Smith Chiropractic, PSC

Dr. Jeff Smith, D.C. 1104 N. Main St. * Monticello, KY 42633 606-340-0340

For Auto Accident Cases:

Personal injury protection, also known as pip coverage only allows a certain dollar limit to cover medical expenses.

Due to PIP coverage being limited, Smith Chiropractic will require a copy of your current medical insurance card to act as a secondary payor if the PIP coverage is exhausted when we bill for services rendered. You will be responsible for any deductibles, copays or co-insurance that your medical insurance states is due.

If you do not have any active medical insurance, you will be fully responsible for all charges on your account even if your case is in litigation. You may pay with cash or credit card only. Thank you.

Patient Print Name	
Patient Signature	
Date	

CONFIDENTIAL PATIENT INFORMATION

DATE	 E	<i>t</i> -

PLEASE PRINT

PATIENT INFORMATION:			
FULL NAME		DAT	E OF BIRTH// AGE Male □ Female □
ADDRESS			APT# SSN
CITY	STATE	ZIP CODE	HOME PHONE ()
CELL PHONE ()	CELL CAR	RIER	EMAIL
EMPLOYER'S NAME		OCCUPATION_	
WORK ADDRESS		CITY	STATE ZIP
WORK PH. # ()	EXT	DATE	SYMPTOMS BEGAN://
MARITAL STATUS: SINGLE □ N	ARRIED WIDOWE	D HOW DID Y	DU HEAR ABOUT US?
EMERGENCY CONTACT		PHONE	
CLAIM INFORMATION:			
IS YOUR CONDITION DUE TO AM	AUTO ACCIDENT	A PERSONAL IN	JURY A WORK INJURY OTHER
TYPE OF CLAIM: CASH ☐ GF	ROUP HEALTH INS	PERSONAL INJU	JRY □ WORKER'S COMP □ MEDICARE □
I WILL BE PAYING TODAY BY CA	ASH ☐ CHECK ☐	VISA MASTE	RCARD AMEX DISCOVER OTHER
INSURED'S EMPLOYER: SAME AS INSURED'S SSN SAME AS ABOV	S ABOVE	INSUR	ED'S DOB SAME AS ABOVE DRESS
			PHONE#()
			NUMBER
*****************	***********	**********	***********************
SECONDARY INSURANCE CO		AD	DRESS
CITY	STATE	ZIP CODE	PHONE#()
POLICY NUMBER	-Aller	GROUF	NUMBER
party who accepts assignment. B. I authorize payment of any medical by payment to this office of any sum I now or contractually obligated to make payment C. I understand and agree that health ar office will prepare any necessary reports directly to this office will be credited to me	enefit from third-parties for or hereafter owe this office to me or you based upon to do accident policies are an and forms to assist me in a y account upon receipt. He le for payment. I also und	benefits submitted for by my attorney, out of p the charges submitted in arrangement between making collection from owever, I clearly unders erstand that if I suspen-	ind request payment of insurance benefits either to myself or to the my claim to be paid directly to this office. I authorize the direct proceeds of any settlement of my case and by any insurance company for products and services rendered. I understand that this an insurance company and myself. Furthermore, I understand that this the insurance company and that any amount authorized to be paid stand and agree that all services rendered to me are charged directly did not terminate my care and treatment, any fees for products or
Patient's Signature			Data

Date:

Guardian Signature:

VERIFICATION OF INSURANCE BENEFITS

IF GROUP INSURANCE: Is there coverage for Chiroprac	ctic Care? YES NO DATE
Plan Administered by	Is Doctor In Network Out of Network
Pre-Authorization Required? ? YES □ NO □	
IN NETWORK BENEFITS	OUT OF NETWORK BENEFITS
Amount of Deductible:\$/Individual \$/Family	Amount of Deductible:\$/Individual \$/Family
Deductible met? YES 🗆 NO 🗀 \$ Remaining	Deductible met? YES □ NO □ \$ Remaining
Deductible Calendar 🗆 or Fiscal 🗆 Renewal Date//	Deductible Calendar □ or Fiscal □ Renewal Date//
Max. Yearly Benefit ? \$ % Co-pay \$ % Coverage	Max. Yearly Benefit ? \$ Co-pay \$ % Coverage _
Max. Yearly Visit Limit?	Max. Yearly Visit Limit?
Orthotics Coverage (CPT Code: L3030)? YES NO \$	Orthotics Coverage (CPT Code: L3030)? YES 🗆 NO 🗆 \$
Exclusions/Limitations:	Exclusions/Limitations:
Notes:	76
Spoke to Whom?	Mail Claims to:
Direct Telephone:	Address:
IF AUTO ACCIDENT	City State Zip
Who was found at fault / ticketed Patient ☐ Other Driver ☐	1-200 d =
Insured Auto Insurance Carrier	Address
	Code Phone#()
	CLAIM NUMBER
	Coverage Verified?
Does your auto insurance coverage have Medical Payments Cove	
If yes, Auto Insurance Carrier	Address
	Code Phone#()
POLICY NUMBER	CLAIM NUMBER
	Coverage Verified?
ATTORNEY'S NAME IF WORKER'S COMPENSATION:	PHONE#()
Employer's Name	Employer's #()
Employer's Address:	
	en authorized? ? YES NO By whom?
	Address
CityState ZIP Code	
POLICY NUMBER	CPOUR NUMBER

	QUESTI					Pat	ient Name:			
e a No. 2	pencil to mar	k your answ	ers. When	marking in	an Other	MO	DAY YEAR	DR#	PATIE	NT NUMBER
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B. PATIENT'S COMPLAI					
2. How Did Your Complaint(s) Unknown Suddenly 3. What Happened To Cause O Your Complaint(s)?	Gradually Pr Re-Aggravate	7. What Makes Yo Nothing Sneezing Bending Other	our Condition Wors Coughing Lifting Walking	se? — Reaching — Sitting — Straining at S	Stand Pullin tool Turnii
─ Work Accident/Injury	Auto Accident Home Accident Sport Injury	If Yes, Indicate I Neck Shoulder Buttock	Upr Back O Arm O Elbow O	Mid Back - Low I	Back Ribs Hnd/f
How Would You Rate Your C Where 0 Is No Pain And 10 Is No 0 1 2 3 4 5 6 7 8	s The Worst Pain[1]?	OUTSIDE Of T	Any Recent Treatm his Office[1]? If Yes, List Dates, T		
5. When Are Your Symptoms V					
○ Rest ○ Exercise	Better? Heat Ice Medications	Bowel Function Bladder Function		ove You Noticed A	Change In?
C. HEADACHES					
If You Are Experiencing Where is The Pain Associate Over Temporal Over From Parieta	ed With Your Headache	es Located? Over Temporal Over Pariet	6. What Seems Physical A Excessive Alcohol	To Bring On Your activity Caffe Stress Certa	Headaches
	1 1				
		Base Skull	Times/Week: Times/Month Other	o Your Headaches	மைம் Last[1]?
Skull Baw Joint	Behind Eye Over Sinuses	Skull Skull	Times/Week: Times/Month Other 8. How Long D Less Than Longer Th	のできる。 のではあるの o Your Headaches	Last[1]?
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HEALTH QUESTIO Patient's Name	MNAIRE-HISTORT	What Are Your Current Habits? Packs Per Day	
		Smoking	
DEVIEW OF SVOTENS		Glasses Per Day	
REVIEW OF SYSTEMS		Caffeinated DrinksNever 3 13 23 34 55	
Are You Currently Suffering I Listed Below? If This Is A Re-	From Any Of The Symptoms	Glasses Per Day	
Symptoms Since Your Last Ex	am.	Alcohol Consumption Never 1 1-2 2-3 3-4 5+	
None Of The Symptoms	O No New Symptoms Since	Drug/Substance Abuse Yes of Yes, Discuss With Doo	
Listed Below	Your Last Exam	Drug/Substance Abuse If Yes, Discuss With Doo Days Per Week	ctor
		Exercise	
General Fatigue	Skin Rash Skin Ra	Kinds Of Exercise You Do:	
⇒ Weakness	C Redness Of Skin	Walking Jogging Cycling Swimming	9
Fever (continuous)	 Skin Itching 	Golf Tennis Strength Training	
Closs Of Sleep	 Skin Dryness 	Other:	
⇒ Chills (continuous)	 Eczema(red, inflamed skin) 		
 Weight Change (unplanned) 		G. MEDICAL HISTORY	
Night Sweats	 Nail Changes (unplanned) 	1.HEALTH CARE	
⇒ Headaches	Bruise Easily	a. Have You Ever Been To A Chiropractor?Yes	NON
⇒ Dizziness	Cough (chronic)	b. Do You Have A Family Physician Yes	No
⇒ Fainting	Wheezing (chronic)	Date Of Last Physical Exam:	
Convulsions	Olifficulty Breathing	Physician's Name:	
Nervousness	Swollen Extremities	Address:	
Anxiety Anxiety Anxiety Anxiety	○ Blue Extremities	Phone:()_	
Depression (prolonged)	○ Varicosities (visible veins)	c. Have You Been Hospitalized In The Past? Yes	No
Phobias (excessive fears)	Rapid Heart Beat	Date & Reason For Hospitalization:	
Memory Loss Or Impairment			0.
→ Mood Swings (excessive)	Heart Palpitations		355
	O Heart Murmur	d. Have You Ever Had Surgery?	No
Hearing Trouble O O	Decreased Appetite	Date, Reason, Results Of Surgery:	
Ringing in Ears	co Increased Appetite		
Pain in Ears	Abdominal Pain		
Ear Discharge O	Hemorrhoids	e. Have You Ever Had A Serious Accident/Injury?	No
Vision Trouble O	○ Excess Gas	List Date & Describe Injury:	
Pain in Eyes O O Eye Discharge O O	O Vomiting (excessive)	O Auto:	
Eye Discharge O O Nose/Sinus Pain	Diarrhea (excessive)	O Work-Related:	-
Excessive Drainage	Constipation (excessive)	O Personal:	
	○ Heartburn/Indigestion	Sports Injury:	
Nose Bleeds (chronic) Nasal Infections (chronic)	Painful Urination Inability To Hold Lidge	Other:	
Absence Of Smell	Inability To Hold Urine Frequent Urination	f. Are You Currently Taking Any Vitamins,	No
	Orinary Retention	Minerals, Or Herbs? (List Supplements) Yes	No
⇒ Bleeding Gums	Bed-wetting		-
	o Irregular Menstruation	a Ara You Currenth, Tables A. M. I Yas	No
Absence Of Taste	Painful Menstruation	g. Are You Currently Taking Any Medications?	No
	Abnormal Vaginal Bleeding	For What Condition(s) Are You Taking Medication?	
Tonsilitis/Infected Tonsils	Sterility	Anti-inflammatory (Aspirin, Ibuprofen, Motrin, etc.):	
Difficulty With Swallowing	Impotence	○ Pain/Analgesics:	
→ Heat/Cold Intolerance	Clumps In Breast(s)	Anti-Depressants:	
Sugar In Urine	Redness/Itching of Breast	Muscle Relaxants:	
Goiter (enlargedThyroid gland)		Blood Pressure Pills:	
Tremor (shaking)	Discharge from Breast(s)	Antibiotics:	
3/	Breast Pain	Birth Control Pills:	
Other (Please Describe)		Corticosteroid:	
		Other:	
			7
		In The Past Have You Use Any Of The Following? Birth Control Pills Corticosteroid	
		h. Are You Allergic To Any Medications? Yes	No
	8-4	n. Ale Tou Abeluic To Any Medicabons 7	0

1i. WOMEN ONLY:	CONTINUED Yes No	H. OCCUPATIONAL INFORMATION - ACTIVITIES OF DAILY LIVING
To Your Knowledge, Are	You Pregnant?	1. Are You Right Or Left Handed? Right Left
If Pregnant In Past, Were I		The roating it of Lett Handed? Origin OLER
Are You Seeing An OB-GY		2. Job Type
Number Of Births: @@@		Retired Unemployed Full-Time Studer
Date Of Last Exam:		If Any Of Above Skip Rest, Sign At Patient's Signature
Physician's Name:		Full Time Part Time Temporary
Address:		Self-Employed Other
	Phone:()	
2. FAMILY HISTORY		3. During Your Work Week, You Work How Many:
	Amilia Sala Sala Sala Sala Sala Sala Sala	Hours Per Day @@@@@@@@@@@@@@@ Days Per Week @@@@@@@@@@ Other
Cancer Diabeles High Blood Pess Arthernia Sesse		How Long Have You Been With Your Present Employer
A STORE OF THE STO		4. How Long have fou been with four Flesent Employe
0,02522642	204386000000	Years of on on on on
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rothers color ab ab ab ab ab ab ab ab		Months တက္တာလာတာတာတာတာတာတာတာ
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isters cocoopado aparto		5. Do Your Present Complaints Affect The Number
hildren co co do do do do co co co	Rand (1) (1) (1) (1) (1) (1) (1) (1) (1) (1)	Of Hours You Work Per Day? Yes No
escribe Others:		6 What is Your Brimes, West 7
		6. What is Your Primary Work Position and Location?
Conditions Or Illness	20	a. Work Position: b. Work Location:
	Have or Have Had In The Past	Seated Standing Desk Counter Workbench
Any Of The Following Illne	esses:	Other Other
No Current Or Previous		7. What Movements Does Your Job Require?
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[30] - [4]	© © Urinary Retention © © Frequent Urination	8. Does Your Work Include Any Of The Following Use?
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HEALTH STATUS QUESTIONNAIRE	Patient Name:	post l			
	MO DAY YEAR	DR# PATIENT NUMBER			
Please Read: This survey asks for your views about your the information will help your health care provider track how you and how well you are able to do your usual activities.	nealth. යන න ජ ou feel යාව යනය				
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Answer every question by filling in the appropriate bubble. If you	ou are ලාලා ලාලා	220000000000000000000000000000000000000			
unsure about how to answer a question, please give the best a you can and make a comment at the end of the questionnaire.	nswer യയ തയായ	@@@@@@@@@@@@@@@			
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	9 0 30				
In general, would you say your health is:	B. Compared to one ye	ear ago, how would you rate your			
[MARK ONLY ONE ANSWER]	health in general nov	V? [MARK ONLY ONE ANSWER]			
⊕ Excellent	Much better now	than one year ago			
	Somewhat better	now than one year ago			
⊕ Good		TO THE RESIDENCE OF THE PARTY O			
co Fair	Somewhat worse	now than one year ago			
⊕ Poor	D Much worse now				
The following items are about activities you might do dur					
[MARK ONLY ONE ANSWER ON EACH LINE] 1. Vigorous activities, such as running. lifting heavy objects, 2. Moderate activities, such as moving a table, pushing a va 3. Lifting or carrying groceries 4. Climbing several flights of stairs 5. Climbing one flight of stairs 6. Bending, kneeling, or stooping 7. Walking more than a mile 8. Walking several blocks 9. Walking one block 10. Bathing or dressing yourself During the past four weeks, have you had any of the follo daily activities as a result of your physical health? [MARK EITHER YES OR NO ON EACH LINE]	cuum cleaner, bowling, or pl	aying golf (x)			
Cut down the amount of time you spent on work or other Accomplished less than you would like	activities	es No Id OD Id OD			
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G.	How much bodily pair [MARK ONLY ONE AN	n have you had during ISWER1	the past four weeks?		49/25-00-000 VE 2.20
	⊲ None	⇒ Mild	⊕ Severe		
_	⇒ Very mild	⊲o Moderate	₃ Very severe		
H.	During the past four w both work outside the [MARK ONLY ONE AN D Not at all A little bit	nome and housework?	in interfere with your no ?) 35 Extremely	ormal work (including	
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	How much of the time [MARK ONLY ONE AN 1. Did you feel full of p 2. Have you been a ve 3. Have you felt so dow 4. Have you felt calm 5. Did you have a lot o 6. Have you feel worn o 8. Have you been a ha 9. Did you feel tired?	SWER ON EACH LINE bep? ery nervous person? wn in the dumps that no and peaceful? of energy? hearled and blue? ut?	weeks	(D) (D) (1)	
J.	During the past four with your social activit [MARK ONLY ONE AN All of the time Most of the time	ies (like visiting with if	e time has your physicationds, relatives, etc.)? © None of the time	ai health or emotiona	l problems interfered
K.	[MARK ONLY ONE AN: 1. I seem to get sick a 2. I am as healthy as a 3. I expect my health to 4. My health is excelle	SWER ON EACH LINE little easier than other p inybody I know. o get worse.	1	θ θ θ θ θ θ θ θ θ θ θ θ θ θ θ θ θ θ θ	© 30 ™ ©
L.	Please answer YES or	NO			
	[MARK ONLY ONE AN	SWER ON EACH LINE]		Yes No
	1. In the past year, have	e you had two weeks or	more during which you fo sthat you usually cared at	elt sad, blue, or depres	
	Have you had two ye felt okay sometimes.	ears or more in your life	when you felt depressed	or sad most days, eve	
	3. Have you felt depres	ssed or sad much of the	e time in the past year?		a a
0	Additional Comments:				
	SIGNATURE:	5 1111 1	1202	2000	- 11-11-11-11-11-11-11-11-11-11-11-11-11
	CONTRACTOR AND ADDRESS OF THE PARTY.				DATE:

NECK PAIN DISABILITY INDEX QUESTIONNAIRE

Please Read: This questionnaire is designed to enable us to understand how much your neck pain has affected your ability to manage your everyday activities.

Please answer each section by darkening the one bubble that most applies to you. We realize that you may feel that more than one statement may relate to you, but please, just pencil in the one choice which closely describes your problem now.

Please use a No. 2 pencil to fill in your answer. Fill in bubbles completely as indicated here: Erase changes cleanly. Do not fold this form.

	ent Name: DAY YEAR	DR#	PATIENT NUMBER
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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.

2. PERSONAL CARE

- 3) 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.
- D I do not get dressed, I wash with difficulty and stay in bed.

3. LIFTING

- I can lift heavy weights, without extra pain.
- 1 can lift heavy weights, but it gives extra pain.
- Pain prevents me from lifting heavy weights off the floor, but I can if they are conveniently positioned, for example, on a table.
- Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
- D I can lift very light weights.
- D I cannot lift or carry anything at all.

4. READING

- I can read as much as I want to with no pain in my neck.
- on 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.
- D I cannot read as much as I want because of severe pain in my neck.
- I cannot read at all.

5. HEADACHES

- I have no headaches at all.
- or I have slight headaches which come infrequently.
- T have moderate headaches which come infrequently.
- I have moderate headaches which come frequently.
- Thave severe headaches which come frequently.
- @ I have headaches almost all the time.

After Version & Mior, 1997

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SIGNATURE:

DATE:

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6. CONCENTRATION

- a I can concentrate fully when I want to with no difficulty.
- D I can concentrate fully when I want to with slight difficulty.
- Thave a fair degree of difficulty in concentrating when I want to.
- I have a lot of difficulty in concentrating when I want to.
- D I have a great deal of difficulty in concentrating when I want to.
- and i have a great dear of difficulty in concentrating when I want to
- I cannot concentrate at all.

7. WORK

- I can do as much work as I want to.
- do I can only do my usual work, but no more.
- to I can do most of my usual work, but no more.
- or I cannot do my usual work.
- to I can hardly do any work at all.
- 1 cannot do any work at all.

8. DRIVING

- I can drive my car without any neck pain.
- 20 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.

9. SLEEPING

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

10. RECREATION

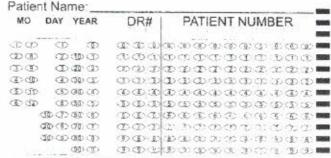
- 1 am able to engage in all of my recreational activities, with no neck pain at all.
- T am able to engage in all of my recreational activities, with some pain in my neck.
- 1 am able to engage in most, but not all of my usual recreational activities because of pain in my neck.
- I am able to engage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

REVISED OSWESTRY LOW BACK PAIN DISABILITY QUESTIONNAIRE

Please Read: This guestionnaire is designed to enable us to understand how much your low back pain has affected your ability to manage your everyday activities.

Please answer each section by darkening the one bubble that most applies to you. We realize that you may feel that more than one statement may relate to you, but please, just pencil in the one choice which most closely describes your problem right now.

Please use a No. 2 pencil to fill in your answers. Fill in bubbles completely as indicated here: Erase changes cleanly. Do not fold this form.



From: N.Hudson, K. Tome-Nicholson, A Breen; 1989 Revised 09/11/92

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.

2. PERSONAL CARE

- at I would not have to change my way of washing or dressing in order to avoid pain.
- 1 do not normally change my way of washing or dressing even though it causes some pain.
- Washing and dressing increases the pain, but I manage not to change my way of doing it.
- washing and dressing increases 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 or dressing without help.

3. LIFTING

- I can lift heavy weights without extra pain.
- I can lift heavy weights, but it causes extra pain.
- Pain prevents me from lifting heavy weights off the floor.
- Department Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned, e.g., on a table.
- E Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
- I can only lift very light weights, at the most.

4. WALKING

- Pain does not prevent me from walking any distance.
- do 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 1/4 mile.
- D I can only walk while using a cane or on crutches.
- D I am in bed most of the time and have to crawl to the toilet.

5. SITTING

- D I can sit in any chair as long as I like without pain
- @ I can only sit in my favorite chair as long as I like.
- Pain prevents me from sitting more than one hour.
- De Pain prevents me from sitting more than 1/2 hour.
- Department Pain prevents me from sitting more than ten minutes.
- Pain prevents me from sitting at all.

6. STANDING

- I can stand as long as I want without pain.
- g I have some pain while standing, but it does not increase with time.
- I cannot stand for longer than one hour without increasing pain.
- I cannot stand for longer than 1/2 hour without increasing pain.
- a: I cannot stand for longer than ten minutes without increasing pain.
- I avoid standing, because it increases the pain straight away.

7. SLEEPING

- a I get no pain in bed.
- on I get pain in bed, but it does not prevent me from sleeping well.
- 2. Because of pain, my normal night's sleep is reduced by less than one-quarter.
- g. Because of pain, my normal night's sleep is reduced by less than one-half.
- Because of pain, my normal night's sleep is reduced by less than three-quarters.
- Pain prevents me from sleeping at all.

8. SOCIAL LIFE

- My social life is normal and gives me no pain.
- (B) My social life is normal, but increases the degree of my pain.
- @ Pain has no significant effect on my social life apart from limiting my more energetic interests, e.g., dancing, etc.
- g: Pain has restricted my social life and I do not go out very often.
- Pain has restricted my social life to my home.
- thave hardly any social life because of the pain.

- I get no pain while traveling.
- (B.) get some pain while traveling, but none of my usual forms of travel make it any worse.
- as I get extra pain while traveling, but it does not compel me to seek alternative forms of travel.
- t get extra pain while traveling which compels me to seek alternative forms of travel.
- Pain restricts all forms of travel.
- Pain prevents all forms of travel except that done lying down.

10. CHANGING DEGREE OF PAIN

- (x) My pain is rapidly getting better.
- My pain fluctuates, but overall is definitely getting better.
- My pain seems to be getting better, but improvement is slow at present.
- My pain is neither getting better nor worse.
- My pain is gradually worsening.
- My pain is rapidly worsening.

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SIGNATURE:

DATE:

ROLAND-MORRIS ACUTE LOW BACK PAIN DISABILITY QUESTIONNAIRE

Please Read: When your back hurts, you may find it difficult to do some of the things you normally do.

This list contains some sentences that people have used to describe themselves when they have back pain. When you read them you may find that some stand out because they describe you today.

As you read the list, think of yourself today. Mark the bubble next to any sentence that describes you today. If the sentence does not describe you, then leave the bubble blank and go on to the next one.

Remember, only mark the sentence if you are sure that it describes you today.

Please use a No. 2 pencil to fill in your answers.
Fill in bubbles completely as indicated here:
Erase changes cleanly. Do not fold this form.

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I stay at home most of the time because of my back.	My back is painful almost all the time.
© I change position frequently to try and get my back comfortable.	I find it difficult to turn over in bed because of my back.
③ I walk more slowly than usual because of my back.	My appetite is not very good because of my back.
Because of my back I am not doing any of the jobs that I usually do around the house.	I have trouble putting on my socks (or stockings because of the pain in my back.
⇒ Because of my back, I use a handrail to get upstairs.	⊕ I only walk short distances because of my back pain.
© Because of my back, I lie down to rest more often.	□ I sleep less well because of my back.
☼ Because of my back, I have to hold on to something to get out of any easy chair.	Because of my back pain, I get dressed with help from someone else.
Because of my back, I try to get other people to do things for me.	I sit down for most of the day because of my back.
I get dressed more slowly than usual because of my back.	ap I avoid heavy jobs around the house because of my back.
only stand up for short periods of time because of my back.	Because of my back pain, I am more irritable and bad tempered with people than usual.
⊕ Because of my back, I try not to bend or kneel down.	⇒ Because of my back, I go upstairs more slowly than usual.
্রহ I find it difficult to get out of a chair because of my	② I stay in bed most of the time because of my back.

SIGNATURE:

DATE:_

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Appendix 1: Disability Questionnaire from "A Study of the Natural History of a Reliable and Schoitive Measure of Disability in Low Back Pain." Spine 1983, 8(2): 141-4

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Dear Patient:	w upu to describe	fomable	Patient No MO DAY Y		PATIENT NUMBER
complete it carefully as the	w you to describe your au e information provided will	tomobile accident in de assist the doctor in eva	tall, Please	actino de de de de de de	ന്ധതനാനാനത
documenting your condition	n. THANK YOU.		OD 30 OD 3		ം കൈയയയായാന സനനനനന
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		: am / pm	Head	erations (cuts), when	27.7
DESCRIPTION	OF ACCIDENT / I	NJURY	○ Head ○ Neck	Shoulders	⊕ Buttocks
	stionnaire Marked (Skip \$		Upper / Mid Back	SECUL Arms	OF I Hips
─ Workmen's Compensa	tion Accident / Injury		C Lower Back	oro ⊲o Elbows oro ⇔ Forearms	○ ○ Thighs
⇒ Slip/Fall Accident	Pedestrian Accident.		⇒ Pelvis	30 CD Wrists	© CD Knees
Other: Accident	○ Injury		Chest / Rib Cage	TO TO Hands	æ oo Legs oo Ankles
What was the			Abdomen	110100	OR OF Feet
. while was the cal	se of your accident	/ injury?	○ Other _	15	The Carl Coll
			5. Describe any oth	er significant injury	
		8	0		
			C E	****	AAAA
			6. Emergency Care	At Accident/Injury S	iite
. Describe in your	own words what hap	ppened:	a. Did you receive	e emergency care?	○ Yes ○ No
0			b. What type of e	mergency care did y	rou roosius?
	ELECTRIC HAN	7787		Splints Brace	○ Neck Collar
			Other	Sprints Drace	C Neck Collar
			100 THE TOTAL MINES 200		
			7. Destination After	Accident / Injury	
	100000		a. Where did you	go? b. By whom	were you driven?
7		-		Home Myself	Ambulance
				Work _ Friend	Family Member
			Other	C Other	25.05
			D. HOSPITAL VISIT	AFTER ACCIDE	NT/IN ILIDY
MUES ASSESSED			1. When did you go	to the hospital?	TARRETT TO THE PARTY OF THE PAR
	FTER ACCIDEN	T/INJURY		Later That Day Next	Day . D
Did you lose cons	clousness?		○ Date	Other	
○ Yes ○	No O Dan't Kno	OW.		Otrici	
How did you for to			C Hospital Name:	С Ехап	nined By Doctor:
How did you feel?				0.7570.0276	2 17 2 1 2 1 2 1 2 1 2 1 2 1 2 1 2 1 2 1
[2] . 마위 경상 (2) 20 20	Dazed Dizzy	○ Nervous	We are the time		
_ weak	Other		Admitted: Yes	No Date Discharge	d:
Where did you imr	nediately develop p	ain?	2 16	5 N 315 V	
○ Head	Shoulders	amr ⊕⇔Buttocks	2. If x-rays were take		t(s)?
○ Neck	OD CD Arms	© ⊕ Hips	☐ Head ☐ Neck	ac _c Shoulders	ು ⇔ Buttocks
OUpper / Mid Back	@ © Elbows	Thighs	Upper / Mid Back	CRO CLO Arms	∋c ⇔ Hips
C Lower Back	® ⊕ Forearms	⊚ © Knees	C Lower Back	For Elbows	official Thighs
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Other			○ Other		ALCE PEBI
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	SIT AFTER ACCID was performed, of wh		k. Elbows	ು ⇔ Sprain	⊚ ⇔ Dislocat
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O Neck	C Lower Back	Abdomen	® © Other		
Other			l. Forearms		
If a MDI was n	erformed, of what boo	ty nart/e\2	® © Strain	office County	ero ero Dielesent
네는 것 내용하다. 그런 보다 그리고 하다.	Upper / Mid Back			O® ○ Sprain	® Dislocati
○ Head ○ Neck	O Lower Back	○ Chest / Rib Cage ○ Abdomen	⊕ ⊕ Fracture	೨೦೦ ℃ Lacerations	® ⊕ Contusio
Other	C Lower Back	C Abdomen	(E) (C) Other	The second second	
Ouner			m. Wrists		
What was the	diagnosis given at the	hospital?	® Strain	die een Guanie	D
a. Head	diagnosis given at the	Hospital:	® © Fracture		® © Dislocat
Concussion	Skull Fracture	○ Lacerations	© © Other		® ⊕ Contusion
○ Contusions	Other	Lacerations	CD CD Other		
Contusions	O Other		n. Hands / Fingers		
b. Jaw			® © Strain		on on Distance
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c. Neck			o. Buttocks		05:00 Table 1
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CO Other			00 00 Fracture	© ℂ Sprain ℂ ℂ Lacerations	
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○ Contusions		Coldidations	oto ⊕ Strain	oto oc Sprain	⊕ ⊕ Dislocat
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g. Chest / Rib	Cage		Of O Other	S EUROS BURGIS	T T COMOS
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j. Arms	final and the second second				Dislocation
00 00 Strain	® ℂ Sprain	⊴p ⊕ Dislocation	○ Fracture	 Lacerations 	○ Contusions
ORD OLD Fracture	8.4	© © Confusions	w. Describe any a	dditional diagnosi	s given:
The state of the s	- Laceradoris	CE SE CONTUSIONS			- 5
® © Other			. 0		

D. HOSFIIAL	- VISIT AF	No. 15.	NI/INJURY	i. Shoulders
What treatme	int was adm	inistered at the	hospital?	D D Pain D D Stiffness D D Numbness R: ⊥ Tinglir
Oral Medicati	on S	utures Sp	fint Collar	Ø ⊕ Other
Injection	○ lo	e Packs 🗆 Ca	st Support	W14400000000000000000000000000000000000
Topical Antise	ptics — H	ot Packs Sra	ace Surgery	j. Arms
Bandages	= 0		100 14 00 00 1 0 00 1	OD ← Pain ← CD ← Stiffness ← CD ← Numbress ← CD ← Tinglin
				® © Other
7. Instructions	Given When	Discharged Fro	m Hospital	
a. Were you t			And the first of the control of the	k. Elbows
General P	ractitioner C	Chiropractor	Neurologist	GOCC Pain GOC Stiffness GOC Numbress GOC Tinglin
	herapist :		○Internist	OF CD Other
General S		Plastic Surgeon		
Other	경영주장 교육하는 그 없었다			I. Forearms
				00 © Pain 00 © Stiffness 00 © Numbness 00 € Tinglin
b. What recor	mmendation	ns were made?		© CO Other
O No Further		o Follow-up Instruction	ns Observation	37 37 07 07 07 07 07 07 07 07 07 07 07 07 07
Rest	Olce OHe		Support	m. Wrists
□ Time Off V				© © Pain © © Stiffness © © Numbness © Lat Tinglin
*** TV *** 12 (70 L)				Go CO Other
c. Were medi	cations pres	scribed?		(8) D One
		ry Antibiotic	C Nervousness	n. Hands / Fingers
Other		,	1101100011000	
				© C Pain © C Stiffness © Numbness © ⊤ Tingtin
FOLLOWING	THE AC	CIDENT / INJU	JRY	SS 3.7 Other
		tional symptoms		o. Buttocks
co immediately		That Evening		State Pain OR of Stiffness Store Numbness Store Tinglin
C Days		C Month		OC Other
0.				S. C. Sulei
. What addition	nal symptom	ns developed?		p. Hips
a. Head				
Pain	⇔ Stiffness	∴ Numbness	s C Tingling	③D ← Pain → D ← Stiffness → Numbness → Tinglin → D ← D Other
Other				30.32 0010
				q. Thighs
b. Jaw				© © Pain © © Stiffness © ∴ Numbness № . Tinglin
C Pain	Stiffness	○ Numbness	s Tingling	op ⊕ Other
Other		97	3-9	
				r. Knees
c. Neck				© © Pain © © Stiffness © © Numbness ∞ Tingling
Pain	⇒ Stiffness	Numbness	S Tingling	® © Other
Other			3.18	and the state of t
		315165		s. Legs
d. Upper / Mid	Idle Back		0	
	Stiffness	Numbness	S □ Tingling	
C Other				No Maria
				t. Ankles
e. Lower Back	4			
○ Pain	Stiffness	Numbness	Tingling	do CD Pain do CD Stiffness as ⊤ Numbness as ⊤ Tingling do CD Other
Other		12 at 125	2	NAME OF STREET
				u. Feet / Toes
f. Pelvis				
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Other	0.0000000000000000000000000000000000000		5.5.1.0.3811.9	The Mar Willer
				v. Other
g. Chest / Rib	Cage		870	
< ⊃ Pain	Stiffness	Numbness		3 Since your accident / injury have your author 14
Other		- 11011011633	- inging	3. Since your accident / injury have you suffered from? Blurred Vision Chest Pain Nausea
		59	122	
h. Abdomen				Double Vision
○ Pain	C Stiffness	(=) Mumbinger	⊝ Tingling	Reduced Vision Palpitations Frequent Urination
	Semiless	reumbness	Ingling	○ Impaired Hearing
Other				Ringing In Ears Diarrhea Painful Urination

4. Additionally has	ve you experienced	NJURY (Continued) any of the following?	The state of the s		
Anxiety	Convulsions	Restlessness	Diagnosis And Treatment Recommendation:		
Depression	Dizziness	○ Insomnia			
Mood Swings		ERLER DE CONTRA			
○ Nervousness					1000
Poor Memory	사건하다 하게 취임하다	V6 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1			
□ Tension □			DI D		
Other		○ Weight Gain ○ Weight Loss	g. Plastic Surgeon Name: Diagnosis And Treatment Recommendation:		
Are you restrict result of this ac	ed in any of the follo	owing areas as a			
Daily Living Other	Occupational/Work	C Recreational Activities			
			h Psychologist		
6. Have you misse	ed work due to this a	accident / injury?	Oingpools And Treatment D		
Missed No Work			C Diagnosis And Treatment Recommendation:		-
Missed Work From	m:1	그렇다			-
Other					43
Did you self trea	at your symptoms?				
Oloe OHeat	○ Bed Rest ○ Ov	er-The-Counter Medication	i. Other OName:	ЭТуре:	
O Other			Diagnosis And Treatment C		
. Did you seek me	edical care elsewher	re?	C Diagnosis And Treatment Recommendation;		
a. General Pract	titioner Name:				
		ion:			
N 4-10-1-17.					-
	Awings Headaches Light Sensitivity Raduced Appetite Raduced Ra	9 Have you had any of the following to the			
				20028676	
Value I beautiful Control				ludies	
b. Internist	○ Name:		C) Otto		
Diagnosis And	Treatment Recommendati	ion:	10. What is the reason for sanking to doub.		
The Langue Services			Persisting Complaints	nsuitai	tion
				Moms	
Tel Comment			F. INSURANCE / ATTORNEY INFORMAT	ION	N. A.
a China		N. C.	1. Have you contacted an insurance adjuster		No
		2004) F-A/1/06	or representative regarding this claim?	(Y)	UND.
Diagnosis And	Treatment Recommendati	on:	Company:	340	-82
	1040				
		- 19			
	-		Claim #:		
20.0	14 - 15 - 15 - 15 - 15 - 15 - 15 - 15 -				
4 No. 1			2. Have you engaged services of an attorney?	· (V)	OD.
d. Neurologist			Attorney:	1	-
O Diagnosis And	Treatment Recommendation	on:	Address	ř	
				1	
			City:State:Zip:		
				II.	
o Orthonodist			3. Have you filed an accident / injury report?	(Y)	ON.
e. Orthopedist				179.74	15000
Diagnosis And '	Treatment Recommendation	on.	4. Have you filed for insurance benefits?	90	080
	.00		1000 190		market and a second
		1980-	6 11 11 4 4 4 1		
			Patient's Or Guardian Signature: Date:		

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Dear Patient:			111		ent Name:	DR# I	DATICAC	T N R IA ADED
This questionnaire will allow you to de	scribe your automobile	e accident in detail	Please		The second second	LAC#	PAREN	NUMBER
complete it carefully as the information documenting your condition. THANK	n provided will assist th	ne doctor in evalua	iting and	DO	35 Ja	I DO		DOOOO
Jan Saladan Tilland				Zs.	02:00 T			DODOO
				3000	(I) M (I)			മതതതത
Jse a No. 2 pencil to mark yo	our answers. Whe	en marking in a	n Other	@ (10)	ഭായത			popopo
Juddie please explain in the spa	ace allowed Fill in	hubbles come	letely as	00 db	D 40 C			DOOOQ
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					000 000 CD			രാധാധായായ
VIEW CONTRACTOR					OD State			, , , , , , , , , , , , , ,
VEHICLE YOU WERE I		4	j.		(9D) (D)			നെ നേനാനാന നേനാനാനാനാന
Vehicle type?	2. Vehicle size		d W	2 3	age did th			
- Car Pickup	Subcompact	○ Full-Size	C	Minimal	○ Mode		Extensive	○ Totaled
Van Truck	Compact	○ Mini	<	Unsure	Other			C TOTAL CO
Station Wagon Bus	∴ Mid-Size	C Light						
C Other	○ Other		2. Seco	nd Vehi	cle To Stri	ke Vehicl	e You Were	e In
What was your location in	45		a. Ve	hicle ty	pe?		ehicle size	
What was your location in			4,35	Car	C Pic	skup c	Subcompac	t CFull-Sig
Driver Front P Passenger Location: C Left		ar Passenger		Van	○ Tr		Compact .	○ Mini.
Other	○ Middle ○ Rig	gni			fagon C. Bu	s = <	Mid-Size	C Light
. What was the vehicle you	were in doing?	-	- 0	Other		5	Other	
Mark only ONE bubble bel	ow to answer this	squestion	c Ho	ur did t	ale collected			
a. Vehicle stopped for		- daconon		Head On	us venicie	strike the	e vehicle y	ou were in?
Traffic Light Intersec	ction Stop Sign	○ Traffic			ed On Right			Rear Ended
Pedastrian Parked				Other		9	ideswiped On	Len
Other		Ī			75-7			11-305-441
			d. W	at dam	age did thi	is vehicle	sustain?	
b. Vehicle slowing down for				Minimal	○ Moder		- Table 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1	○ Totaled
Traffic Light Intersec		□ Traffic		Unsure	○ Other			- rouncu
Pedestrian Turning	○ Parking							
☐ Other			3. Desci	ribe Oth	er Vehicle	s To Strik	e Vehicle '	You Were in
c. Vehicle moving			○ Vel	nicle Type:			ow it struck:	1551
Slowly Moderat	tely ⊃ Fast	1	○ Vei	sicle Size:		$\supset D$	amage:	
MPH Accelera			A Milana					
Other	33.754		4. Were	traffic c	itations is	sued as a		he accident
				Citations i		u-s		Other Vehicle
d. Vehicle doing other		1	CUM	er Or ven	icle You Were	เก	<> You	O Unsure
Other			C. COND	ITION	S AT TIM	E OF A	CCIDENT	
	98)	1			day did the			
What damage did the vehic	le you were in su	istain?	<⊃ Day		⇒Dawn	C Du		B.E. color
C Minimal Moderate	⇒ Extensive ⇒		O Oth	2.50			ibh C	Night
Unsure Cher	SEIL IS			13.5.3				
FOTHER VEHICLES IN	WOLVED WAY	NOVE VI	2. What	was the	condition	of the ro	ad?	
		CCIDENT	○ Dry		<>Damp	√ We		Snow Covered
First Vehicle To Strike Vehicle type?			⊃lcy		C Other			
	b. Vehicle size?	CONTRACTOR CO. C. C.	120-240704-17					
r nemap	 Subcompact 	○ Full-Size	3. Visibil		220000000			
Van Truck Station Wagon Bus	Compact	C⇒ f\times			he visibilit	y at impa	ct?	
Other		Ca Light		3ood	⇒ Fair	<⊃ Po	or	
	C Other		0.0	Other		-	- 2004	
c. How did this vehicle strik	ce the vehicle ve	i woro in?	6 15	-14-14-4		1-1-4-12-1-12-12-12-12-12-12-12-12-12-12-12-1	232	Self-Regree
Head On From Right	From Left OF	a were in r			was poor,			
Sideswiped On Right	Sideswiped On Le			Sun Light	C Darknes	ss \bigcirc Ra	in O	Snow
	~ Selverwibed Ou Pt	=(O F	0.00	C>Traffic			
Cther			00					

	AT MOMENT OF IMPACT	b. Right Upper Ext	tremity (Arm)	
1.	Were you prepared for the accident?	Steering Wheel	Dashboard	Windshleid Windshleid
	Accident A Complete Surprise	Right Side Door	C Left Side Door	⇒ Armrest
	Awars Of Impending Collision And Braced For Impact	Right Window	C Left Window	⇒ Headrest
107		○ Ceiling	Console	Shift Lever
	Foot On Brake Pedal	C Front Seat	Rear View Mirror	2.0000000000000000000000000000000000000
	a. Was your foot on brake pedal at impact ? Yes	No Other		-
	b. Was it knocked off pedal by impact? Yes	No c. Left Upper Extre	emity (Arm)	
		Steering Wheel	C Dashboard	Windshield
3.	Use Of Restraints	Right Side Door	: Left Side Door	Antirest
	a. Restraint Belts	C Right Window	Left Window	- Headrest
	1. Were you wearing a restraint belt? Syes S		Console	Shift Lever
		Front Seat	Rear View Mirror	's plant revel
	2. What type of restraint belt were you wearing?	< ○ Other	and the state of t	53
	Shoulder-Lap Belt			
		d. Torso		
	b. Headrests	Steering Wheel	Dashboard	Windshield
	 Was vehicle equipped with headrests? Yes 	No Right Side Door	Left Side Door	
		C Right Window	C Left Window	C: Armrest
	2. What position was the headrest in?	○ Ceiling	Console	
	○ Low	○ Front Seat	Rear View Mirror	Shift Lever
		Other	C) Rear view mirror	
	c. Air Bags	Cooler		
	1. Was vehicle equipped with air bags?	e. Right Lower Ext	remity (Lea)	
		Steering Wheel	Dashboard	on Manager
		C Right Side Door	C Left Side Door	 Windshield
	2. Did the air bags deploy?	[10] [10] [10] [10] [10] [10] [10] [10]		Armrest
		□ Geiling	C Left Window Console	Headrest
4.	Your Body	○ Front Seat		C. Shift Lever
	a. What was your body position at impact?	Other	Rear View Mirror	
	Straight Slouched Forward Rotated: Right Left	C 501161		
	Don't Recall _ Other	f. Left Lower Extre	mity (Log)	
	- 100	Steering Wheel	Dashboard	ELL VEHICLE
	b. What direction was your body thrown?	Right Side Door	C Left Side Door	Windshield
		C Right Window	Left Window	Armrest
	· Across Vehicle Outside Vehicle Under Vehicle		○ Console	Headrest
	○ Don't Recall ○ Other	C Front Seat	Rear View Mirror	Shift Lever
		<> Other	Co rees view being	
5. 1	Your Head And Neck			
- 2	a. What position were your head/neck in at impact?	2. Did your body strik	a any other chica	in 2
	Straight	Description Of Other C	bions Your Dad the	is r
	□ Don't Recall ○ Other	C Sesampaon of Other C	rojecis rour body mit	
1	 Through what motion were your head/neck pitched 	2		
	Forward\Backward	-		
	Don't Recall Other			
	ESTUT OF MERION	F. ADDITIONAL INFO	DRMATION	
	ESULT OF IMPACT	 Additional Information Abo 	out Your Automobile Acc	ident
	Which objects in the vehicle did the force of the collision cause your body to strike?	ACT SOLINAS ACT		
		110		
8	a. Head			
	Steering Wheel			
	Right Side Door Left Side Door Armrest			
	Right Window Deft Window Headrest			
	- and transfer Citedatest			
	Ceiling Console Shift Lever			
	- Alle			
	○ Ceiling ○ Console ○ Shift Lever			
152	Ceiling Console Shift Lever Front Seat Rear View Mirror	Patient's Or Guardian	Signature ²	Date: