

CONFIDENTIAL PATIENT CASE HISTORY

Please complete this questionnaire. This confidential history will be part of your permanent records.

Today's Date / / Signature of Patient _____
Signature of Parent/Spouse/Guardian _____

Patient Title: (check one) Mr. Mrs. Ms. Miss Dr. Prof. Rev.

First Name _____ Nick Name _____

Last Name _____ Middle Name _____ Suffix _____

Address 1 _____

Address 2 _____

City _____ State _____ Zip Code _____

Primary Phone _____ Secondary Phone _____

Mobile Phone _____

Home Email _____ Work Email _____

Which email address would you like us to use to communicate with you? (Check one)

Home Work

Contact Method (Check one)

Primary Phone Secondary Phone Mobile Phone Home Email Work Email

Date of Birth / / Age _____ Gender (Check one) Male Female Unspecified

Marital Status (Check one) Single Married Other SSN _____

Employment Status (Check one)

Employed FT Student PT Student Other Retired Self Employed

Race (Check one)

- | | | | |
|-----------------------------------|---|--------------------------------------|--|
| <input type="checkbox"/> White | <input type="checkbox"/> Black/African American | <input type="checkbox"/> Hispanic | <input type="checkbox"/> American Indian/Alaskan Native |
| <input type="checkbox"/> Asian | <input type="checkbox"/> Asian Indian | <input type="checkbox"/> Chinese | <input type="checkbox"/> Filipino |
| <input type="checkbox"/> Japanese | <input type="checkbox"/> Korean | <input type="checkbox"/> Vietnamese | <input type="checkbox"/> Native Hawaiian or other Pacific Island |
| <input type="checkbox"/> Samoan | <input type="checkbox"/> Guamanian or Chamorro | <input type="checkbox"/> Other _____ | <input type="checkbox"/> I choose not to specify |

Multi-Racial (Check one) Yes No Unknown

Ethnicity (Check one) Hispanic or Latino Not Hispanic or Latino I choose not to specify

Preferred Language (Check one)

- | | | | | | |
|----------------------------------|-------------------------------------|---|--|--|---------------------------------|
| <input type="checkbox"/> English | <input type="checkbox"/> Spanish | <input type="checkbox"/> American Sign Language | <input type="checkbox"/> Chinese | <input type="checkbox"/> French | <input type="checkbox"/> German |
| <input type="checkbox"/> Tagalog | <input type="checkbox"/> Vietnamese | <input type="checkbox"/> Italian | <input type="checkbox"/> Korean | <input type="checkbox"/> Russian | <input type="checkbox"/> Polish |
| <input type="checkbox"/> Arabic | <input type="checkbox"/> Portuguese | <input type="checkbox"/> Japanese | <input type="checkbox"/> French Creole | <input type="checkbox"/> Greek | <input type="checkbox"/> Hindi |
| <input type="checkbox"/> Persian | <input type="checkbox"/> Urdu | <input type="checkbox"/> Gujarati | <input type="checkbox"/> Armenian | <input type="checkbox"/> I choose not to specify | |

Verification Question (Choose only one question by checking the question, then give the answer to that question)

- What is the name of your favorite pet? In what city were you born? What high school did you attend?
- What is your favorite movie? What is your mother's maiden name? On what street did you grow up?
- What was the make of your first car? When is your anniversary? What is your favorite color?

Verification Answer to the Chosen question: _____

Do you currently smoke tobacco of any kind? Yes Former smoker Never been a smoker

If yes, how often do you smoke: Current every day smoker Current sometimes smoker

If yes, what is your level of interest in quitting smoking? Date began smoking, even if former smoker?

- 0 1 2 3 4 5 6 7 8 9 10
- No interest Very Interested

Current medications, including dosage if known.

If there are no current medications, check here:

- 1) _____ 5) _____
- 2) _____ 6) _____
- 3) _____ 7) _____
- 4) _____ 8) _____

List any known allergies you have had to any medications.

If no allergies are known, check here:

- 1) _____ 3) _____
- 2) _____ 4) _____

Occupation _____ Employer _____

Who referred you to us? _____ How else did you hear about us? _____

What is your major complaint? _____

How long have you had this condition? _____

Have you had this or similar conditions in the past? _____

Do any positions make it feel worse? _____

Do any positions make it feel better? _____

Is this condition: Improved Unchanged Getting Worse

Is this condition interfering with your: Work Sleep Daily Routine Other _____

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Dr. William Buchanan, DC Elizabeth M. Wooldridge, FNP-C

Other doctors or therapists who have treated THIS _____ condition _____

What do you think caused this condition? _____

List surgical operations and years: _____

Do you have a family physician? Name : _____

Briefly list your main health problems: _____

Has any doctor diagnosed you with Hypertension presently? Yes No If yes, describe: _____

Has any doctor diagnosed you with Diabetes presently? Yes No If yes, what kind? Type I Type II

If yes to Diabetes, was your blood lab-work test for hemoglobin A1c > 9.0%? Yes No Not Sure

If yes, other comments regarding Diabetes: _____

Have you had an X-ray or CT scan or MRI of your low back _____ spine in the past 28 days? Yes No

To be performed by clinic staff:

Height: _____ inches Weight: _____ pounds BP: _____ / _____

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REVIEW OF SYSTEMS

Check only the ones you now have _____ or have had _____ in the past.

<u>GENERAL</u>		NOW	PAST	<u>THROAT</u>		NOW	PAST	<u>GASTROINTESTINAL</u>		NOW	PAST
Weakness	<input type="checkbox"/>	<input type="checkbox"/>	Soreness	<input type="checkbox"/>	<input type="checkbox"/>	Abdominal Pain	<input type="checkbox"/>	<input type="checkbox"/>			
Fatigue	<input type="checkbox"/>	<input type="checkbox"/>	Bad Tonsils	<input type="checkbox"/>	<input type="checkbox"/>	Nausea	<input type="checkbox"/>	<input type="checkbox"/>			
Fever	<input type="checkbox"/>	<input type="checkbox"/>	Hoarseness	<input type="checkbox"/>	<input type="checkbox"/>	Bloated	<input type="checkbox"/>	<input type="checkbox"/>			
Chills	<input type="checkbox"/>	<input type="checkbox"/>	Pain	<input type="checkbox"/>	<input type="checkbox"/>	Belching	<input type="checkbox"/>	<input type="checkbox"/>			
Night Sweats	<input type="checkbox"/>	<input type="checkbox"/>	Trouble Swallowing	<input type="checkbox"/>	<input type="checkbox"/>	Heartburn	<input type="checkbox"/>	<input type="checkbox"/>			
Fainting	<input type="checkbox"/>	<input type="checkbox"/>	Recurrent Infections	<input type="checkbox"/>	<input type="checkbox"/>	Indigestion	<input type="checkbox"/>	<input type="checkbox"/>			
<u>SKIN</u>			<u>NECK</u>			<u>Irregular Bowel Habits</u>		<input type="checkbox"/>	<input type="checkbox"/>		
Color Changes	<input type="checkbox"/>	<input type="checkbox"/>	Neck Enlargement	<input type="checkbox"/>	<input type="checkbox"/>	Constipation	<input type="checkbox"/>	<input type="checkbox"/>			
Nail Changes	<input type="checkbox"/>	<input type="checkbox"/>	Stiff Neck	<input type="checkbox"/>	<input type="checkbox"/>	Diarrhea	<input type="checkbox"/>	<input type="checkbox"/>			
Hair Changes	<input type="checkbox"/>	<input type="checkbox"/>	Soreness	<input type="checkbox"/>	<input type="checkbox"/>	Gas	<input type="checkbox"/>	<input type="checkbox"/>			
Moles	<input type="checkbox"/>	<input type="checkbox"/>	Lumps	<input type="checkbox"/>	<input type="checkbox"/>	Hemorrhoids	<input type="checkbox"/>	<input type="checkbox"/>			
Rashes	<input type="checkbox"/>	<input type="checkbox"/>	Masses	<input type="checkbox"/>	<input type="checkbox"/>	Poor Appetite	<input type="checkbox"/>	<input type="checkbox"/>			
Sores	<input type="checkbox"/>	<input type="checkbox"/>	<u>BREASTS</u>			Food Intolerance	<input type="checkbox"/>	<input type="checkbox"/>			
Weakness	<input type="checkbox"/>	<input type="checkbox"/>	Discharge	<input type="checkbox"/>	<input type="checkbox"/>	Bloody Stools	<input type="checkbox"/>	<input type="checkbox"/>			
<u>HEAD</u>			Lumps	<input type="checkbox"/>	<input type="checkbox"/>	Black Stools	<input type="checkbox"/>	<input type="checkbox"/>			
Headaches	<input type="checkbox"/>	<input type="checkbox"/>	Pain	<input type="checkbox"/>	<input type="checkbox"/>	<u>GENITOURINARY</u>					
Injuries	<input type="checkbox"/>	<input type="checkbox"/>	Bleeding	<input type="checkbox"/>	<input type="checkbox"/>	Urgency	<input type="checkbox"/>	<input type="checkbox"/>			
Bumps	<input type="checkbox"/>	<input type="checkbox"/>	Nipple Changes	<input type="checkbox"/>	<input type="checkbox"/>	Incontinence	<input type="checkbox"/>	<input type="checkbox"/>			
Last Eye Exam	_____		Skin Changes	<input type="checkbox"/>	<input type="checkbox"/>	Straining	<input type="checkbox"/>	<input type="checkbox"/>			
Glasses	<input type="checkbox"/>	<input type="checkbox"/>	Bloated	<input type="checkbox"/>	<input type="checkbox"/>	Back Pain	<input type="checkbox"/>	<input type="checkbox"/>			
Contacts	<input type="checkbox"/>	<input type="checkbox"/>	<u>LUNGS</u>			Frequent Voiding	<input type="checkbox"/>	<input type="checkbox"/>			
Cataracts	<input type="checkbox"/>	<input type="checkbox"/>	Cough	<input type="checkbox"/>	<input type="checkbox"/>	Stones	<input type="checkbox"/>	<input type="checkbox"/>			
<u>EARS</u>			Phlegm	<input type="checkbox"/>	<input type="checkbox"/>	Burning	<input type="checkbox"/>	<input type="checkbox"/>			
Hard of Hearing	<input type="checkbox"/>	<input type="checkbox"/>	Blood	<input type="checkbox"/>	<input type="checkbox"/>	Bed Wetting	<input type="checkbox"/>	<input type="checkbox"/>			
Deafness	<input type="checkbox"/>	<input type="checkbox"/>	Short of Breath	<input type="checkbox"/>	<input type="checkbox"/>	Small Stream	<input type="checkbox"/>	<input type="checkbox"/>			
Ringing	<input type="checkbox"/>	<input type="checkbox"/>	Wheezing	<input type="checkbox"/>	<input type="checkbox"/>	Discharge	<input type="checkbox"/>	<input type="checkbox"/>			
Discharge	<input type="checkbox"/>	<input type="checkbox"/>	Pain	<input type="checkbox"/>	<input type="checkbox"/>	Impotence	<input type="checkbox"/>	<input type="checkbox"/>			
Earache	<input type="checkbox"/>	<input type="checkbox"/>	Congestion	<input type="checkbox"/>	<input type="checkbox"/>	Dribbling	<input type="checkbox"/>	<input type="checkbox"/>			
Itching	<input type="checkbox"/>	<input type="checkbox"/>	Inhalant Exposure	<input type="checkbox"/>	<input type="checkbox"/>	Cloudy Urine	<input type="checkbox"/>	<input type="checkbox"/>			
Dizziness	<input type="checkbox"/>	<input type="checkbox"/>	<u>HEART</u>			Urine Color	_____				
Room Spins	<input type="checkbox"/>	<input type="checkbox"/>	Murmur	<input type="checkbox"/>	<input type="checkbox"/>	Spotting Between Periods	<input type="checkbox"/>	<input type="checkbox"/>			
<u>NOSE</u>			Palpitations	<input type="checkbox"/>	<input type="checkbox"/>	Menstrual Cramps	<input type="checkbox"/>	<input type="checkbox"/>			
Decreased Smell	<input type="checkbox"/>	<input type="checkbox"/>	Rapid Heartbeat	<input type="checkbox"/>	<input type="checkbox"/>	Discharge	<input type="checkbox"/>	<input type="checkbox"/>			
Bleeding	<input type="checkbox"/>	<input type="checkbox"/>	Swollen Extremities	<input type="checkbox"/>	<input type="checkbox"/>	Itching	<input type="checkbox"/>	<input type="checkbox"/>			
Pain	<input type="checkbox"/>	<input type="checkbox"/>	Cold Extremities	<input type="checkbox"/>	<input type="checkbox"/>	Painful Intercourse	<input type="checkbox"/>	<input type="checkbox"/>			
Discharge	<input type="checkbox"/>	<input type="checkbox"/>	Chest Pain/Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Irregular Periods	<input type="checkbox"/>	<input type="checkbox"/>			
Obstruction	<input type="checkbox"/>	<input type="checkbox"/>	Varicose Veins	<input type="checkbox"/>	<input type="checkbox"/>	Hot Flashes	<input type="checkbox"/>	<input type="checkbox"/>			
Post Nasal Drip	<input type="checkbox"/>	<input type="checkbox"/>	Blood Clots	<input type="checkbox"/>	<input type="checkbox"/>	Contraception Type	_____				
Deviated Septum	<input type="checkbox"/>	<input type="checkbox"/>	Blue Extremities	<input type="checkbox"/>	<input type="checkbox"/>	Age at First Period	_____				
Runny Nose	<input type="checkbox"/>	<input type="checkbox"/>	<u>BLOOD</u>			Duration of Cycle	_____				
Sinus Congestion	<input type="checkbox"/>	<input type="checkbox"/>	Anemia	<input type="checkbox"/>	<input type="checkbox"/>	Duration of Flow	_____				
<u>MOUTH</u>			Low Blood Iron	<input type="checkbox"/>	<input type="checkbox"/>	No. of Pregnancies	_____				
Bleeding Gums	<input type="checkbox"/>	<input type="checkbox"/>	Easy Bruising	<input type="checkbox"/>	<input type="checkbox"/>	No. of Births	_____				
Sores	<input type="checkbox"/>	<input type="checkbox"/>	Easy Bleeding	<input type="checkbox"/>	<input type="checkbox"/>	No. of Miscarriages	_____				
Dental Problems	<input type="checkbox"/>	<input type="checkbox"/>	Swollen Nodes	<input type="checkbox"/>	<input type="checkbox"/>	No. of Abortions	_____				
Bad Breath	<input type="checkbox"/>	<input type="checkbox"/>	Painful Nodes	<input type="checkbox"/>	<input type="checkbox"/>	Menstrual Flow	<input type="checkbox"/> Heavy <input type="checkbox"/> Mod <input type="checkbox"/> Light				
Loss of Taste	<input type="checkbox"/>	<input type="checkbox"/>	Sugar in Blood	<input type="checkbox"/>	<input type="checkbox"/>	Last Period	_____				
Dry Mouth	<input type="checkbox"/>	<input type="checkbox"/>	Red Spots	<input type="checkbox"/>	<input type="checkbox"/>	Last Pap Smear	_____				
Ulcers	<input type="checkbox"/>	<input type="checkbox"/>				Last Vaginal Exam	_____				
Blisters	<input type="checkbox"/>	<input type="checkbox"/>				Last Mammogram	_____				
						Last Prostate Exam	_____				

Dr. Rachel Waldrop, DC
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NEUROLOGIC NOW PAST

- Seizures
- Vertigo
- Dizziness
- Hand Trembling
- Loss of Sensation
- Incoordination
- Loss of Facial
- Weak Grip
- Paralysis
- Difficulty Speech
- Tingling
- Loss of Memory
- Numbness

ENDOCRINE

- Weight Loss
- Weight Gain
- Extremely Thin
- Heat Intolerance
- Cold Intolerance
- Hair Changes
- Breast Changes

IMMUNIZATION/VACCINATION

- DPT
- Mumps
- Smallpox
- Typhoid
- Tetanus
- Measles
- Pneumococcal
- Influenza
- Polio
- MMR

BLOOD TYPE

- A + A -
- B + B -
- AB + AB -
- O + O -
- Other _____

PSYCHIATRIC NOW PAST

- Hyperventilation
- Insecurity
- Depression
- Troubled Sleep
- Irritable
- Undecidedness
- Timid
- Hallucinations
- Loss of Memory
- Alcoholism
- Drug Addiction
- Drug Dependent
- Suicidal Thoughts
- Extreme Worry
- Sexual Problems

MUSCULOSKELETAL NOW PAST

- Muscle Pain
- Muscle Weakness
- Muscle Cramps
- Muscle Twitching
- Joint Stiffness
- Joint Pain

PAST MEDICAL HISTORY. Check only the ones you have had in the past.

- | | |
|--|--|
| Hay Fever <input type="checkbox"/> | Parasites <input type="checkbox"/> |
| Mumps <input type="checkbox"/> | Epilepsy <input type="checkbox"/> |
| Rheumatic Fever <input type="checkbox"/> | Paralysis <input type="checkbox"/> |
| Allergies <input type="checkbox"/> | Polio <input type="checkbox"/> |
| Angina <input type="checkbox"/> | Mental Illness <input type="checkbox"/> |
| Cancer <input type="checkbox"/> | Alcoholism <input type="checkbox"/> |
| Tumor <input type="checkbox"/> | Depression <input type="checkbox"/> |
| Blood Disease <input type="checkbox"/> | Nervous Breakdown <input type="checkbox"/> |
| Leukemia <input type="checkbox"/> | Migraine <input type="checkbox"/> |
| Heart Trouble <input type="checkbox"/> | Gout <input type="checkbox"/> |
| Varicose Veins <input type="checkbox"/> | Hemorrhoids <input type="checkbox"/> |
| Phlebitis <input type="checkbox"/> | Prostate Problems <input type="checkbox"/> |
| Hypertension <input type="checkbox"/> | Sexual Problems <input type="checkbox"/> |
| Stroke <input type="checkbox"/> | Gonorrhea <input type="checkbox"/> |
| Ulcers <input type="checkbox"/> | Syphilis <input type="checkbox"/> |
| Jaundice <input type="checkbox"/> | Diabetes <input type="checkbox"/> |
| Skin Trouble <input type="checkbox"/> | Bladder Trouble <input type="checkbox"/> |
| Gallstones <input type="checkbox"/> | Kidney Stones <input type="checkbox"/> |
| Liver Trouble <input type="checkbox"/> | Kidney Infections <input type="checkbox"/> |
| Hepatitis <input type="checkbox"/> | Dysentery <input type="checkbox"/> |

Date of Last Chest X-Ray _____ Normal Abnormal

Last TB Skin Test _____ Normal Abnormal

Date _____

Allergies: _____

Date _____

Date _____

Date _____

FAMILY HISTORY List any of the diseases listed above which run in your family.

Relative	Age if Living	Age at Death	Cause of Death	State of Health	Illnesses
Father	_____	_____	_____	_____	_____
Mother	_____	_____	_____	_____	_____
Brother(s)	_____	_____	_____	_____	_____
Sister(s)	_____	_____	_____	_____	_____
Maternal Grandfather	_____	_____	_____	_____	_____
Maternal Grandmother	_____	_____	_____	_____	_____
Paternal Grandfather	_____	_____	_____	_____	_____
Paternal Grandmother	_____	_____	_____	_____	_____

SOCIAL HISTORY Check the boxes and fill in.

Current Weight _____ Have you recently lost or gained weight? _____

Mental Work Heavy Moderate Light Hours per day _____

Physical Work Heavy Moderate Light Hours per day _____

Exercise Heavy Moderate Light Hours per week _____ Type _____

Alcohol Beer/Week _____ Liquor/Week _____ Wine/Week _____ No. of Years _____

Caffeine Cups/Day _____ No. of Years _____
(Coffee, Tea, Cola)

Aspirin No./Day _____ No. of Years _____ Others _____

SYMPTOMS Mark the areas of your symptoms on the figure to the right.

Use the following symbols:

Aches Numbness oooo Pins/Needles Stabbing ////

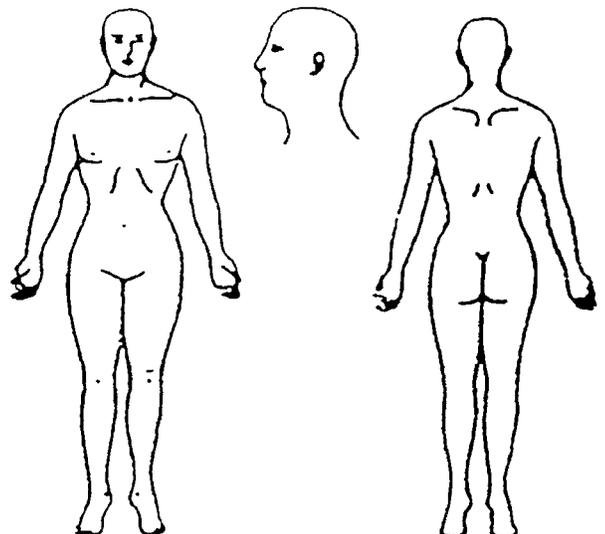
Mark an "X" on the following two lines:

How bad are your symptoms now?

None Most Severe

How bad have they been in the past?

None Most Severe



Patient Name _____

DOB _____

PT# _____

DATE _____

WALDROP CHIROPRACTIC AND WELLNESS, PLLC
521 South Montgomery Street Suite 3 Starkville, MS 39759
(662)546-4400 Fax (662)268-4634

INFORMED CONSENT for EXAMINATION and TREATMENT

I hereby consent to the performance of examination and treatment by the licensed doctor(s) of chiropractic and medical practitioners who may be employed by or engaged in practice in this clinic.

I have had an opportunity to discuss with the doctor(s) or other clinic personnel the nature and purpose of the different physio therapy procedures and chiropractic treatment (manipulation/adjustment). I understand that neither chiropractic nor medical treatment is an exact science and that my care may involve judgments based upon facts and information known to the doctor. The doctor uses this judgment to attempt to anticipate or explain risks and complications and an undesirable result does not necessarily indicate an error in judgment. No guarantee for results can be made or expected but rather I wish to rely on the doctor to choose and recommend a best course of treatment based upon facts known that is in my best interest.

I further understand that there are certain degrees of risk associated with chiropractic health care and physical therapy, which includes rarely, but not limited to fractures, disc injuries, strokes, and strain/sprains and am therefore willing to accept and consent to the risk associated with the care that I am about to receive.

I have read, or the above information has been explained regarding consent. I have had an opportunity to ask questions about my examination and treatment. By signing below, I agree and intend this consent form to cover the procedures prescribed for my condition and for any future conditions for which I seek treatment.

Female Patients: By my signature on this form I do hereby state that to the best of my knowledge, I am not pregnant, nor is pregnancy suspected or confirmed at this particular time. Date of last menstrual period _____.

Patient's Name (Print)

Patient's Signature

Date

Relationship or authority if not signed by patient

Witness

Dr. Rachel Waldrop, DC
Dr. William Buchanan, DC

Dr. Dalton Gean, DC
Elizabeth M. Wooldridge, FNP-C
Form W114

PATIENT NAME: _____

PATIENT DOB: _____

PATIENT #: _____

WALDROP CHIROPRACTIC AND WELLNESS, PLLC
521 South Montgomery Street Suite 3 Starkville, MS 39759
(662)546-4400 Fax (662)268-4634

HIPAA PRIVACY AUTHORIZATION FORM

Dr. Waldrop and members of the practice staff may need to use your name, address, phone number and clinical records to contact you with appointment reminders, information about treatment alternatives or other health related information that may be of interest to you. If this contact is made by phone and you are not home, a message will be left on your answering machine or with a family member.

You can restrict the individuals to which your health care information is released or you may revoke your authorization to us at any time; however, your revocation must be in writing and mailed to us at our office address. We will not be able to honor your revocation request if we have already released your health information before we receive your request to revoke your authorization. In addition, if you were required to give your authorization as a condition of obtaining insurance, the insurance company may have a right to your health information if they decide to contest any of your claims.

Information that we use or disclose based on the authorization you are giving us may be subject to re-disclosure by anyone who has access to the reminder or other information and may no longer be protected by the federal privacy rules.

You have the right to refuse to give this authorization. If you do not give us authorization, it will not affect the treatment we provide to you or the methods we use to obtain reimbursement for your care.

We offer spinal adjustments in an open room style, with other patients in the same room. Occasionally comments about your symptoms, improvement or lack thereof may be discussed at your office visits. Private rooms are available for any other needed consultations.

You may inspect or request a copy, for a fee, the information that we use to contact you to provide appointment reminders, information about treatment alternatives or other health related information at any time (#164.524). This Notice is effective as of August 11, 2010. This authorization will expire seven years after the date in which you last received services from us. You may receive a copy of this form when needed.

I authorize you to use or disclose my health information in the manner described. I also acknowledge that I have read and received a copy of Waldrop Chiropractic and Wellness's Privacy Policy.

PATIENT SIGNATURE: _____ **DATE:** _____

NEXT OF KIN: _____ **RELATIONSHIP:** _____ **PHONE:** _____

Patient Name:	DOB:	PT#:	Date:
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NECK DISABILITY INDEX

This questionnaire has been designed to give the doctor information as to how your neck pain has affected your ability to manage in everyday life. Please answer every section and mark in each section only **ONE** box which applies to you. We realize you may consider that two of the statements in any one section relate to you, but please just mark the box which **MOST CLOSELY** describes your problem.

Section 1 - PAIN INTENSITY
<input type="checkbox"/> I have no pain at the moment. <input type="checkbox"/> The pain is very mild at the moment. <input type="checkbox"/> The pain is moderate at the moment. <input type="checkbox"/> The pain is fairly severe at the moment. <input type="checkbox"/> The pain is very severe at the moment. <input type="checkbox"/> The pain is the worst imaginable at the moment.

Section 6 - CONCENTRATION
<input type="checkbox"/> I can concentrate fully when I want to without difficulty. <input type="checkbox"/> I can concentrate fully when I want to with slight difficulty. <input type="checkbox"/> I have a fair degree of difficulty in concentrating when I want to. <input type="checkbox"/> I have a lot of difficulty in concentrating when I want to. <input type="checkbox"/> I have a great deal of difficulty in concentrating when I want to. <input type="checkbox"/> I cannot concentrate at all.

Section 2 - PERSONAL CARE (Washing, Dressing, etc.)
<input type="checkbox"/> I can look after myself normally without causing extra pain. <input type="checkbox"/> I can look after myself normally but it causes extra pain. <input type="checkbox"/> It is painful to look after myself and I am slow and careful. <input type="checkbox"/> I need some help but manage most of my personal care. <input type="checkbox"/> I need help every day in most aspects of my life. <input type="checkbox"/> I do not get dressed, I wash with difficulty and stay in bed.

Section 7 - WORK
<input type="checkbox"/> I can do as much work as I want to. <input type="checkbox"/> I can only do my usual work, but no more. <input type="checkbox"/> I can do most of my usual work, but no more. <input type="checkbox"/> I cannot do my usual work. <input type="checkbox"/> I can hardly do any work at all. <input type="checkbox"/> I can't do any work at all.

Section 3 - LIFTING
<input type="checkbox"/> I can lift heavy weights without extra pain. <input type="checkbox"/> I can lift heavy weights but it gives extra pain. <input type="checkbox"/> Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned, for example on a table. <input type="checkbox"/> Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned. <input type="checkbox"/> I can lift very light weights. <input type="checkbox"/> I cannot lift or carry anything at all.

Section 8 - DRIVING
<input type="checkbox"/> I drive my car without any neck pain. <input type="checkbox"/> I can drive my car as long as I want with slight pain in my neck. <input type="checkbox"/> I can drive my car as long as I want with moderate pain in my neck. <input type="checkbox"/> I can't drive my car as long as I want because of moderate pain in my neck. <input type="checkbox"/> I can't drive at all because of severe pain in my neck. <input type="checkbox"/> I can't drive my car at all.

Section 4 - READING
<input type="checkbox"/> I can read as much as I want to with no pain in my neck. <input type="checkbox"/> I can read as much as I want to with slight pain in my neck. <input type="checkbox"/> I can read as much as I want to with moderate pain. <input type="checkbox"/> I can't read as much as I want because of moderate pain in my neck. <input type="checkbox"/> I can hardly read at all because of severe pain in my neck. <input type="checkbox"/> I cannot read at all.

Section 9 - SLEEPING
<input type="checkbox"/> I have no trouble sleeping. <input type="checkbox"/> My sleep is slightly disturbed (less than 1 hr. sleepless). <input type="checkbox"/> My sleep is slightly disturbed (1-2 hrs. sleepless). <input type="checkbox"/> My sleep is moderately disturbed (2-3 hrs. sleepless). <input type="checkbox"/> My sleep is greatly disturbed (3-5 hrs. sleepless). <input type="checkbox"/> My sleep is completely disturbed (5-7 hrs. sleepless).

Section 5 - HEADACHES
<input type="checkbox"/> I have no headaches at all. <input type="checkbox"/> I have slight headaches that come frequently. <input type="checkbox"/> I have moderate headaches that come infrequently. <input type="checkbox"/> I have moderate headaches that come frequently. <input type="checkbox"/> I have severe headaches which come frequently. <input type="checkbox"/> I have headaches almost all the time.

Section 10 - RECREATION
<input type="checkbox"/> I am able to engage in all my recreation activities with no neck pain at all. <input type="checkbox"/> I am able to engage in all my recreation activities, with some neck pain. <input type="checkbox"/> I am able to engage in most, but not all of my usual recreation activities because of the pain in my neck. <input type="checkbox"/> I am able to engage in a few of my recreation activities because of the pain in my neck. <input type="checkbox"/> I can hardly do any recreation activities because of the pain in my neck. <input type="checkbox"/> I can't do any recreation activities at all.

Name (Print):	Signature:
Comments:	Oswestry Neck Score: # Date:

Patient Name:	DOB:	PT#:	Date:
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OSWESTRY LOW BACK PAIN QUESTIONNAIRE

PLEASE READ: This questionnaire is designed to enable your health care provider to understand how much your low back pain has affected your ability to manage everyday activities. Answer each section by marking the **ONE** choice that most applies to you. We realize you may feel that more than one statement may relate to you, but **PLEASE JUST CIRCLE THE ONE CHOICE WHICH MOST CLOSELY DESCRIBES YOUR PROBLEM RIGHT**

Section 1 - PAIN INTENSITY
<input type="checkbox"/> The pain comes and goes and is very mild. <input type="checkbox"/> The pain is mild and does not vary much. <input type="checkbox"/> The pain comes and goes and is moderate. <input type="checkbox"/> The pain is moderate and does not vary much. <input type="checkbox"/> The pain comes and goes and is severe. <input type="checkbox"/> The pain is severe and does not vary much.

Section 6 - STANDING
<input type="checkbox"/> I can stand as long as I like without pain. <input type="checkbox"/> I have some pain while standing but it does not increase with time. <input type="checkbox"/> I cannot stand for longer than one hour without increasing pain. <input type="checkbox"/> I cannot stand for longer than 1/2 hour without increasing pain. <input type="checkbox"/> I cannot stand for longer than 10 minutes without increasing pain. <input type="checkbox"/> I avoid standing because it increases the pain straight away.

Section 2 - PERSONAL CARE
<input type="checkbox"/> I would not have to change my way of washing or dressing to avoid pain. <input type="checkbox"/> I do not normally change my way of washing and dressing even though it causes some pain. <input type="checkbox"/> Washing and dressing increase the pain, but I manage not to change my way of doing it. <input type="checkbox"/> Washing and dressing increase the pain and I find it necessary to change my way of doing it. <input type="checkbox"/> Because of the pain, I am unable to do some washing and dressing without help. <input type="checkbox"/> Because of the pain, I am unable to do <i>any</i> washing and dressing without help.

Section 7 - SLEEPING
<input type="checkbox"/> I get no pain in bed. <input type="checkbox"/> I get pain in bed but it does not prevent me from sleeping well. <input type="checkbox"/> Because of pain my normal night's sleep is reduced by less than 1/4. <input type="checkbox"/> Because of pain my normal night's sleep is reduced by less than 1/2. <input type="checkbox"/> Because of pain my normal night's sleep is reduced by less than 3/4. <input type="checkbox"/> Pain prevents me from sleeping at all.

Section 3 - LIFTING
<input type="checkbox"/> I can lift heavy weights without extra pain. <input type="checkbox"/> I can lift heavy weights but it causes extra pain. <input type="checkbox"/> Pain prevents me from lifting heavy weights off the floor. <input type="checkbox"/> Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned. (e.g., on a table) <input type="checkbox"/> Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned. <input type="checkbox"/> I can only lift very light weights at the most.

Section 8 - SOCIAL LIFE
<input type="checkbox"/> My social life is normal and gives me no pain. <input type="checkbox"/> My social life is normal but increases the degree of pain. <input type="checkbox"/> Pain has no significant effect on my social life apart from limiting my more energetic interests, e.g., dancing, etc. <input type="checkbox"/> Pain has restricted my social life and I do not go out very often. <input type="checkbox"/> Pain has restricted my social life to my home. <input type="checkbox"/> I have hardly any social life because of the pain.

Section 4 - WALKING
<input type="checkbox"/> Pain does not prevent me from walking any distance. <input type="checkbox"/> Pain prevents me from walking more than one mile. <input type="checkbox"/> Pain prevents me from walking more than 1/2 mile. <input type="checkbox"/> Pain prevents me from walking more than 1/4 mile. <input type="checkbox"/> I can only walk while using a cane or on crutches. <input type="checkbox"/> I am in bed most of the time and have to crawl to the toilet.

Section 9 - TRAVELING
<input type="checkbox"/> I get no pain while traveling. <input type="checkbox"/> I have some pain while traveling but none of my usual forms of travel make it any worse. <input type="checkbox"/> I have extra pain while traveling but it does not compel me to seek alternate forms of travel <input type="checkbox"/> I get extra pain while traveling that compels me to see alternative forms of travel. <input type="checkbox"/> Pain restricts all forms of travel. <input type="checkbox"/> Pain prevents all forms of travel except that done lying down.

Section 5 - SITTING
<input type="checkbox"/> I can sit in any chair as long as I like without pain. <input type="checkbox"/> I can only sit in my favorite chair as long as I like. <input type="checkbox"/> Pain prevents me from sitting more than 1 hour. <input type="checkbox"/> Pain prevents me from sitting more than 1/2 hour. <input type="checkbox"/> Pain prevents me from sitting more than ten minutes. <input type="checkbox"/> Pain prevents me from sitting at all.

Section 10 - CHANGING DEGREE OF PAIN
<input type="checkbox"/> My pain is rapidly getting better. <input type="checkbox"/> My pain fluctuates but overall is definitely getting better. <input type="checkbox"/> My pain seems to be getting better, but improvement is slow at present. <input type="checkbox"/> My pain is neither getting better nor worse. <input type="checkbox"/> My pain is gradually worsening. <input type="checkbox"/> My pain is rapidly worsening.

Name (Print):	Signature:
Comments:	Oswestry Low Back Score: # Date: