

**IF YOU ARE HERE FOR PROBLEMS RELATING TO
THE BRAIN, PLEASE FILL OUT PAGES 2 - 10 ONLY.**

THANK YOU

***PLEASE BRING FILMS (MRI, CT SCAN, ETC..) TO YOUR APPOINTMENT!**

NEW PATIENT OFFICE INFORMATION

PATIENT'S NAME _____ DOB ____/____/____
ADDRESS _____ SSN ____/____/____
CITY _____ STATE _____ ZIP _____ HOME # (____) _____ - _____
ALTERNATE #(CELL, WORK) (____) _____ - _____
EMPLOYER _____ PHONE#(____) _____ - _____ ext _____
ADDRESS _____
EMERGENCY CONTACT _____ PHONE#(____) _____ - _____

INSURANCE INFORMATION: (please print)

PRIMARY COMPANY

INSURANCE CO.NAME _____ PHONE #(____) _____ - _____
ADDRESS FOR CLAIMS _____
INSURANCE POLICY HOLDER _____
POLICY HOLDER'S SSN ____ - ____ - _____ D.O.B. ____/____/____

(IF THIS IS WORKERS COMP CLAIM, PLEASE COMPLETE BELOW)

DATE OF INJURY ____/____/____ WORKERS COMP CLAIM # _____
CLAIM ADJUSTOR _____
ADJUSTING INSURANCE CO _____
ADDRESS _____ PH
ONE: _____ FAX: _____
EMPLOYER AT TIME OF INJURY _____
SUPERVISORS NAME _____

ALL PROFESSIONAL SERVICES RENDERED ARE CHARGED TO THE PATIENT, NECESSARY FORMS WILL BE COMPLETED TO EXPEDITE INSURANCE PAYMENTS. HOWEVER, THE PATIENT IS RESPONSIBLE FOR ALL FEES, REGARDLESS OF INSURANCE COVERAGE. THE AFORE MENTIONED PATIENT REQUESTS THAT PAYMENT OF AUTHORIZED MEDICARE/OTHER INSURANCE COMPANY BENEFITS BE MADE ON MY BEHALF TO ONE OF THE FOLLOWING PHYSICIANS THAT TREATED MY CONDITION: BRENT C. MORGAN, M.D., JOSEPH B. STACHNIAK, M.D., JEFFERY F. CATTORINI, M.D., JOHN R. TOMPKINS M.D. OR ROB D. DICKERMAN D.O. Ph.D. FOR ANY SERVICES FURNISHED ME BY THAT PARTY WHO ACCEPTS ASSIGNMENT REGULATIONS PERTAINING TO MEDICARE/OTHER INSURANCE COMPANY BENEFITS APPLY.

I AUTHORIZE ANY HOLDER OF MEDICAL OR OTHER INFORMATION ABOUT ME, BE RELEASED TO THE SOCIAL SECURITY ADMINISTRATION, HEALTHCARE FINANCING ADMINISTRATION, INTERMEDIARIES, ANY OTHER INSURANCE COMPANY OR CARRIER OF ANY INFORMATION NEEDED FOR THIS OR A RELATED MEDICARE/OTHER INSURANCE COMPANY CLAIM.

I UNDERSTAND MY SIGNATURE REQUESTS THAT PAYMENTS BE MADE AND AUTHORIZES RELEASE OF MEDICAL INFORMATION NECESSARY TO PAY THE CLAIM IF ITEM 9 OF HCFA-1500 IS COMPLETED, MY SIGNATURE AUTHORIZES RELEASING OF THE INFORMATION TO THE INSURER OR AGENCY SHOWN IN MEDICARE/OTHER INSURANCE COMPANY ASSIGNED CASES, PHYSICIAN OR SUPPLIER AGREES TO ACCEPT THE CHARGE DETERMINATION OF THE MEDICARE/OTHER INSURANCE COMPANY AS THE FULL CHARGE AND THE PATIENT IS RESPONSIBLE ONLY FOR DEDUCTIBLE COINSURANCE AND NON-COVERED SERVICES. COINSURANCE AND THE DEDUCTIBLE ARE BASED UPON THE CHARGE DETERMINATION OF THE MEDICARE/OTHER INSURANCE COMPANY.

SIGNATURE

PRINTED NAME

DATE

**FINANCIAL POLICY FOR THE OFFICE OF
DR. ROB D. DICKERMAN, D.O., PH.D.,P.A.**

THANK YOU FOR CHOOSING US AS ONE OF YOUR HEALTHCARE PROVIDERS; WE ARE COMMITTED TO YOUR SUCCESSFUL TREATMENT. PLEASE UNDERSTAND THAT PAYMENT OF YOUR BILL IS CONSIDERED A PART OF YOUR TREATMENT. THE FOLLOWING IS A STATEMENT OF OUR FINANCIAL POLICY WHICH WE REQUEST YOU READ AND SIGN

**ALL PATIENTS ARE REQUIRED TO COMPLETE THIS INFORMATION
BEFORE SEEING THE PHYSICIAN.**

CO-PAYMENT IS DUE AT TIME OF SERVICE

WE ACCEPT CASH, CHECKS, VISA, MASTERCARD,

REGARDING INSURANCE:

WE MAY ACCEPT ASSIGNMENT OF INSURANCE BENEFITS AFTER YOUR VISIT. HOWEVER, WE DO REQUIRE YOUR CO-PAYMENT TO BE PAID AT THE TIME OF SERVICE. THE BALANCE IS YOUR RESPONSIBILITY WHETHER YOUR INSURANCE COMPANY PAYS OR NOT. WE SHALL FILE YOUR PRIVATE INSURANCE AS A COURTESY FOR ALL PATIENT PROCEDURES. WE CANNOT BILL YOUR INSURANCE COMPANY UNLESS YOU BRING ALL INSURANCE INFORMATION. YOUR INSURANCE POLICY IS A CONTRACT BETWEEN YOU AND YOUR INSURANCE COMPANY. WE ARE NOT A PARTY TO THAT CONTRACT. **IN THE EVENT YOUR INSURANCE COMPANY HAS NOT PAID THE BALANCE IN 45 DAYS, IT WILL BE AUTOMATICALLY TRANSFERRED AND BILLED DIRECTLY TO YOU.** WE ARE MEDICARE PROVIDERS AND MEMBERS OF SEVERAL HMO'S AND PPO'S. WE DO FILE INSURANCE FOR THOSE CARRIERS, HOWEVER, YOU WILL BE RESPONSIBLE FOR YOUR DEDUCTIBLE AND CO-INSURANCE. PLEASE GIVE YOUR INSURANCE CARD (S) TO THE RECEPTIONIST SO WE MAY COPY THE CARD A PICTURE ID SO AS TO HELP US FILE THE CLAIM.

REFERRAL NUMBERS:

SINCE MANY OF OUR PATIENTS PARTICIPATE IN MANAGED CARE PLANS, WE MUST REMIND YOU THAT YOUR PRIMARY CARE PHYSICIAN HAS REFERRED YOU; IT IS YOUR RESPONSIBILITY TO OBTAIN YOUR REFERRAL NUMBER PRIOR TO YOUR VISIT. IN THE EVENT YOU DO NOT DO SO, YOU WILL HAVE THE CHOICE TO RESCHEDULE UNTIL A REFERRAL NUMBER IS OBTAINED OR WILL NEED TO PAY FOR THE VISIT IN FULL AT TIME OF SERVICE.

ALL DEBTS THAT EXHAUSTED INSURANCE COLLECTION AND THAT ARE GREATER THAN 120 DAYS WILL BE TURNED OVER TO A COLLECTION AGENCY UNLESS ARRANGEMENTS WITH THIS OFFICE HAVE BEEN MADE.

THANK YOU FOR UNDERSTANDING OUR FINANCIAL POLICY. PLEASE LET OUR INSURANCE STAFF KNOW IF YOU HAVE ANY QUESTIONS OR IF WE CAN HELP YOU UNDERSTAND YOUR INSURANCE CARRIERS PAPERWORK.

I HAVE READ AND UNDERSTAND THE FINANCIAL POLICY FOR THIS OFFICE AND AGREE TO ADHERE TO THIS POLICY.

PATIENT'S SIGNATURE

PRINTED NAME

DATE

DR. ROB D. DICKERMAN, D.O.,PH.D., P.A.

PATIENT CONSENT AND ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY NOTICE

I UNDERSTAND THAT AS PART OF THE PROVISION OF HEALTHCARE SERVICES, NORTH TEXAS NEUROSURGICAL ASSOCIATES, P.A. CREATES AND MAINTAINS HEALTH RECORDS AND OTHER INFORMATION DESCRIBING AMONG OTHER THINGS, MY HEALTH HISTORY, SYMPTOMS, EXAMINATION AND TEST RESULTS, DIAGNOSES, TREATMENT, AND ANY PLANS FOR FUTURE CARE OR TREATMENT.

I HAVE BEEN PROVIDED WITH A NOTICE OF PRIVACY PRACTICE THAT PROVIDES A MORE COMPLETE DESCRIPTION OF THE USES AND DISCLOSURES OF CERTAIN HEALTH INFORMATION. I UNDERSTAND THAT I HAVE THE RIGHT TO REVIEW THE NOTICE PRIOR TO SIGNING THIS CONSENT. I UNDERSTAND THAT THE ORGANIZATION RESERVES THE RIGHT TO CHANGE THEIR NOTICE AND PRACTICES PRIOR TO IMPLEMENTATION WILL MAIL A COPY OF ANY REVISIED NOTICE TO THE ADDRESS I HAVE PROVIDED. I UNDERSTAND THAT I HAVE THE RIGHT TO OBJECT TO THE USE OF MY HEALTH INFORMATION FOR DIRECTORY PURPOSES. I UNDERSTAND THAT I HAVE THE RIGHT TO REQUEST RESTRICTIONS AS TO HOW MY HEALTH INFORMATION MAY BE USED OR DISCLOSED TO CARRY OUT TREATMENT, PAYMENT, OR HEALTHCARE OPERATIONS (QUALITY ASSESSMENT AND IMPROVEMENT ACTIVITIES, UNDERWRITING, PREMIUM RATING, CONDUCTING OR ARRANGING FOR MEDICAL REVIEW, LEGAL SERVICES, AND AUDITING FUNCTIONS, ETC.) AND THAT THE ORGANIZATION IS NOT REQUIRED TO AGREE TO THE RESTRICTIONS REQUESTED.

BY SIGNING THIS FORM, I CONSENT TO THE USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION ABOUT ME FOR THE PURPOSES OF TREATMENT, PAYMENT AND HEALTH CARE OPERATIONS. I HAVE THE RIGHT TO REVOKE THIS CONSENT, IN WRITING, EXCEPT WHERE DISCLOSURES HAVE ALREADY MADE IN RELIANCE ON MY PRIOR CONSENT.

THIS CONSENT IS GIVEN FREELY WITH THE UNDERSTANDING THAT:

1.ANY AND ALL RECORDS, WHETHER WRITTEN OR ORAL OR IN ELECTRONIC FORMAT ARE CONFIDENTIAL AND CANNOT BE DISCLOSED FOR REASONS OUTSIDE OF TREATMENT, PAYMENT OR HEALTH CARE OPERATIONS WITHOUT MY PRIOR WRITTEN AUTHORIZATION, EXCEPT AS OTHERWISE PROVIDED BY LAW.

2. A PHOTOCOPY OR FAX OF THIS CONSENT IS AS VALID AS THIS ORIGINAL.

3.I HAVE THE RIGHT TO REQUEST THAT THE USE OF MY PROTECTED HEALTH INFORMATION, WHICH IS USED OR DISCLOSED FOR THE PURPOSES OF TREATMENT, PAYMENT OR HEALTH CARE OPERATIONS BE RESTRICTED. I ALSO UNDERSTAND THAT THE PRACTICE AND I MUST: AGREE TO ANY RESTRICTIONS IN WRITING THAT I REQUEST ON THE USE AND DISCLOSURE OF MY PROTECTED HEALTH INFORMATION; AND AGREE TO TERMINATE ANY RESTRICTIONS IN WRITING ON THE USE AND DISCLOSURE OF MY PROTECTED HEALTH INFORMATION WHICH HAVE BEEN PREVIOUSLY AGREED UPON.

PATIENTS PRINTED NAME

DATE

PATIENTS SIGNATURE

SOCIAL SECURITY NUMBER

ANY OTHER PERSON WHOM YOU WOULD LIKE TO HAVE YOUR PERSONAL HEALTH INFORMATION RELEASED TO? _____

Patient Agreement For Controlled Substance Prescription

Controlled substance medications (narcotics) can be very useful, but have high potential for misuse and abuse and are closely controlled by the local, state, and federal governments. Used properly, they are very effective pain medications. If used excessively however, they can cause adverse effects such as vomiting, constipation, lethargy, liver and kidney failure, or even death. To insure these medications are used properly, I agree to the following conditions:

1. I am responsible for my controlled substance medications. If the prescription or medication is lost, misplaced, stolen, or I use it up sooner than prescribed, I understand that it will not be replaced.
2. I will not request nor accept controlled substance medication from any other physician or individual while I am receiving such medication Dr. Rob D. Dickerman, D.O, Ph.D., P.A. (except if I am a patient in a hospital). Besides being illegal to do so, it may endanger my health.
3. I agree to use one and only one pharmacy.
4. For your safety, your physician may, from time to time, request a urinalysis test to better regulate the medications.
5. I understand that if I violate any of the above conditions or refuse to take a urine test at my physician's request, my controlled substance prescription and treatment by Dr. Rob D. Dickerman, D.O., Ph.D., P.A. may be ended immediately. If the violation involves obtaining controlled substances from another individual as described above, I may also be reported to my primary physician, local medical facilities, and other authorities.

I have been informed by my physician about narcotic effects, including normal physiologic effects of tolerance (need for more medicine to achieve pain relief), dependence (withdrawal will occur if I stop the medicine abruptly), and addiction (abnormal physiological dependence), which is rare in patients with pain. Withdrawal can be a consequence of overuse, and oftentimes can be unpleasant (e.g. nausea, vomiting, diarrhea, sweating, rapid pulse, etc.)

Patient Name: _____

Patients Signature: _____

REFERRING PHYSICIAN/ OTHER:

PHARMACY NAME/ PHONE:

DR. ROB D. DICKERMAN, D.O., PH.D., P.A.

PLEASE PRINT:

PATIENT NAME: _____ DATE ___/___/___

DATE OF BIRTH: ___/___/___ AGE: _____ GENDER: FEMALE MALE

HEIGHT: _____ WEIGHT: _____

WE KNOW THAT FILLING OUT THESE FORMS CAN BE DIFFICULT-BUT PLEASE COMPLETE THEM CAREFULLY. YOUR ACCURATE RESPONSES WILL GIVE US A BETTER UNDERSTANDING OF YOU AND YOUR PROBLEM. FROM THIS INFORMATION, WE CAN PROVIDE YOU THE BEST MEDICAL CARE POSSIBLE.

PLEASE HELP YOURSELF, AND US BY TAKING THE TIME REQUIRED TO ANSWER THE QUESTIONS ACCURATELY. BE CAREFUL TO FOLLOW THE DIRECTIONS IN EACH SECTION. CLEARLY MARK THE CHECK BOXES, CIRCLE APPROPRIATE ITEMS OR WRITE LEGIBLE WHERE INDICATED.

THANK YOU FOR YOUR COOPERATION.

ARE YOU ALLERGIC TO ANY MEDICATIONS? _____

LIST ALL MEDICATIONS THAT YOU ARE TAKING, INCLUDING PRESCRIPTIONS, OVER-THE-COUNTER, AND HERBALS. FOR PRESCRIPTION MEDICATIONS, INDICATE THE DOCTOR WHO PRESCIBED THEM. IF YOU ARE NOT TAKING ANY MEDICATION, CHECK THIS LINE _____

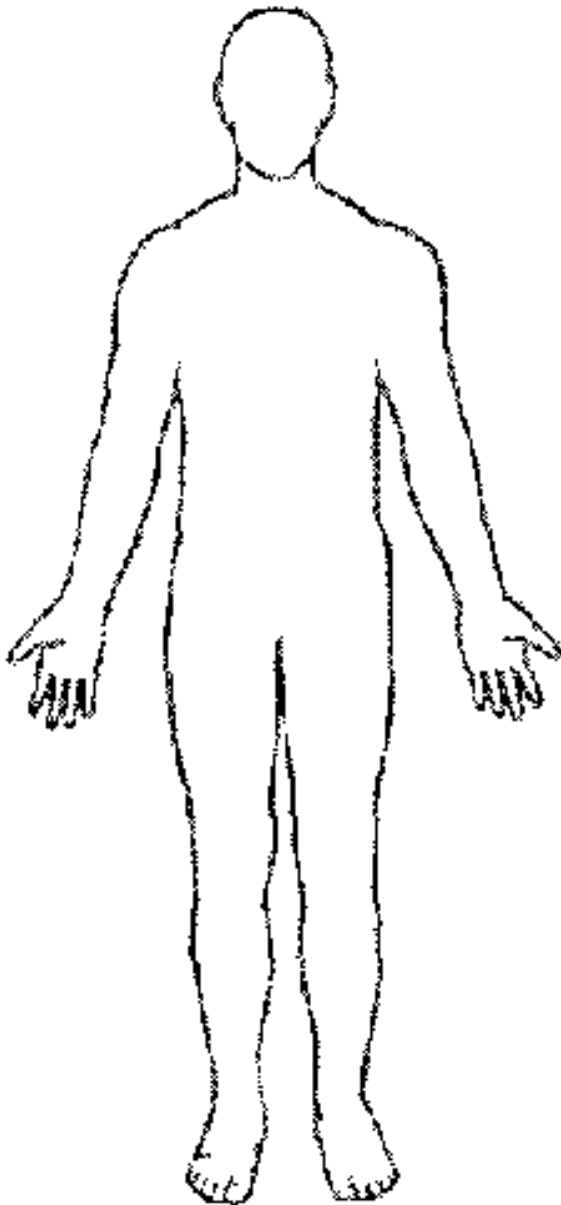
MEDICATION REASON TAKEN	HOW OFTEN TAKEN	DOCTOR
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

WHAT DO YOU WANT TO HAPPEN AS A RESULT OF THIS VISIT? _____

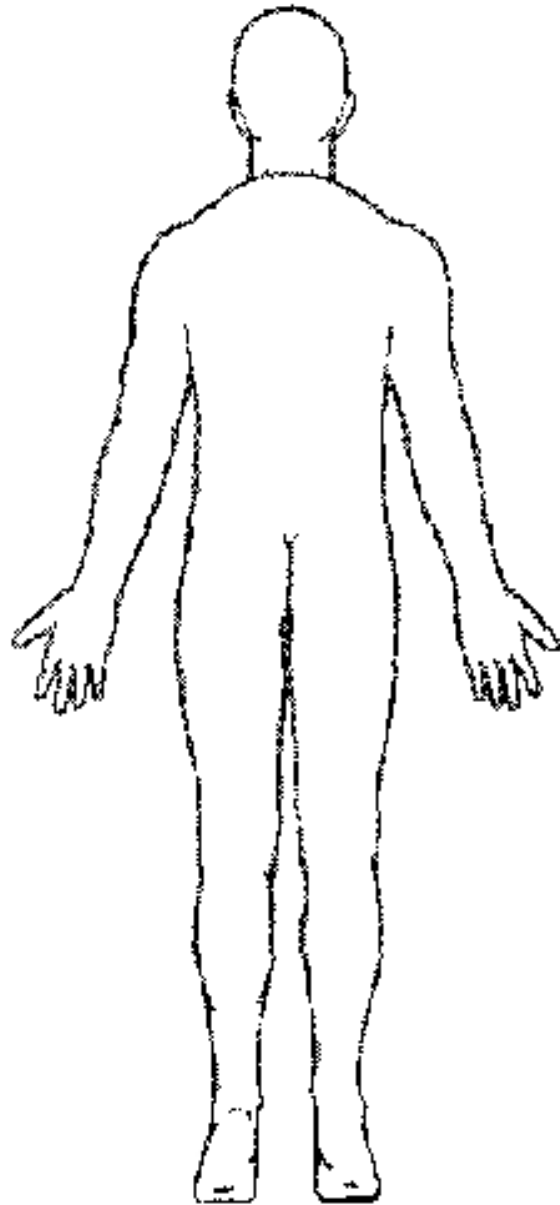
PAIN DIAGRAM

PLEASE MARK THE AREAS WHERE YOU EXPERIENCE THE FOLLOWING SENSATIONS:

Ache	Numbness	Pins & Needles	Burning	Stabbing
^^^	ooo	ooo	xxx	///
^^^	ooo	ooo	xxx	///
^^^	ooo	ooo	xxx	///



FRONT



BACK

PREVIOUS TESTS

_____ I HAVE HAD NONE OF THE TESTS LISTED BELOW

			IF YES, PLEASE LIST DATE
X-RAYS	NO	YES	_____
MRI SCAN	NO	YES	_____
CT SCAN	NO	YES	_____
MYELOGRAM	NO	YES	_____
DISCOGRAM	NO	YES	_____
NERVE TEST(EMG/NCV)	NO	YES	_____

GENERAL MEDICAL HISTORY

CIRCLE ALL THE CONDITIONS BELOW THAT YOU HAVE CURRENTLY OR HAD PREVIOUSLY.

- | | |
|---------------------|--------------------------|
| HEART ATTACK | DEGENERATIVE ARTHRITIS |
| HEART MURMUR | RHEUMATOID ARTHRITIS |
| ANGINA | GOUT |
| HIGH BLOOD PRESSURE | ANXIETY |
| STROKE | DEPRESSION |
| VARICOSE VEINS | EMPHYSEMA |
| STOMACH ULCER | TUBERCULOSIS |
| DUODENAL PROBLEMS | CHRONIC BRONCHITIS |
| COLON PROBLEMS | FREQUENT PNEUMONIA |
| DIABETES | ASTHMA |
| HEPATITIS | ANEMIA (LOW BLOOD COUNT) |
| CIRRHOSIS | BLEEDING TENDENCY |
| KIDNEY STONES | SEXUAL DIFFICULTY |
| KIDNEY INFECTION | ENLARGED PROSTATE |
| MENSTRUAL PROBLEMS | |

CANCER (TYPE) _____

OTHER _____

LIST ANY MAJOR SURGERY YOU HAVE HAD, **OTHER THAN** ON YOUR BACK OR NECK.

TYPE OF SURGERY	YEAR
1. _____	_____
2. _____	_____
3. _____	_____
4. _____	_____
5. _____	_____

SOCIAL HISTORY

MARITAL STATUS (CIRCLE ONE ANSWER)

MARRIED SINGLE
SEPARATED WIDOW / WIDOWER
DIVORCED

SMOKING

DO YOU, OR HAVE YOU EVER, SMOKED? NO YES IF YES COMPLETE THE FOLLOWING:

I SMOKE ____ PACKS PER DAY AND I HAVE SMOKED FOR ____ YEARS

I DID SMOKE ____ PACKS PER DAY, BUT I QUIT SMOKING ____ YEARS AGO.

DO YOU USE ANY SMOKELESS TOBACCO PRODUCTS? YES NO

ALCOHOL

DO YOU DRINK? (CIRCLE YOUR ANSWERS)

BEER: YES NO

WINE: YES NO

“HARD” DRINKS YES NO

FREQUENCY OF DRINKING: NEVER RARELY SOCIALLY DAILY

EDUCATION (CIRCLE THE HIGHEST LEVEL OF EDUCATION YOU COMPLETED)

GRAMMAR SCHOOL COLLEGE
HIGH SCHOOL POST-GRADUATE

EFFECT OF YOUR BACK / NECK PAIN ON YOUR LIFESTYLE (CIRCLE YOUR ANSWER)

I DESCRIBE MY HOME SETTING AS SUPPORTIVE OF ME DURING THIS TIME. YES NO

I DESCRIBE MY WORK SETTING AS SUPPORTIVE OF ME DURING THIS TIME. YES NO

MY PAIN HAS AFFECTED MY INTERACTION WITH MY FAMILY AND FRIENDS. YES NO

THE CHANGES IN MY LIFESTYLE DUE TO MY PROBLEM HAVE BEEN YES NO
DIFFICULT FOR ME.

WHAT IS YOUR ABILITY TO ENJOY LIFE? EXCELLENT VERY GOOD GOOD FAIR POOR

ARE YOU CURRENTLY INVOLVED IN LITIGATION WITH REGARDS TO YOUR BACK PAIN?
YES NO

IS THERE ANYTHING WE HAVE FAILED TO ASK THAT YOU BELIVE IS IMPORTANT FOR US TO
KNOW? YES NO IF YES, EXPLAIN _____

HOW DOES EACH OF THE FOLLOWING AFFECT YOUR PAIN?
PLEASE CIRCLE
YOUR ANSWER.

SITTING	BETTER	WORSE	NO CHANGE
STANDING	BETTER	WORSE	NO CHANGE
WALKING	BETTER	WORSE	NO CHANGE
LYING DOWN	BETTER	WORSE	NO CHANGE
RISING FROM A CHAIR	BETTER	WORSE	NO CHANGE
HEAT	BETTER	WORSE	NO CHANGE
COLD	BETTER	WORSE	NO CHANGE
MASSAGE	BETTER	WORSE	NO CHANGE
PHYSICAL ACTIVITY	BETTER	WORSE	NO CHANGE

PREVIOUS TREATMENTS

WE NEED TO KNOW ABOUT THE TREATMENT YOU HAVE ALREADY RECEIVED FOR YOUR CURRENT BACK/NECK PAIN.

HAVE YOU HAD:	CIRCLE ANSWER		DATE OF LAST TREATMENT
PHYSICAL THERAPY	YES	NO	
CHIROPRACTIC CARE	YES	NO	
INJECTIONS	YES	NO	
PSYCHOLOGICAL	YES	NO	
CONSULTATION OTHER	YES	NO	

HAVE YOU HAD SURGERY ON YOU SPINE? YES NO IF YES, COMPLETE THE FOLLOWING:

TYPE OF SURGERY: (most recent)

WHEN: _____

SURGEON:

DID IT HELP YOUR PAIN? YES NO

TYPE OF SURGERY: (EARLIER)

WHEN: _____

SURGEON:

DID IT HELP YOUR PAIN? YES NO

FACTORS OF COMPLAINT

HOW AND WHEN DID YOUR PROBLEM BEGIN (PLEASE MARK EACH ANSWER THAT APPLIES TO YOUR BACK/NECK PAIN):

- I DO NOT KNOW HOW IT BEGAN
- IT COMES AND GOES
- I HAVE HAD IT A LONG TIME (ABOUT _____ YEARS)
- INJURY (DATE OF INJURY: _____)
- ON THE JOB INJURY (DATE: _____ EXPLAIN HOW THE INJURY HAPPENED: _____)
- PLACE OF EMPLOYMENT _____

HOW BAD IS YOUR PAIN? PLACE AN "X" (----X----) ON EACH OF THE LINES BELOW TO INDICATE YOUR CURRENT PAIN.

- LOW BACK?
NO PAIN-----WORST POSSIBLE
- LEG?
NO PAIN-----WORST POSSIBLE
- MIDDLE BACK?
NO PAIN-----WORST POSSIBLE
- NECK?
NO PAIN-----WORST POSSIBLE
- ARM?
NO PAIN-----WORST POSSIBLE

DO YOU HAVE THE FOLLOWING PROBLEMS? PLEASE CIRCLE AN ANSWER FOR EACH QUESTION.

- | | | | |
|---------------------------------------|------------|-----------|------|
| WEAKNESS | ARMS/HANDS | LEGS/FEET | NONE |
| NUMBNESS (LOSS OF FEELING) | ARMS/HANDS | LEGS/FEET | NONE |
| TINGLING (FALLING ASLEEP) | ARMS/HANDS | LEGS/FEET | NONE |
| IS YOUR PAIN WORST AT NIGHT? | YES | NO | |
| DOES YOUR PAIN AWAKEN YOU FROM SLEEP? | YES | NO | |
| DOES COUGHING AFFECT YOUR PAIN? | YES | NO | |

DO YOUR LEGS TIRE/HURT IF YOU WALK TOO FAR? YES NO

IF YES, ANSWER THE FOLLOWING:

HOW FAR CAN YOU WALK LESS THAN 1 BLOCK 1-3 BLOCKS MORE THAN 3 BLOCKS

DOES RESTING YOUR LEGS RELIEVE THE PAIN? YES NO

DOES BENDING FORWARD RELIEVE THE PAIN? YES NO

BLADDER CONTROL (URINE) NO PROBLEM CANNOT EMPTY BLADDER LOSS OF CONTROL
 BOWEL CONTROL: NO PROBLEM CONSTIPATION LOSS OF CONTROL

PATIENT QUESTIONNAIRE

THIS SURVEY ASKS FOR YOUR VIEWS ABOUT YOUR HEALTH. THE INFORMATION WILL HELP KEEP TRACK OF HOW WELL YOU ARE ABLE TO USE YOUR USUAL ACTIVITIES. PLEASE ANSWER EACH QUESTION BY MARKING ONE LINE. IF YOU ARE UNSURE ABOUT HOW TO ANSWER PLEASE GIVE THE BEST ANSWER THAT YOU CAN.

IN GENERAL WOULD YOU SAY THAT YOUR HEALTH IS:
___EXCELLENT ___VERY GOOD ___GOOD ___FAIR___POOR

THE FOLLOWING ITMES ARE ABOUT ACTIVITIES THAT YOU MIGHT DO DURING A TYPICAL DAY. DOES YOUR HEALTH NOW LIMIT YOU FROM THESE ACTIVITIES? IF SO, HOW MUCH.

MODERATE ACTIVITIES SUCH AS MOVING A TABLE, PUSHING A VACUUM CLEANER, BOWLING, OR PLAYING GOLF?
___LIMITED A LOT ___LIMITED A LITTLE ___NOT LIMITED AT ALL

CLIMBING SEVERAL FLIGHTS OF STAIRS?
___LIMITED A LOT ___ LIMITED A LITTLE ___NOT LIMITED AT ALL

DURING THE **PAST 4 WEEKS**, HAVE YOU HAD ANY OF THE FOLLOWING PROBLEMS WITH YOUR WORK OR OTHER REGULAR DAILY ACTIVITIES **AS A RESULT OF YOUR PHYSICAL HEALTH?**
ACCOMPLISH LESS THAN YOU WOULD LIKE. ___YES ___NO
WERE LIMITED IN THE KIND OF WORK OR ACTIVITIES ___YES ___NO

DURING THE **PAST 4 WEEKS**, HAVE YOU HAD ANY OF THE FOLLOWING PROBLEMS WITH YOUR WORK OR OTHER REGULAR DAILY ACTIVITES **AS A RESULT OF ANY EMOTIONAL PROBLEMS** (SUCH AS FEELING DEPRESSED OR ANXIOUS)
ACCOMPLISHED LESS THAN YOU LIKE ___YES ___NO
DID NOT DO WORK OR OTHER ACTIVITIES ___YES ___NO
AS CAREFULLY AS USUAL.

DURING THE **PAST 4 WEEKS** HOW MUCH DID **PAIN** INTERFERE WITH YOUR NORMAL WORK(INCLUDING WORK OUTSIDE THE HOME AND HOUSEWORK
___NOT AT ALL___A LITTLE BIT___MODERATE___QUITE A BIT___EXTREMELY

THESE QUESTIONS ARE ABOUT HOW YOU FEEL AND HOW THINGS HAVE BEEN WITH YOU DURING THE **PAST 4 WEEKS**. FOR EACH QUESTION PLEASE GIVE THE ONE ANSWER THAT COMES CLOSEST TO THE WAY YOU HAVE BEEN FEELING. HOW MUCH OF THE TIME DURING THE **PAST 4 WEEKS**
HAVE YOU FELT CALM AND PEACEFUL
___NOT AT ALL___A LITTLE BIT___MODERATE___QUITE A BIT___EXTREMELY
DID YOU HAVE A LOT OF ENERGY
___NOT AT ALL___A LITTLE BIT___MODERATE___QUITE A BIT___EXTREMELY
HAVE YOU FELT DOWNHEARTED AND BLUE
___NOT AT ALL___A LITTLE BIT___MODERATE___QUITE A BIT___EXTREMELY

DURING THE **PAST 4 WEEKS**, HOW MUCH OF THE TIME HAS YOUR **PHYSICAL HEALTH OR EMOTIONAL PROBLEMS** INTERFERED WITH YOUR SOCIAL ACTIVITIES(LIKE VISITING WITH FRIENDS, RELATIVES, ETC.)
___ALL OF THE TIME___MOST OF THE TIME___SOME OF THE TIME___A LITTLE OF THE TIME
___NONE OF THE TIME

BACK PAIN QUESTIONNAIRE

IF YOU HAVE LOW BACK PAIN PLEASE COMPLETE THIS PAGE, IF YOU ONLY HAVE NECK PAIN, SKIP THIS PAGE.

PLEASE COMPLETE THIS QUESTIONNAIRE. IT IS DESIGNED TO GIVE US INFORMATION ON HOW YOUR BACK (OR LEG) TROUBLE AFFECTED YOUR ABILITY TO MANAGE IN EVERYDAY LIFE. PLEASE ANSWER EVERY SECTION. MARK ONE LINE ONLY IN EACH SECTION THAT MOST CLOSELY DESCRIBES YOU TODAY.

SECTION 1-PAIN INTENSITY

- I HAVE NO PAIN AT THE MOMENT
- THE PAIN IS VERY MILD AT THE MOMENT
- THE PAIN IS MODERATE AT THE MOMENT
- THE PAIN IS FAIRLY SEVERE AT THE MOMENT
- THE PAIN IS VERY SEVERE AT THE MOMENT
- THE PAIN IS THE WORST AT THE MOMENT

SECTION 2-PERSONAL CARE

- I CAN LOOK AFTER MYSELF WITHOUT PAIN
- I CAN LOOK AFTER MYSELF BUT IS CAUSES PAIN
- IT IS PAINFUL TO LOOK AFTER MYSELF, I AM CAREFUL
- I NEED SOME HELP BUT MANAGE MOST OF MY CARE
- I NEED HELP EVERYDAY WITH PERSONAL CARE
- I DO NOT GET DRESSED, WASH WITH DIFFICULTY AND STAY IN BED.

SECTION 3-LIFTING

- I CAN LIFT HEAVY WEIGHT WITHOUT EXTRA PAIN
- I CAN LIFT HEAVY WEIGHT BUT IT GIVES ME PAIN
- PAIN PREVENTS ME FROM LIFTING HEAVY WEIGHTS OFF THE FLOOR, BUT I CAN MANAGE IF THEY ARE ON A TABLE
- I CAN LIFT ONLY VERY LIGHT WEIGHT
- I CANNOT LIFT OR CARRY ANYTHING AT ALL

SECTION 4-WALKING

- PAIN DOES NOT PREVENT ME FROM WALKING ANY DISTANCE
- PAIN PREVENTS ME FROM WALKING MORE THAN 1 MILE
- PAIN PREVENTS ME FROM WALKING MORE THAN ½ MILE
- PAIN PREVENTS ME FROM WALKING MORE THAN 100 YARDS
- I CAN ONLY WALK USING A STICK OR CRUTCHES
- I AM IN BED MOST OF THE TIME AND HAVE TO CRAWL TO THE TOILET

SECTION 5-SITTING

- I CAN SIT STILL IN ANY CHAIR AS LONG AS I LIKE
- I CAN SIT IN MY FAVORITE CHAIR AS LONG AS I LIKE
- PAIN PREVENTS ME FROM SITTING FOR MORE THAN 1 HOUR
- PAIN PREVENTS ME FROM SITTING FOR MORE THAN ½ HOUR
- PAIN PREVENTS ME FROM SITTING FOR MORE THAN 10 MINUTES
- PAIN PREVENTS ME FROM SITTING AT ALL

SECTION 6-STANDING

- I CAN STAND AS LONG AS I WANT WITHOUT PAIN
- I CAN STAND AS LONG AS I WANT BUT IT GIVES ME PAIN
- PAIN PREVENTS ME FROM STANDING FOR MORE THAN 1 HOUR
- PAIN PREVENTS ME FROM STANDING FOR MORE THAN ½ HOUR
- PAIN PREVENTS ME FROM STANDING FOR MORE THAN 10 MINUTES
- PAIN PREVENTS ME FROM STANDING AT ALL

SECTION 7-SLEEPING

- MY SLEEP IS NEVER DISTURBED BY PAIN
- MY SLEEP IS OCCASIONALLY DISTURBED BY PAIN
- BECAUSE OF PAIN I HAVE LESS THAN 6 HOURS SLEEP
- BECAUSE OF PAIN I HAVE LESS THAN 4 HOURS SLEEP
- BECAUSE OF PAIN I HAVE LESS THAN 2 HOURS SLEEP
- PAIN PREVENTS ME FROM SLEEPING AT ALL

SECTION 8-SEX LIFE (IF APPLICABLE)

- MY SEX LIFE IS NORMAL AND CAUSES NO PAIN
- MY SEX LIFE IS NORMAL BUT CAUSES SOME PAIN
- MY SEX LIFE IS NEARLY NORMAL BUT IS VERY PAINFUL
- MY SEX LIFE IS SEVERELY RESTRICTED BY PAIN
- MY SEX LIFE IS NEARLY ABSENT BECAUSE OF PAIN
- PAIN PREVENTS ANY SEX LIFE AT ALL

SECTION 9-SOCIAL LIFE

- MY SOCIAL LIFE IS NORMAL AND CAUSES ME NO EXTRA PAIN
- MY SOCIAL LIFE IS NORMAL BUT INCREASES THE PAIN
- PAIN HAS NO SIGNIFICANT AFFECT ON MY SOCIAL LIFE
- PAIN HAS RESTRICTED MY SOCIAL LIFE AND I DO NOT GO OUT OFTEN
- PAIN HAS RESTRICTED MY SOCIAL LIFE TO MY HOME
- I HAVE TO SOCIAL LIFE BECAUSE OF MY PAIN

SECTION 10-TRAVELING

- I CAN TRAVEL ANYWHERE WITHOUT EXTRA PAIN
- I CAN TRAVEL ANYWHERE BUT IT GIVES ME EXTRA PAIN
- PAIN IS BAD BUT I CAN MANAGE JOURNEYS OVER 2 HOURS
- PAIN RESTRICTS ME TO JOURNEYS OF LESS THAN 1 HOUR
- PAIN RESTRICTS ME TO SHORT NECESSARY JOURNEYS UNDER 30 MINUTES

NECK PAIN QUESTIONNAIRE

IF YOU HAVE NECK PAIN COMPLETE THIS PAGE, IF YOU HAVE ONLY BACK PAIN, SKIP THIS PAGE

PLEASE COMPLETE THIS QUESTIONNAIRE. IT IS DESIGNED TO GIVE US INFORMATION ON HOW YOUR NECK TROUBLE HAS AFFECTED YOUR ABILITY TO MANAGE IN EVERYDAY LIFE. PLEASE ANSWER **EVERY SECTION**. MARK **ONLY ONE LINE** IN EACH SECTION THAT MOST CLOSELY DESCRIBES YOU TODAY.

SECTION 1-PAIN INTENSITY

- I HAVE NO PAIN AT THE MOMENT
- THE PAIN IS VERY MILD AT THE MOMENT
- THE PAIN IS MODERATE AT THE MOMENT
- THE PAIN IS FAIRLY SEVERE AT THE MOMENT
- THE PAIN IS VERY SEVERE AT THE MOMENT
- THE PAIN IS THE WORST IMAGINABLE AT THE MOMENT

SECTION 2-PERSONAL CARE (WASHING, DRESSING, ETC)

- I CAN LOOK AFTER MYSELF NORMALLY WITHOUT CAUSING PAIN
- I CAN LOOK AFTER MYSELF NORMALLY BUT IT IS VERY PAINFUL
- IT IS PAINFUL TO LOOK AFTER MYSELF I AM SLOW AND CAREFUL
- I NEED SOME HELP BUT MANAGE MOST OF MY PERSONAL CARE
- I NEED HELP EVERYDAY IN MOST ASPECTS OF SELF CARE
- I DO NOT GET DRESSED, WASH WITH DIFFICULTY AND STAY IN BED

SECTION 3-LIFTING

- I CAN LIFT HEAVY WEIGHTS WITHOUT EXTRA PAIN
- I CAN LIFT HEAVY WEIGHTS BUT IT GIVES ME EXTRA PAIN
- PAIN PREVENTS ME FROM LIFTING HEAVY WEIGHTS OFF THE FLOOR, BUT I CAN MANAGE IF THEY ARE ON THE TABLE
- I CAN ONLY LIFT VERY LIGHT WEIGHTS
- I CANNOT LIFT OR CARRY ANYTHING AT ALL

SECTION 4-READING

- I CAN READ AS MUCH AS I WANT WITH NO PAIN IN MY NECK
- I CAN READ AS MUCH AS I WANT 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 PAIN IN MY NECK
- I CANNOT READ AS MUCH AS I WANT BECAUSE OF SEVERE PAIN IN MY NECK
- I CANNOT READ AT ALL

SECTION 5-HEADACHES

- I HAVE NO HEADACHES AT ALL
- I HAVE SLIGHT HEADACHES THAT COME INFREQUENTLY
- I HAVE MODERATE HEADACHES THAT COME INFREQUENTLY
- I HAVE MODERATE HEADACHES THAT COME FREQUENTLY
- I HAVE SEVERE HEADACHES WHICH COME FREQUENTLY
- I HAVE HEADACHES ALMOST ALL THE TIME

SECTION 6- CONCENTRATION

- I CAN CONCENTRATE FULLY WHEN I WANT WITH NO DIFFICULTY
- I CAN CONCENTRATE FULLY WHEN I WANT WITH SLIGHT DIFFICULTY
- I HAVE A FAIR DEGREE OF DIFFICULTY CONCENTRATING WHEN I WANT
- I HAVE A LOT OF DIFFICULTY CONCENTRATING WHEN I WANT
- I CANNOT CONCENTRATE AT ALL

SECTION 7-WORK

- I CAN DO AS MUCH WORK AS I WANT TO
- I CAN ONLY DO MY USUAL WORK, BUT NO MORE
- I CAN DO MOST OF MY USUAL WORK, BUT NO MORE
- I CANNOT DO MY USUAL WORK
- I CAN HARDLY DO ANY WORK AT ALL
- I CANNOT DO ANY WORK AT ALL

SECTION 8-DRIVING

- I CAN DRIVE MY CAR WITHOUT ANY NECK PAIN
- I CAN DRIVE MY CAR AS LONG AS I WANT WITH SLIGHT NECK PAIN
- I CAN DRIVE MY CAR AS LONG AS I WANT WITH MODERATE NECK PAIN
- I CANNOT DRIVE AS LONG AS I WANT BECAUSE OF MODERATE NECK PAIN
- I CAN HARDLY DRIVE AT ALL BECAUSE OF SEVERE NECK PAIN
- I CANNOT DRIVE MY CAR AT ALL

SECTION 9-SLEEPING

- I HAVE NO TROUBLE SLEEPING
- MY SLEEP IS SLIGHTLY DISTURBED (< 1 HOUR SLEEPLESS)
- MY SLEEP IS MILDLY DISTURBED (1-2 HOURS SLEEPLESS)
- MY SLEEP IS MODERATELY DISTURBED (2-3 HOURS SLEEPLESS)
- MY SLEEP IS GREATLY DISTURBED (3-5 HOURS SLEEPLESS)
- MY SLEEP IS COMPLETELY DISTURBED (5-7 HOURS SLEEPLESS)

SECTION 10-RECREATION

- I AM ABLE TO ENGAGE IN ALL OF MY RECREATIONAL ACTIVITIES WITH NO NECK PAIN AT ALL
- I AM ABLE TO ENGAGE IN ALL OF MY RECREATIONAL ACTIVITIES WITH SOME PAIN IN MY NECK
- I AM ABLE TO ENGAGE IN MOST, BUT NOT ALL OF MY USUAL RECREATIONAL ACTIVITIES BECAUSE OF NECK PAIN
- I AM ABLE TO ENGAGE IN A FEW OF MY USUAL RECREATIONAL ACTIVITIES BECAUSE OF NECK PAIN