

# APPLICATION FOR CARE AT Hill Family Chiropractic, P.A.

Whom may we thank for referring you to this office? \_\_\_\_\_

Today's Date: \_\_\_\_\_

HRN: \_\_\_\_\_

## PATIENT DEMOGRAPHICS

Name: \_\_\_\_\_ Birth Date: \_\_\_\_-\_\_\_\_-\_\_\_\_ Age: \_\_\_\_\_ ☐ Male ☐ Female

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

E-mail Address: \_\_\_\_\_ Home Phone: \_\_\_\_\_ Mobile Phone: \_\_\_\_\_

Marital Status: ☐ Single ☐ Married Do you have Insurance: ☐ Yes ☐ No Work Phone: \_\_\_\_\_

Social Security #: \_\_\_\_\_ Driver's License #: \_\_\_\_\_

Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_

Spouse's Name \_\_\_\_\_ Spouse's Employer \_\_\_\_\_

Number of children and ages: \_\_\_\_\_

Name & Number of Emergency Contact: \_\_\_\_\_ Relationship: \_\_\_\_\_

## HISTORY OF COMPLAINT

Please identify the condition(s) that brought you to this office:

Primary: \_\_\_\_\_ Secondary: \_\_\_\_\_

Third: \_\_\_\_\_ Fourth: \_\_\_\_\_

On a scale of **1** to **10**. With **10** being the **worst** pain and **zero** being **no** pain: Rate your above complaints by **CIRCLING THE NUMBER**:

**Primary** complaint: 0 - 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10

**Second** complaint: 0 - 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10

**Third** complaint: 0 - 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10

**Fourth** complaint: 0 - 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10

When did the problem(s) begin? \_\_\_\_\_ When is the problem at its worst? ☐ AM ☐ PM ☐ Mid-Day ☐ late PM  
How long does it last? ☐ It is constant OR ☐ I experience it on and off during the day OR ☐ It comes and goes throughout the week  
How did the injury happen? \_\_\_\_\_

Condition(s) ever been treated by anyone in the past? ☐ No ☐ Yes (If yes):

When & By whom? \_\_\_\_\_ How long were you under care: \_\_\_\_\_

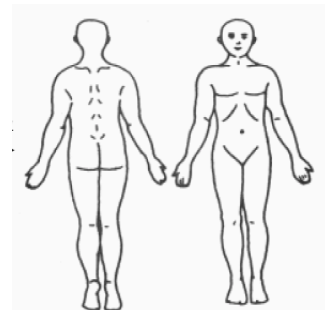
What were the results? \_\_\_\_\_ Name of Previous Chiropractor: \_\_\_\_\_ ☐ N/A

What **relieves** your symptoms? \_\_\_\_\_

What makes your symptoms **feel worse**? \_\_\_\_\_

**PLEASE MARK** the areas on the Diagram with the following **letters** to describe your symptoms:

R = Radiating B = Burning D = Dull A = Aching N = Numbness S = Sharp/Stabbing T = Tingling



**LIST RESTRICTED ACTIVITY:****CURRENT ACTIVITY LEVEL:****USUAL ACTIVITY LEVEL:**

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Identify any other injury(s) to your spine, minor or major, that the doctor should know about:

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**PAST HISTORY**

Have you suffered with any of this or a similar problem in the past? ☐ No ☐ Yes If yes, how many times? \_\_\_\_\_

When was the last episode? \_\_\_\_\_ How did the injury happen? \_\_\_\_\_

Other forms of treatment tried: ☐ No ☐ Yes (If yes) please state what type of treatment: \_\_\_\_\_

who provided it: \_\_\_\_\_, How long ago: \_\_\_\_\_, What were the results: \_\_\_\_\_

☐ Favorable

☐ Unfavorable ☐ please explain. \_\_\_\_\_

Please identify any and all types of jobs you have had in the past that have imposed any physical stress on you or your body:

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If you have ever been diagnosed with any of the following conditions, please indicate with a **P** for in the **Past**, **C** for **Currently** have or **N** for **Never** have had:

\_\_\_ Broken Bone \_\_\_ Dislocations \_\_\_ Tumors \_\_\_ Rheumatoid Arthritis \_\_\_ Fracture \_\_\_ Disability \_\_\_ Cancer

\_\_\_ Heart Attack \_\_\_ Osteo Arthritis \_\_\_ Diabetes \_\_\_ Cerebral Vascular \_\_\_ Other serious conditions: \_\_\_\_\_

PLEASE identify ALL PAST and any CURRENT conditions you feel may be contributing to your present problem:

|                                             | <u>HOW LONG AGO</u> | <u>TYPE OF CARE RECEIVED</u> | <u>BY WHOM</u> |
|---------------------------------------------|---------------------|------------------------------|----------------|
| INJURIES <input type="checkbox"/>           |                     |                              |                |
| SURGERIES <input type="checkbox"/>          |                     |                              |                |
| CHILDHOOD DISEASES <input type="checkbox"/> |                     |                              |                |
| ADULT DISEASES <input type="checkbox"/>     |                     |                              |                |

**SOCIAL HISTORY**

1. Smoking: ☐ cigars ☐ pipe ☐ cigarettes How often? ☐ Daily ☐ Weekends ☐ Occasionally ☐ Never

2. Alcoholic Beverage: consumption occurs ☐ Daily ☐ Weekends ☐ Occasionally ☐ Never

3. Recreational Drug use: ☐ Daily ☐ Weekends ☐ Occasionally ☐ Never

4. Hobbies -Recreational Activities- Exercise Regime: How does your present problem affect? (See ADL form)

**FAMILY HISTORY:**

1. Does anyone in your family suffer with the same condition(s)? ☐ No ☐ Yes

If yes whom: ☐ Grandmother ☐ Grandfather ☐ Mother ☐ Father ☐ Sister(s) ☐ Brother(s) ☐ Son(s) ☐ Daughter(s)

Have they ever been treated for their condition? ☐ No ☐ Yes ☐ I don't know

2. Any other hereditary conditions the doctor should be aware of? ☐ No ☐ Yes: \_\_\_\_\_

Is your problem the result of ANY type of accident? ☐ Yes, ☐ No

Patient signature: \_\_\_\_\_ Today's Date: \_\_/\_\_/\_\_

## ACTIVITIES OF LIFE

Please identify how your current condition is affecting your ability to carry out activities that are routinely part of your life:

| <u>ACTIVITIES:</u>       | <u>EFFECT:</u>                     |                                           |                                           |                                            |
|--------------------------|------------------------------------|-------------------------------------------|-------------------------------------------|--------------------------------------------|
| Carry Children/Groceries | <input type="checkbox"/> No Effect | <input type="checkbox"/> Painful (can do) | <input type="checkbox"/> Painful (limits) | <input type="checkbox"/> Unable to Perform |
| Sit to Stand             | <input type="checkbox"/> No Effect | <input type="checkbox"/> Painful (can do) | <input type="checkbox"/> Painful (limits) | <input type="checkbox"/> Unable to Perform |
| Climb Stairs             | <input type="checkbox"/> No Effect | <input type="checkbox"/> Painful (can do) | <input type="checkbox"/> Painful (limits) | <input type="checkbox"/> Unable to Perform |
| Pet Care                 | <input type="checkbox"/> No Effect | <input type="checkbox"/> Painful (can do) | <input type="checkbox"/> Painful (limits) | <input type="checkbox"/> Unable to Perform |
| Extended Computer Use    | <input type="checkbox"/> No Effect | <input type="checkbox"/> Painful (can do) | <input type="checkbox"/> Painful (limits) | <input type="checkbox"/> Unable to Perform |
| Lift Children/Groceries  | <input type="checkbox"/> No Effect | <input type="checkbox"/> Painful (can do) | <input type="checkbox"/> Painful (limits) | <input type="checkbox"/> Unable to Perform |
| Read/Concentrate         | <input type="checkbox"/> No Effect | <input type="checkbox"/> Painful (can do) | <input type="checkbox"/> Painful (limits) | <input type="checkbox"/> Unable to Perform |
| Getting Dressed          | <input type="checkbox"/> No Effect | <input type="checkbox"/> Painful (can do) | <input type="checkbox"/> Painful (limits) | <input type="checkbox"/> Unable to Perform |
| Shaving                  | <input type="checkbox"/> No Effect | <input type="checkbox"/> Painful (can do) | <input type="checkbox"/> Painful (limits) | <input type="checkbox"/> Unable to Perform |
| Sexual Activities        | <input type="checkbox"/> No Effect | <input type="checkbox"/> Painful (can do) | <input type="checkbox"/> Painful (limits) | <input type="checkbox"/> Unable to Perform |
| Sleep                    | <input type="checkbox"/> No Effect | <input type="checkbox"/> Painful (can do) | <input type="checkbox"/> Painful (limits) | <input type="checkbox"/> Unable to Perform |
| Static Sitting           | <input type="checkbox"/> No Effect | <input type="checkbox"/> Painful (can do) | <input type="checkbox"/> Painful (limits) | <input type="checkbox"/> Unable to Perform |
| Static Standing          | <input type="checkbox"/> No Effect | <input type="checkbox"/> Painful (can do) | <input type="checkbox"/> Painful (limits) | <input type="checkbox"/> Unable to Perform |
| Yard work                | <input type="checkbox"/> No Effect | <input type="checkbox"/> Painful (can do) | <input type="checkbox"/> Painful (limits) | <input type="checkbox"/> Unable to Perform |
| Walking                  | <input type="checkbox"/> No Effect | <input type="checkbox"/> Painful (can do) | <input type="checkbox"/> Painful (limits) | <input type="checkbox"/> Unable to Perform |
| Washing/Bathing          | <input type="checkbox"/> No Effect | <input type="checkbox"/> Painful (can do) | <input type="checkbox"/> Painful (limits) | <input type="checkbox"/> Unable to Perform |
| Sweeping/Vacuuming       | <input type="checkbox"/> No Effect | <input type="checkbox"/> Painful (can do) | <input type="checkbox"/> Painful (limits) | <input type="checkbox"/> Unable to Perform |
| Dishes                   | <input type="checkbox"/> No Effect | <input type="checkbox"/> Painful (can do) | <input type="checkbox"/> Painful (limits) | <input type="checkbox"/> Unable to Perform |
| Laundry                  | <input type="checkbox"/> No Effect | <input type="checkbox"/> Painful (can do) | <input type="checkbox"/> Painful (limits) | <input type="checkbox"/> Unable to Perform |
| Garbage                  | <input type="checkbox"/> No Effect | <input type="checkbox"/> Painful (can do) | <input type="checkbox"/> Painful (limits) | <input type="checkbox"/> Unable to Perform |
| Driving                  | <input type="checkbox"/> No Effect | <input type="checkbox"/> Painful (can do) | <input type="checkbox"/> Painful (limits) | <input type="checkbox"/> Unable to Perform |
| Other: _____             | <input type="checkbox"/> No Effect | <input type="checkbox"/> Painful (can do) | <input type="checkbox"/> Painful (limits) | <input type="checkbox"/> Unable to Perform |

List Prescription & Nonprescription drugs you take: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

WHO IS YOUR M.D.: \_\_\_\_\_

**\*We offer massages by a licensed massage therapist. Will you be implementing the benefits of massage therapy in your care?** \_\_\_\_\_

Patient signature: \_\_\_\_\_ Today's Date: \_\_/\_\_/\_\_

Continued on next page

Please Mark using the letters: P for in the Past, C for Currently have, or N for Never:

- |                                                                |                                                       |
|----------------------------------------------------------------|-------------------------------------------------------|
| <input type="checkbox"/> HEADACHE                              | <input type="checkbox"/> DOUBLE VISION                |
| <input type="checkbox"/> NECK PAIN                             | <input type="checkbox"/> RINGING IN EARS              |
| <input type="checkbox"/> JAW PAIN/ TMJ                         | <input type="checkbox"/> LOSS OF HEARING              |
| <input type="checkbox"/> SHOULDER PAIN                         | <input type="checkbox"/> DEPRESSION                   |
| <input type="checkbox"/> UPPER BACK PAIN                       | <input type="checkbox"/> IRRITABILITY                 |
| <input type="checkbox"/> MID BACK PAIN                         | <input type="checkbox"/> CHANGES IN MOOD              |
| <input type="checkbox"/> LOW BACK PAIN                         | <input type="checkbox"/> ADD/ADHD                     |
| <input type="checkbox"/> HIP PAIN                              | <input type="checkbox"/> ALLERGIES                    |
| <input type="checkbox"/> BACK CURVATURE                        | <input type="checkbox"/> PROSTATE PROBLEMS            |
| <input type="checkbox"/> SCOLIOSIS                             | <input type="checkbox"/> IMPOTENCE/SEXUAL DYSFUNCTION |
| <input type="checkbox"/> NUMBNESS/TINGLING (ARMS HAND,FINGERS) | <input type="checkbox"/> DIGESTIVE PROBLEMS           |
| <input type="checkbox"/> NUMBNESS/TINGLING (LEG,FEET,TOES)     | <input type="checkbox"/> COLON TROUBLE                |
| <input type="checkbox"/> HIV/AIDS                              | <input type="checkbox"/> DIARRHEA/CONSTIPATION        |
| <input type="checkbox"/> CURRENTLY PREGNANT                    | <input type="checkbox"/> MENOPAUSAL PROBLEMS          |
| <input type="checkbox"/> FREQUENT COLDS/FLU                    | <input type="checkbox"/> MENSTRUAL PROBLEMS           |
| <input type="checkbox"/> CONVULSIONS/EPILEPSY                  | <input type="checkbox"/> PMS                          |
| <input type="checkbox"/> TREMORS                               | <input type="checkbox"/> BED WETTING                  |
| <input type="checkbox"/> CHEST PAIN                            | <input type="checkbox"/> LEARNING DISABILITIES        |
| <input type="checkbox"/> PAIN WHEN COUGHING/SNEEZING           | <input type="checkbox"/> EATING DISORDER              |
| <input type="checkbox"/> FOOT OR KNEE PAIN/PROBLEMS            | <input type="checkbox"/> HEARTBURN                    |
| <input type="checkbox"/> SINUS/DRAINAGE ISSUES                 | <input type="checkbox"/> HEART CONDITION              |
| <input type="checkbox"/> SWOLLEN/PAINFUL JOINTS                | <input type="checkbox"/> HIGH BLOOD PRESSURE          |
| <input type="checkbox"/> SKIN PROBLEMS/ISSUES                  | <input type="checkbox"/> LOW BLOOD PRESSURE           |
| <input type="checkbox"/> TROUBLE SLEEPING                      | <input type="checkbox"/> ASTHMA                       |
| <input type="checkbox"/> ULCERS                                | <input type="checkbox"/> DIFFICULTY BREATHING         |
| <input type="checkbox"/> DIZZINESS                             | <input type="checkbox"/> LUNG CONDITION               |
| <input type="checkbox"/> LOSS OF BALANCE                       | <input type="checkbox"/> KIDNEY CONDITION             |
| <input type="checkbox"/> SYNCOPE (FAINTING)                    | <input type="checkbox"/> GALL BLADDER CONDITION       |
| <input type="checkbox"/> BLURRED VISION                        | <input type="checkbox"/> LIVER CONDITION              |
|                                                                | <input type="checkbox"/> HEPATITIS (A/B/C)            |

Patient signature: \_\_\_\_\_ Today's Date: \_\_/\_\_/\_\_

**Hill Family Chiropractic, P.A.**  
**Informed Consent**

**REGARDING:** Chiropractic Adjustments, Modalities, and Therapeutic Procedures:

*I have been advised that chiropractic care, like all forms of health care, holds certain risks. While the risk are most often very minimal, in rare cases, complications such as sprain/strain injuries, irritation of a disc condition, and although rare, minor fractures, and possible stroke, which occurs at a rate between one instance per one million to one per two million, have been associated with chiropractic adjustments.*

*Treatment objectives as well as the risks associated with chiropractic adjustments and all other procedures provided at [Hill Family Chiropractic, P.A.](#) have been explained to me to my satisfaction and I have conveyed my understanding of both to the doctor. After careful consideration, I do hereby consent to treatment by any means, method, and or techniques, the doctor deems necessary to treat my condition at any time throughout the entire clinical course of my care.*

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  Witness Initials  
**Patient or Authorized Person's Signature** **Date**

**REGARDING:** X-rays/Imaging Studies

**FEMALES ONLY** ☐ *please read carefully and check the boxes, include the appropriate date, then sign below if you understand and have no further questions, otherwise see our receptionist for further explanation.*

☐ **The first day of my last menstrual cycle was on** \_\_\_\_ - \_\_\_\_ - \_\_\_\_ **(Date)**

☐ I have **been provided** a full explanation of when I am most likely to **become pregnant**, and to the **best of my knowledge**, I am **not** pregnant.

*By my signature below I am acknowledging that the doctor and or a member of the staff has discussed with me the hazardous effects of ionization to an unborn child, and I have conveyed my understanding of the risks associated with exposure to x-rays. After careful consideration I therefore, do hereby consent to have the diagnostic x-ray examination the doctor has deemed necessary in my case.*

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  Witness Initials  
**Patient or Authorized Person's Signature** **Date**

*I hereby authorize payment to be made directly to [Hill Family Chiropractic, P.A.](#) for all benefits which may be payable under a healthcare plan or from any other collateral sources. I authorize utilization of this application or copies thereof for the purpose of processing claims and effecting payments, and further acknowledge that this assignment of benefits does not in any way relieve me of payment liability and that I will remain financially responsible to [Hill Family Chiropractic, P.A.](#) for any and all services I receive at this office.*

\_\_\_\_\_  
**Patient or Authorized Person's Signature**

\_\_\_\_\_-\_\_\_\_\_-\_\_\_\_\_  
**Date Completed**

\_\_\_\_\_  
**Patient or Authorized Person's Signature**

\_\_\_\_\_-\_\_\_\_\_-\_\_\_\_\_  
**Date Completed**

**Doctor's Signature**

**Date Form Reviewed**

This office is required, by law, to maintain the privacy and security of your Protected Health Information. We must provide you with written notice concerning your rights to your health information, and the potential circumstances under which, by law, or as dictated by our office policy, we are permitted to use and disclose information about you to a third party without your authorization. Below is a brief summary of these circumstances. If you would like a more detailed explanation, one will be provided to you. Please review carefully, sign receipt of acknowledgement, and return to our front desk staff. **Keep this page for your records.**

**YOUR RIGHTS:**

1. To inspect or obtain a copy of your records within 15 days of your request. We may charge a reasonable, cost-based fee for a copy. X-rays are original records, and you are therefore not entitled to them. If you would like us to outsource them to have copies made, we will be happy to accommodate you. However, you will be responsible for this cost.
2. To ask for amendments to your health information you think is incomplete or incorrect. We may say "no" to your request, but we'll tell you why in writing within 60 days.
3. To request confidential communications (contact you in a specific way or send mail to a different address).
4. To request restrictions on certain uses and disclosures, and with whom we release information to, although we are not required to comply. If we do agree, the restriction is in place until receiving written notice of your intent to remove the restriction.
5. To receive an accounting of disclosures (those with whom we've shared your information).
6. To receive a paper copy of the extended detail Notice of Privacy Practices.
7. To choose someone to act for you. If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
8. To file a complaint if you feel your rights are violated

**USES AND DISCLOSURES:**

1. Treatment purposes - use your health information and share it with other health care providers who are treating you.
2. Run our organization - use and share your health information to run our practice, improve your care, and contact you when necessary.
3. Bill for your services - use and share your health information to bill and get payment from health plans or other entities.
4. Inadvertent disclosures – an open treating area means open discussion. If you need to speak privately with the doctor, please let our staff know so we can place you in a private room.
5. Help with public health and safety issues - in order to prevent or lessen a serious or eminent threat to the health or safety of a person or general public.
6. For health research purposes.
7. Comply with the law - share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.
8. Work with a medical examiner or funeral director - share health information with a coroner, medical examiner, or funeral director in the event of a patient's death.
9. For workers' compensation claims, law enforcement purposes or with a law enforcement official, and other government requests – including health oversight agencies for activities authorized by law, special government functions such as military, national security, and presidential protective services.
10. Respond to lawsuits and legal actions - share health information about you in response to a court or administrative order, or in response to a subpoena.
11. Emergency – in the event of a medical emergency we may notify a family member.
12. Phone calls and/or emails – we may call your home and leave messages regarding appointment reminders or apprise you of changes in practice hours or upcoming events.
13. Change of ownership - in the event this practice is sold your health information will become the property of the new owner. You maintain the right to request copies of your health information be transferred to another provider.

To the extent that we have your substance use disorder patient records, subject to 42 CFR part 2, we will not share that information for investigations or legal proceedings against you without (1) your written consent or (2) a court order and a subpoena.

**COMPLAINT:**

If you wish to make a complaint about how we handle your health information, please contact our privacy official using the information noted above. If you are still not satisfied with the manner in which this office handles your complaint, you can submit a formal complaint to:

U.S. Dept. of Health and Human Services, Office of Civil Rights  
200 Independence Avenue, SW, Washington DC 20201  
877-696-6775  
[www.hhs.gov/ocr/privacy/hipaa/complaints/](http://www.hhs.gov/ocr/privacy/hipaa/complaints/)

**NOTICE REGARDING YOUR RIGHT TO PRIVACY continued ...**

Please complete the following where indicated and return to our front desk staff.

Patient initials: \_\_\_\_\_ - retaining *page 1 of 2*

I hereby acknowledge I have read and received a copy of Hill Family Chiropractic, P.A.'s Privacy Practices Notice.

I understand my rights as well as the practice's duty to protect my health information, and have conveyed my understanding of these rights and duties to the doctor. I further understand that this office reserves the right to amend this "Notice of Privacy Practices" at any time in the future and will make the new provisions effective for all information that it maintains past and present.

I am aware the practice will not use or share my information other than as described here unless I have provided written authorization stating otherwise. I understand I may change my mind at any time by providing written notification to the practice.

I am aware an extended detail version of this "Notice" is available to me upon request.

At this time, I do not have any questions regarding my rights or any of the information I have received.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Print Name: \_\_\_\_\_ Telephone: \_\_\_\_\_

If not signed by the patient, please indicate relationship:

\_\_\_\_\_ Parent or guardian of minor patient

\_\_\_\_\_ Guardian or conservator of an incompetent patient

\_\_\_\_\_ Beneficiary or personal representative of deceased patient

Name of Patient: \_\_\_\_\_

**For Office Use Only**

Signed form received by: \_\_\_\_\_

Reason acknowledgment not obtained: \_\_\_\_\_

Efforts to obtain: \_\_\_\_\_

PATIENT'S NAME: \_\_\_\_\_ HR#: \_\_\_\_\_ DATE: \_\_\_\_\_

## HIPAA Personal Health Information Release

I, \_\_\_\_\_, hereby authorize [Insert Practice Name] to discuss with and/or release information to the following people concerning my appointments, insurance, billing, and health treatment rendered.

- ☐ Spouse Name: \_\_\_\_\_
- ☐ Significant Other Name: \_\_\_\_\_
- ☐ Parent/Legal Guardian Name: \_\_\_\_\_
- ☐ Child(ren) Name(s): \_\_\_\_\_
- ☐ Any Specified Person Name: \_\_\_\_\_
- ☐ Information is not to be discussed with or released to anyone.

### Restrictions:

- ☐ No Restrictions
- ☐ Only discuss my appointment time with the above-named individual(s).
- ☐ Only discuss issues concerning my account, including insurance and/or billing with the above-named individual(s).
- ☐ Only discuss the health treatment rendered to me with the above-named individual(s).

### Messages:

Please call ☐ my home ☐ my work ☐ my cell phone  
Phone Number: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

If unable to reach me:

- ☐ you may leave a detailed message
- ☐ please leave a message asking me to return your call
- ☐ \_\_\_\_\_

I understand I may terminate this consent at any time by giving written notice to [Insert Practice Name]. Any changes to this form will require a new consent form to be completed, signed, and dated.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

## QUADRUPLE VISUAL ANALOGUE SCALE

Patient Name \_\_\_\_\_

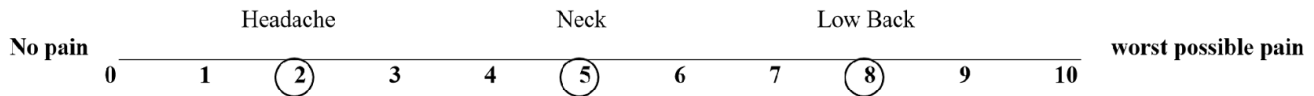
Date \_\_\_\_\_

**Please read carefully:**

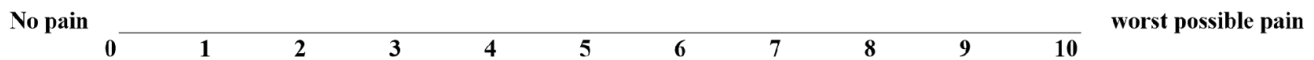
**Instructions:** Please circle the number that best describes the question being asked.

**Note:** If you have more than one complaint, please answer each question for each individual complaint and indicate the score for each complaint. Please indicate your pain level right now, average pain, and pain at its best and worst.

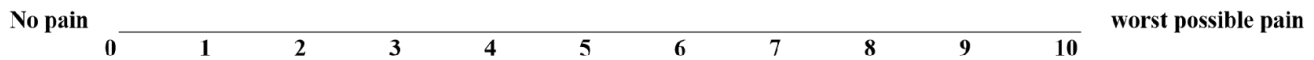
**Example:**



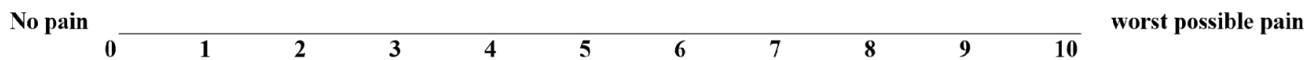
**1 – What is your pain RIGHT NOW?**



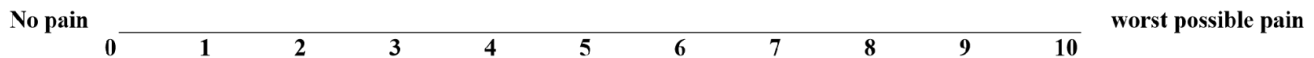
**2 – What is your TYPICAL or AVERAGE pain?**



**3 – What is your pain level AT ITS BEST (How close to “0” does your pain get at its best)?**



**4 – What is your pain level AT ITS WORST (How close to “10” does your pain get at its worst)?**



**OTHER COMMENTS:**

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Examiner \_\_\_\_\_

Reprinted from *Spine*, 18, Von Korff M, Deyo RA, Cherkin D, Barlow SF, Back pain in primary care: Outcomes at 1 year, 855-862, 1993, with permission from Elsevier Science.