNATURE _____ **DATE** _____

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FINANCIAL POLICY

ALL PAYMENT IS EXPECTED AT THE TIME OF SERVICE: This includes all applicable office charges, coinsurance, deductible and copayments for participating insurance companies. After 30 days of non-payment, a **$1.50 late payment charge** will be applied to your account, and an additional charge will be added every 30 days. The office accepts cash, personal checks (there is a service charge of $25.00 for returned checks), VISA, MasterCard and Discover. This office utilizes e-Pay – electronic statements send through email and/or text messages. By consenting to our financial policy, you are giving Life in Motion Chiropractic consent to send balances due via e-Pay.

We bill participating insurance companies as a courtesy to you. If we have not received payment from your insurance company within 45 days of the date of service, you may be expected to pay the balance in full. You are responsible for all services not covered by your insurance carrier.

We do not bill all secondary insurance companies; primary and secondary must be linked electronically to bill. Please check with your insurance company to verify. Patients will be responsible for charges not billed to your secondary insurance. Your time of service receipt includes all information necessary for you to submit claims to your insurance company.

MANAGED CARE: Some insurance companies require authorizations for chiropractic care. All visits not covered by lack of an authorization or denied by your insurance, for any reason will then become the responsibility of the patient. Please contact your insurance company for details pertaining to your insurances Prior Authorization guidelines. If your insurance denies your authorization for any reason the balance due will be the responsibility of the patient. **An insurance card does not guarantee payment, any changes made to your policy needs to be addressed at your visit.**

MEDICARE, MEDICAID, UPMC for You and UPMC for Life plans do not cover all chiropractic services. Office visit examinations and in office x-rays are not covered.

Auto and Work related charges will be billed to your insurance carrier, if for any reason claims are returned or denied, the balance due will become the patient's responsibility. Life in Motion will not be responsible for any misinformation given on patient's insurance coverage by the insurance companies or patient. **Once Auto/Worker Comp. medical benefit limits have been maxed out the patient will be liable for the balance remaining. Please be aware of your medical payment limits when scheduling your appointments.**

Missed Appointments/Late Cancellations: Cancellations are requested 24 hours prior to the appointment. We reserve the right to charge for missed or late-canceled appointments. Excessive abuse of scheduled appointments may result in discharge from the practice.

No Show Policy: If New Patient and/or Second Visit (ROF) is not cancelled and rescheduled prior to the appointment (No Show), a $30.00 charge will be billed to your account.

I have read and understand the **Life in Motion Chiropractic's** Financial Policy. I agree to assign insurance benefits to Life in Motion Chiropractic whenever necessary. I also agree that if it becomes necessary to forward my account to a collection agency, in addition to the amount owed, I also will be responsible for the fee charged by the collection agency for costs of collections.

Signature of insured/authorized representative: _____ Date: _____

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PATIENT HEALTH INFORMATION CONSENT FORM (HIPAA 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 from 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 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 understands that the practice of neither chiropractic nor medicines is an exact science, and that my care may involve the making of judgments based upon the facts know to the doctor at the time, that it is not reasonable to expect the doctor to anticipate or explain all risks and complications, that an undesirable result does not necessarily indicate an error in judgment, that no one guarantee as to results has been made to nor relied upon by me, and I wish to rely on the doctor to exercise judgment during the course of the procedure which he or she feels at the time, based upon the facts then known, is in my best interest and that there are other risks, including but not limited to fractures, disc injuries, strokes, dislocations and sprains.
5. The patient may provide a written request to revoke consent at any time during care. This would not affect 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.
6. 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.
7. Patients have the right to file a formal complaint with our privacy official about any possible violations of these policies and procedures.
8. 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 given care.

I have read and understand how my Patient Health Information will be used and I agree to these policies and procedures and also give consent for chiropractic care.

Signature of Patient Date

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MEDICAL INFORMATION RELEASE FORM
(HIPAA RELEASE FORM)

Name:_____ DOB: _____/_____/_____

Release of Information:

[ ] 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: _____

[ ] Information is not to be released to anyone.

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

Messages:

Please call: [ ] my home [ ] my work [ ] my cell number:_____
If unable to reach me:

[ ] you may leave a detailed message

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

[ ] _____

The best time to reach me is:
Day:_____ Between (time):_____

Signed:_____ Date: _____/_____/_____

Witness:_____ Date: _____/_____/_____

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INFORMED CONSENT FOR CHIROPRACTIC ADJUSTMENTS AND CARE

To the Patient: *You have a right to be informed about your condition, the recommended chiropractic treatment, and the potential risks involved with the recommended treatment. This information will assist you in making an informed decision whether or not to have the treatment. This information is not meant to scare or alarm you; it is simply an effort to make you better informed.*

I/We hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures on me or on _____, by Dr. Nathaniel A. Reese, Dr. Elizabeth E. Smolick-Reese, or any other licensed Doctors of Chiropractic who may be employed by or engaged in practice at Life in Motion Chiropractic Center.

I have had an opportunity to discuss with Dr. Nathaniel Reese, Dr. Elizabeth Smolick-Reese and other clinic personnel the nature and purpose of chiropractic adjustments and other procedures. I understand that the practice of neither chiropractic nor medicines is an exact science, and that my care may involve the making of judgements based upon the facts known to the doctor at the time, that is not reasonable to expect the doctor to anticipate or explain all risks and complications, that an undesirable result does not necessarily indicate an error in judgement, that no one guarantee as to results has been made nor relied upon by me, and I wish to rely on the Doctor of Chiropractic to exercise judgement during the course of the procedure which he feels at the time, based upon the facts then known, is in my best interest.

I have also been advised that there are other rare risks, 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. I also understand that no guarantees or promises have been made to me concerning the results expected from the treatment.

I have read 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 agree to the named procedures.

_____ _____

Patient's Name Parent/Guardian Signature

_____

Patient's Signature

_____

Witness

_____

Date

Doctor's Notes

Discussion: _____

Other: _____

Oswestry Disability Questionnaire

Patient Name _____ Date _____

This questionnaire will give your provider information about how pain affects your everyday life. Please answer every section by marking the one statement that applies to you.

Pain Intensity

0. ☐I have no pain at the moment.
1. ☐The pain is very mild at the moment.
2. ☐The pain is moderate at the moment.
3. ☐The pain is fairly severe at the moment.
4. ☐The pain is very severe at the moment.
5. ☐The pain is the worst imaginable at the moment.

Personal Care (Washing, Dressing, etc.)

0. ☐I can look after myself normally without causing extra pain.
1. ☐I can look after myself normally, but it causes extra pain.
2. ☐It is painful to look after myself and I am slow and careful.
3. ☐I need some help but manage most of my personal care.
4. ☐I need help every day in most aspects of self-care.
5. ☐I do not get dressed, wash with difficulty and stay in bed.

Lifting

0. ☐I can lift heavy weights without extra pain.
1. ☐I can lift heavy weights, but it gives me extra pain.
2. ☐Pain prevents me from lifting heavy weights off the floor, but I can if they are in convenient places.
3. ☐Pain prevents me from lifting heavy weights, but I can manage light to medium weights.
4. ☐I can only lift very light weights.
5. ☐I cannot lift or carry anything.

Walking

0. ☐Pain does not prevent me walking any distance.
1. ☐Pain prevents me from walking more than one mile.
2. ☐Pain prevents me from walking more than ½ mile.
3. ☐Pain prevents me from walking more than ¼ mile.
4. ☐I can only walk using a cane or crutches.
5. ☐I am in bed most of the time and have to crawl to the toilet.

Sitting

0. ☐I can sit in any chair as long as I like.
1. ☐I can only sit in my favorite chair as long as I like.
2. ☐Pain prevents me sitting more than one hour.
3. ☐Pain prevents me from sitting more than 30 minutes.
4. ☐Pain prevents me from sitting more than 10 minutes.
5. ☐Pain prevents me from sitting at all.

Standing

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

Sleeping

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

Social Life

0. ☐My social life is normal and gives me no extra pain.
1. ☐My social life is normal but increases the degree of pain.
2. ☐Pain has no significant effect on my social life apart from limiting my more energetic interests.
3. ☐Pain has restricted my social life and I do not go out as often.
4. ☐Pain has restricted my socia life to my home.
5. ☐I have no social life because of pain.

Traveling

0. ☐I can travel anywhere without pain.
1. ☐I can travel anywhere but it gives me extra pain.
2. ☐Pain is bad but I manage journeys over 2 hours.
3. ☐Pain restricts me to journeys of less than 1 hour.
4. ☐Pain restricts me to short necessary journeys under 30 minutes.
5. ☐Pain prevents me from traveling except to receive treatment.

Employment/Homemaking

0. ☐My normal homemaking/job activities do not cause pain.
1. ☐My normal homemaking/job activities increase my pain, but I can still perform these tasks.
2. ☐I can perform most of my homemaking/job activities, except for more physically stressful activities.
3. ☐Pain prevents me from doing anything but light duties.
4. ☐Pain prevents me from doing even light duties.
5. ☐Pain prevents me from performing any job or homemaking chores.

Score

Index Score = [sum of statements selected / (# of sections with a statement selected x 5)] x 100

Back Index

ACN Group, Inc. Form BI-100

ACN Group, Inc. Use Only rev 3/27/2003

Patient Name _____ **Date**

This questionnaire will give your provider information about how your back condition affects your everyday life. Please answer every section by marking the one statement that applies to you. If two or more statements in one section apply, please mark the one statement that most closely describes your problem.

Pain Intensity

⓪ The pain comes and goes and is very mild.
① The pain is mild and does not vary much.
② The pain comes and goes and is moderate.
③ The pain is moderate and does not vary much.
④ The pain comes and goes and is very severe.
⑤ The pain is very severe and does not vary much.

Sleeping

⓪ I get no pain in bed.
① I get pain in bed but it does not prevent me from sleeping well.
② Because of pain my normal sleep is reduced by less than 25%.
③ Because of pain my normal sleep is reduced by less than 50%.
④ Because of pain my normal sleep is reduced by less than 75%.
⑤ Pain prevents me from sleeping at all.

Sitting

⓪ I can sit in any chair as long as I like.
① I can only sit in my favorite chair as long as I like.
② Pain prevents me from sitting more than 1 hour.
③ Pain prevents me from sitting more than 1/2 hour.
④ Pain prevents me from sitting more than 10 minutes.
⑤ I avoid sitting because it increases pain immediately.

Standing

⓪ I can stand as long as I want without pain.
① I have some pain while standing but it does not increase with time.
② I cannot stand for longer than 1 hour without increasing pain.
③ I cannot stand for longer than 1/2 hour without increasing pain.
④ I cannot stand for longer than 10 minutes without increasing pain.
⑤ I avoid standing because it increases pain immediately.

Walking

⓪ I have no pain while walking.
① I have some pain while walking but it doesn't increase with distance.
② I cannot walk more than 1 mile without increasing pain
③ I cannot walk more than 1/2 mile without increasing pa n.
④ I cannot walk more than 1/4 mile without increasing pa n.
⑤ I cannot walk at all without increasing pain.

Personal Care

⓪ I do not have to change my way of washing or dressing in order to avoid pain.
① I do not normally change my way of washing or dressing even though it causes some pain.
② Washing and dressing increases the pain but I manage not to change my way of doing it.
③ Washing and dressing increases the pain and I find it necessary to change my way of doing it.
④ Because of the pain I am unable to do some washing and dressing without help.
⑤ Because of the pain I am unable to do any washing and dressing without help.

Lifting

⓪ I can lift heavy weights without extra pain.
① I can lift heavy weights but it causes extra pain.
② Pain prevents me from lifting heavy weights off the floor.
③ Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned (e.g., on a table).
④ Pain prevents me from lifting heavy weights off the floor, but I can manage light to medium weights if they are conveniently positioned.
⑤ I can only lift very light weights.

Traveling

⓪ I get no pain while traveling.
① I get some pain while traveling but none of my usual forms of travel make it worse.
② I get extra pain while traveling but it does not cause me to seek alternate forms of travel.
③ I get extra pain while traveling which causes me to seek alternate forms of travel.
④ Pain restricts all forms of travel except that done while lying down.
⑤ Pain restricts all forms of travel.

Social Life

⓪ My social life is normal and gives me no extra pain.
① My social life is normal but increases the degree of pain.
② Pain has no significant affect on my social life apart from limiting my more energetic interests (e.g., dancing, etc).
③ Pain has restricted my social life and I do not go out very often.
④ Pain has restricted my social life to my home.
⑤ I have hardly any social life because of the pain.

Changing degree of pain

⓪ My pain is rapidly getting better.
① My pain fluctuates but overall is definitely getting better.
② My pain seems to be getting better but improvement is slow.
③ My pain is neither getting better or worse.
④ My pain is gradually worsening.
⑤ My pain is rapidly worsening.

Index Score = [Sum of all statements selected / (# of sections with a statement selected x 5)] x 100

Back Index Score

Neck Index

ACN Group, Inc. Form NI-100

ACN Group, Inc. Use Only rev 3/27/2003

Patient Name _____ **Date**

This questionnaire will give your provider information about how your neck condition affects your everyday life. Please answer every section by marking the one statement that applies to you. If two or more statements in one section apply, please mark the one statement that most closely describes your problem.

Pain Intensity

⓪ I have no pain at the moment.
① The pain is very mild at the moment.
② The pain comes and goes and is moderate.
③ The pain is fairly severe at the moment.
④ The pain is very severe at the moment.
⑤ The pain is the worst imaginable at the moment.

Personal Care

⓪ I can look after myself normally without causing extra pain.
① I can look after myself normally but it causes extra pain.
② It is painful to look after myself and I am slow and careful.
③ I need some help but I manage most of my personal care.
④ I need help every day in most aspects of self care.
⑤ I do not get dressed, I wash with difficulty and stay in bed.

Sleeping

⓪ I have no trouble sleeping.
① My sleep is slightly disturbed (less than 1 hour sleepless).
② My sleep is mildly disturbed (1-2 hours sleepless).
③ My sleep is moderately disturbed (2-3 hours sleepless).
④ My sleep is greatly disturbed (3-5 hours sleepless).
⑤ My sleep is completely disturbed (5-7 hours sleepless).

Lifting

⓪ I can lift heavy weights without extra pain.
① I can lift heavy weights but it causes extra pain.
② Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned (e.g., on a table).
③ Pain prevents me from lifting heavy weights off the floor, but I can manage light to medium weights if they are conveniently positioned.
④ I can only lift very light weights.
⑤ I cannot lift or carry anything at all.

Reading

⓪ I can read as much as I want with no neck pain.
① I can read as much as I want with slight neck pain.
② I can read as much as I want with moderate neck pain.
③ I cannot read as much as I want because of moderate neck pain.
④ I can hardly read at all because of severe neck pain.
⑤ I cannot read at all because of neck pain.

Driving

⓪ I can drive my car without any neck pain.
① I can drive my car as long as I want with slight neck pain.
② I can drive my car as long as I want with moderate neck pain.
③ I cannot drive my car as long as I want because of moderate neck pain.
④ I can hardly drive at all because of severe neck pain.
⑤ I cannot drive my car at all because of neck pain.

Concentration

⓪ I can concentrate fully when I want with no difficulty.
① I can concentrate fully when I want with slight difficulty.
② I have a fair degree of difficulty concentrating when I want.
③ I have a lot of difficulty concentrating when I want.
④ I have a great deal of difficulty concentrating when I want.
⑤ I cannot concentrate at all.

Recreation

⓪ I am able to engage in all my recreation activities without neck pain.
① I am able to engage in all my usual recreation activities with some neck pain.
② I am able to engage in most but not all my usual recreation activities because of neck pain.
③ I am only able to engage in a few of my usual recreation activities because of neck pain.
④ I can hardly do any recreation activities because of neck pain.
⑤ I cannot do any recreation activities at all.

Work

⓪ I can do as much work as I want.
① I can only do my usual work but no more.
② I can only do most of my usual work but no more.
③ I cannot do my usual work.
④ I can hardly do any work at all.
⑤ I cannot do any work at all.

Headaches

⓪ I have no headaches at all.
① I have slight headaches which come infrequently.
② I have moderate headaches which come infrequently.
③ I have moderate headaches which come frequently.
④ I have severe headaches which come frequently.
⑤ I have headaches almost all the time.

Index Score = [Sum of all statements selected / (# of sections with a statement selected x 5)] x 100

Neck Index Score _____