

## CONFIDENTIAL PATIENT INFORMATION

First Name \_\_\_\_\_ M.I. \_\_\_\_\_ Last Name \_\_\_\_\_  
 Address \_\_\_\_\_ Unit # \_\_\_\_\_ City \_\_\_\_\_  
 State \_\_\_\_\_ Zip \_\_\_\_\_ Birth Date (mm/dd/yyyy) \_\_\_\_\_ Age \_\_\_\_\_ Sex:  M  F  
 Home # (\_\_\_\_\_) \_\_\_\_\_ Work # (\_\_\_\_\_) \_\_\_\_\_ Ext. \_\_\_\_\_  
 Cell # (\_\_\_\_\_) \_\_\_\_\_ E-mail \_\_\_\_\_  
 Which phone # would you prefer us to contact you with?  Home  Work  Cell  Other \_\_\_\_\_  
 Marital Status:  Single  Married  Other \_\_\_\_\_ Spouse Name \_\_\_\_\_ # of Children \_\_\_\_\_  
 Occupation (optional) \_\_\_\_\_ Employer (optional) \_\_\_\_\_  
 Spouse Occupation (optional) \_\_\_\_\_ Spouse Employer (optional) \_\_\_\_\_  
 Name of Family Doctor \_\_\_\_\_ Family Doctor # (\_\_\_\_\_) \_\_\_\_\_  
 When doctors work together it benefits you. May we have your permission to update your medical doctor regarding your care at this office?  Y  N  
 How did you hear about our office? \_\_\_\_\_

## INSURANCE INFORMATION

Please  all insurance coverage that may be applicable in this case:  
 Major Medical  Medicare  Flex Plans  Auto  Work Comp  Other \_\_\_\_\_  
**Auto Accident & Work Comp Patients Only:**  Auto  Work Comp  N/A  
 Insurance Carrier Name \_\_\_\_\_  
 Insurance Carrier Address \_\_\_\_\_  
 Date of Injury \_\_\_\_\_ Claim Number \_\_\_\_\_  
 Adjuster's Name \_\_\_\_\_ Adjuster's Telephone (\_\_\_\_\_) \_\_\_\_\_

## PRESENT MEDICAL HISTORY

Purpose of today's visit: \_\_\_\_\_  
 Date symptoms appeared or accident happened: \_\_\_\_\_  
 Have you ever had the same or a similar condition?  Y  N If yes, when: \_\_\_\_\_  
 Days lost from work: \_\_\_\_\_ Last physical exam (date): \_\_\_\_\_

**Describe each SYMPTOM that you are having. Indicate severity on pain scale: 1=No Pain and 10=Worst Pain.**

### PAIN OR SYMPTOM DESCRIPTION:

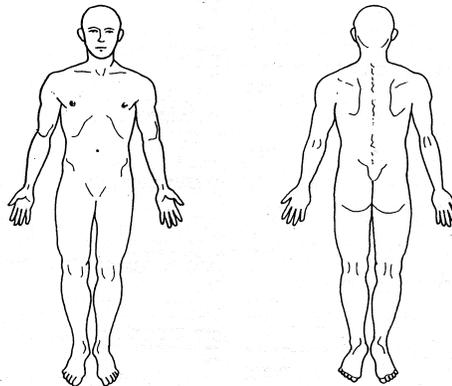
1. \_\_\_\_\_  
 2. \_\_\_\_\_  
 3. \_\_\_\_\_

### SEVERITY OF PAIN SCALE:

1 2 3 4 5 6 7 8 9 10  
1 2 3 4 5 6 7 8 9 10  
1 2 3 4 5 6 7 8 9 10

**PAIN DRAWING:** Mark your painful spots on the picture.

Ache >>> Burning x x x Numbness = = = Pins/Needles o o o Stabbing /// Throbbing ~ ~ ~



Symptoms occur in: Morning Afternoon Night Consistently Come & Go Other  
Symptoms have persisted for (number): \_\_\_Hours \_\_\_Days \_\_\_Weeks \_\_\_Months \_\_\_Years

Check the following activities that **AGGRAVATE YOUR CONDITION:**

Bending Coughing Lifting Lying Reaching Sitting Sneezing  
Standing Turning Head Walking Straining at Stool Other \_\_\_\_\_

Check the following activities that **RELIEVE YOUR CONDITION:**

Bending Lifting Lying Reaching Sitting Standing Turning Head  
Walking Stretching Self Massage Cold Pack Hot Pack Other \_\_\_\_\_

## PAST MEDICAL HISTORY

Have you ever been diagnosed as having or have suffered from:

<input type="checkbox"/> Alcoholism	<input type="checkbox"/> Coughing Blood	<input type="checkbox"/> Fractured Bones	<input type="checkbox"/> Osteoarthritis
<input type="checkbox"/> Blurred Vision	<input type="checkbox"/> Depression	<input type="checkbox"/> Headaches	<input type="checkbox"/> Pace Maker
<input type="checkbox"/> Buzzing Ears	<input type="checkbox"/> Diarrhea	<input type="checkbox"/> High/Low Blood Pressure	<input type="checkbox"/> Rheumatoid Arthritis
<input type="checkbox"/> Cancer	<input type="checkbox"/> Dizziness	<input type="checkbox"/> HIV Positive	<input type="checkbox"/> Seizures/Convulsions
<input type="checkbox"/> Circulatory Problems	<input type="checkbox"/> Drug Addiction	<input type="checkbox"/> Insomnia	<input type="checkbox"/> Shortness of Breath
<input type="checkbox"/> Chronic Fatigue	<input type="checkbox"/> Eating Disorder	<input type="checkbox"/> Light Bothers Eyes	<input type="checkbox"/> Stiff Neck
<input type="checkbox"/> Cold Hands/Feet	<input type="checkbox"/> Epilepsy	<input type="checkbox"/> Loss of Balance	<input type="checkbox"/> Strokes
<input type="checkbox"/> Congenital Disease	<input type="checkbox"/> Excessive Bleeding	<input type="checkbox"/> Loss of Concentration	<input type="checkbox"/> Ulcers
<input type="checkbox"/> Constipation	<input type="checkbox"/> Fainting	<input type="checkbox"/> Muscle Jerking	<input type="checkbox"/> Other _____

Do you have a history of Stroke or Hypertension? Y N Describe \_\_\_\_\_  
Have you had any other major illnesses, injuries, car accidents, surgeries, or hospitalizations (include dates)?  
**Women**, include information about childbirths \_\_\_\_\_

Are you taking any medications/drugs? Y N Describe \_\_\_\_\_  
Do you have any allergies? Y N Describe \_\_\_\_\_  
Have you been treated by a physician for any health condition in the last year? Y N  
Describe condition(s) \_\_\_\_\_

♀ **Women:** Any menstrual difficulties? Y N Describe \_\_\_\_\_  
Are you pregnant? Y N Last Period (date) \_\_\_\_\_  
Last Pap (date) \_\_\_\_\_ Last Mammogram (date) \_\_\_\_\_

## FAMILY MEDICAL HISTORY

Father: Living \_\_\_ Age \_\_\_ Cause of death & age, if deceased: \_\_\_\_\_ (✓ below)  
Mother: Living \_\_\_ Age \_\_\_ Cause of death & age, if deceased: \_\_\_\_\_ (✓ below)

**FAMILY DISEASES:** Indicate whether Father, Mother, Sister, Brother, if applicable:

Arthritis Cancer Kidney Disease Stroke  
Back Pain Heart Disease Scoliosis Other \_\_\_\_\_

## AUTHORIZATION AND RELEASE

I authorize payment of insurance benefits directly to this office. I authorize the release of any information necessary to communicate with healthcare providers and to my insurance company. I understand that I am responsible for all costs of chiropractic care, regardless of insurance coverage. I also understand that if I terminate my schedule of care as determined by my treating doctor, fees for chiropractic services will be immediately due by providing a credit card to be stored on our security file. I am authorizing The Centre for Chiropractic Health, Ltd. to charge my credit card for any unpaid bills or claims.

Patient Name (Print): \_\_\_\_\_ Date: \_\_\_\_\_

Patient Signature: \_\_\_\_\_

## INFORMED CONSENT AND AUTHORIZATION TO TREAT

**Please read and sign the informed consent. This must be read and signed prior to the doctor performing an examination. If you have any questions or concerns, please address them to the doctor.**

### **CHIROPRACTIC:**

Doctors of Chiropractic (D.C.) who use manual therapy techniques such as spinal adjustments are required to advise patients that there may be some risks associated with such treatment.

- a) While rare, some patients have experienced rib fractures, or muscle and ligament strains or sprains following spinal adjustments.
- b) Some types of spinal adjustments of the neck have been associated with injuries to the arteries in the neck leading to or contributing to serious complications including stroke. Stroke has been the subject of tremendous disagreement within and without the profession, with prominent authority saying that there is at most a one-in-a-million chance of such an outcome. We employ tests in our examination, which are designed to identify if you may be susceptible to that kind of injury.
- c) There have been rare reported cases of disc injuries following neck or low back adjustments although no scientific study has ever demonstrated such injuries are caused, or may be caused, by spinal adjustments or chiropractic treatment.

Chiropractic treatment, including spinal adjustments, has been the subject of government reports and multidisciplinary studies conducted over many years and have been demonstrated to be highly effective in treating spinal pain, headaches and other symptoms. Chiropractic care contributes to your overall well-being. The risk of injuries or complications from chiropractic treatment is substantially lower than that associated with many medical or other treatments, medications, and procedures given for the same symptoms.

### **ACUPUNCTURE:**

If acupuncture is performed, I understand and am informed that in the practice of acupuncture there are some risks to treatment, including but not limited to, minor bleeding or bruising, minor pain or soreness, nausea, fainting, infection, shock, convulsions, and stuck or bent needles. I have been advised that only sterilized needles will be used. All acupuncture needles are properly disposed of after each and every treatment.

**I do not expect the doctor to be able to anticipate and explain all possible risks and complications. I wish to rely on the doctor to exercise judgment during the course of treatment which the doctor feels at the time, based upon the facts then known, are in my best interests. I understand that the results are not guaranteed. I acknowledge I have discussed, or have had the opportunity to discuss, with my chiropractor the nature and purpose of the chiropractic treatment (may include spinal adjustments and/or acupuncture) as well as the contents of this Consent. I consent to the treatments recommended to me by my chiropractor.**

Patient Name (Print): \_\_\_\_\_ Date: \_\_\_\_\_

Patient Signature: \_\_\_\_\_

## Neck Pain and Disability Index (Vernon-Minor)

Patient Name: \_\_\_\_\_ File # \_\_\_\_\_ Date: \_\_\_\_\_

This questionnaire has been designed to give the doctor information as to how your back pain has affected your ability to manage everyday life. Please answer every section and mark in each section only the 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.

<p><b>SECTION 1 - PAIN INTENSITY</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> I have no pain at the moment.</li> <li><input type="checkbox"/> The pain is very mild at the moment.</li> <li><input type="checkbox"/> The pain is moderate at the moment.</li> <li><input type="checkbox"/> The pain is fairly severe at the moment.</li> <li><input type="checkbox"/> The pain is very severe at the moment.</li> <li><input type="checkbox"/> The pain is the worst imaginable at the moment.</li> </ul> <p><b>SECTION 2 - PERSONAL CARE</b> (Washing, Dressing, etc)</p> <ul style="list-style-type: none"> <li><input type="checkbox"/> I can look after myself normally without causing extra pain.</li> <li><input type="checkbox"/> I can look after myself normally but it causes extra pain.</li> <li><input type="checkbox"/> It is painful to look after myself and I am slow and careful.</li> <li><input type="checkbox"/> I need some help but manage most of my personal care.</li> <li><input type="checkbox"/> I need help every day in most aspects of self care.</li> <li><input type="checkbox"/> I do not get dressed, I wash with difficulty and stay in bed.</li> </ul> <p><b>SECTION 3 - LIFTING</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> I can lift heavy weights without extra pain.</li> <li><input type="checkbox"/> I can lift heavy weights but it gives extra pain.</li> <li><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.</li> <li><input type="checkbox"/> Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.</li> <li><input type="checkbox"/> I can lift very light weights.</li> <li><input type="checkbox"/> I cannot lift or carry anything at all.</li> </ul> <p><b>SECTION 4 - READING</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> I can read as much as I want to with no pain in my neck.</li> <li><input type="checkbox"/> I can read as much as I want to with slight pain in my neck.</li> <li><input type="checkbox"/> I can read as much as I want with moderate pain in my neck.</li> <li><input type="checkbox"/> I can't read as much as I want because of moderate pain in my neck.</li> <li><input type="checkbox"/> I can hardly read at all because of severe pain in my neck.</li> <li><input type="checkbox"/> I cannot read at all.</li> </ul> <p><b>SECTIONS 5 HEADACHES</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> I have no headaches at all.</li> <li><input type="checkbox"/> I have slight headaches which come infrequently.</li> <li><input type="checkbox"/> I have moderate headaches which come infrequently.</li> <li><input type="checkbox"/> I have moderate headaches which come frequently.</li> <li><input type="checkbox"/> I have severe headaches which come frequently.</li> <li><input type="checkbox"/> I have headaches almost all the time.</li> </ul>	<p><b>SECTION 6 - CONCENTRATION</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> I can concentrate fully when I want to with no difficulty.</li> <li><input type="checkbox"/> I can concentrate fully when I want to with slight difficulty.</li> <li><input type="checkbox"/> I have a fair degree of difficulty in concentrating when I want to.</li> <li><input type="checkbox"/> I have a lot of difficulty in concentrating when I want to.</li> <li><input type="checkbox"/> I have a great deal of difficulty in concentrating when I want to.</li> <li><input type="checkbox"/> I cannot concentrate at all.</li> </ul> <p><b>SECTION 7 - WORK</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> I can do as much work as I want to.</li> <li><input type="checkbox"/> I can only do my usual work, but no more.</li> <li><input type="checkbox"/> I can do most of my usual work, but no more.</li> <li><input type="checkbox"/> I cannot do my usual work.</li> <li><input type="checkbox"/> I can hardly do any work at all.</li> <li><input type="checkbox"/> I can't do any work at all.</li> </ul> <p><b>SECTION 8 - DRIVING</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> I can drive my car without any neck pain.</li> <li><input type="checkbox"/> I can drive my car as long as I want with slight pain in my neck.</li> <li><input type="checkbox"/> I can drive my car as long as I want with moderate pain in my neck.</li> <li><input type="checkbox"/> I can't drive my car as long as I want because of moderate pain in my neck.</li> <li><input type="checkbox"/> I can hardly drive at all because of severe pain in my neck.</li> <li><input type="checkbox"/> I can't drive my car at all.</li> </ul> <p><b>SECTION 9 - SLEEPING</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> I have no trouble sleeping</li> <li><input type="checkbox"/> My sleep is slightly disturbed (less than 1 hr. sleepless).</li> <li><input type="checkbox"/> My sleep is mildly disturbed (1-2 hrs. sleepless).</li> <li><input type="checkbox"/> My sleep is moderately disturbed (2-3 hrs. sleepless).</li> <li><input type="checkbox"/> My sleep is greatly disturbed (3-5 hrs. sleepless).</li> <li><input type="checkbox"/> My sleep is completely disturbed (5-7 hrs. sleepless).</li> </ul> <p><b>SECTION 10 - RECREATION</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> I am able to engage in all my recreation activities with no neck pain at all.</li> <li><input type="checkbox"/> I am able to engage in all my recreation activities, with some pain in my neck.</li> <li><input type="checkbox"/> I am able to engage in most, but not all of my usual recreation activities because of pain in my neck.</li> <li><input type="checkbox"/> I am able to engage in a few of my usual recreation activities because of pain in my neck.</li> <li><input type="checkbox"/> I can hardly do any recreation activities because of pain in my neck.</li> <li><input type="checkbox"/> I can't do any recreation activities at all.</li> </ul>
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**Pain Severity Scale:**

Rate the Severity of your pain by checking one box on the following scale:

No pain	<table border="1" style="display: inline-table; border-collapse: collapse;"> <tr> <td style="width: 20px; height: 20px; text-align: center;">0</td> <td style="width: 20px; height: 20px; text-align: center;">1</td> <td style="width: 20px; height: 20px; text-align: center;">2</td> <td style="width: 20px; height: 20px; text-align: center;">3</td> <td style="width: 20px; height: 20px; text-align: center;">4</td> <td style="width: 20px; height: 20px; text-align: center;">5</td> <td style="width: 20px; height: 20px; text-align: center;">6</td> <td style="width: 20px; height: 20px; text-align: center;">7</td> <td style="width: 20px; height: 20px; text-align: center;">8</td> <td style="width: 20px; height: 20px; text-align: center;">9</td> <td style="width: 20px; height: 20px; text-align: center;">10</td> </tr> </table>	0	1	2	3	4	5	6	7	8	9	10	Excruciating Pain
0	1	2	3	4	5	6	7	8	9	10			

# DISABILITIES OF THE ARM, SHOULDER AND HAND

Please rate your ability to do the following activities in the last week by circling the number below the appropriate response.

	NO DIFFICULTY	MILD DIFFICULTY	MODERATE DIFFICULTY	SEVERE DIFFICULTY	UNABLE
1. Open a tight or new jar.	1	2	3	4	5
2. Write.	1	2	3	4	5
3. Turn a key.	1	2	3	4	5
4. Prepare a meal.	1	2	3	4	5
5. Push open a heavy door.	1	2	3	4	5
6. Place an object on a shelf above your head.	1	2	3	4	5
7. Do heavy household chores (e.g., wash walls, wash floors).	1	2	3	4	5
8. Garden or do yard work.	1	2	3	4	5
9. Make a bed.	1	2	3	4	5
10. Carry a shopping bag or briefcase.	1	2	3	4	5
11. Carry a heavy object (over 10 lbs).	1	2	3	4	5
12. Change a lightbulb overhead.	1	2	3	4	5
13. Wash or blow dry your hair.	1	2	3	4	5
14. Wash your back.	1	2	3	4	5
15. Put on a pullover sweater.	1	2	3	4	5
16. Use a knife to cut food.	1	2	3	4	5
17. Recreational activities which require little effort (e.g., cardplaying, knitting, etc.).	1	2	3	4	5
18. Recreational activities in which you take some force or impact through your arm, shoulder or hand (e.g., golf, hammering, tennis, etc.).	1	2	3	4	5
19. Recreational activities in which you move your arm freely (e.g., playing frisbee, badminton, etc.).	1	2	3	4	5
20. Manage transportation needs (getting from one place to another).	1	2	3	4	5
21. Sexual activities.	1	2	3	4	5

# DISABILITIES OF THE ARM, SHOULDER AND HAND

	NOT AT ALL	SLIGHTLY	MODERATELY	QUITE A BIT	EXTREMELY
22. During the past week, <i>to what extent</i> has your arm, shoulder or hand problem interfered with your normal social activities with family, friends, neighbours or groups? ( <i>circle number</i> )	1	2	3	4	5

	NOT LIMITED AT ALL	SLIGHTLY LIMITED	MODERATELY LIMITED	VERY LIMITED	UNABLE
23. During the past week, were you limited in your work or other regular daily activities as a result of your arm, shoulder or hand problem? ( <i>circle number</i> )	1	2	3	4	5

Please rate the severity of the following symptoms in the last week. (*circle number*)

	NONE	MILD	MODERATE	SEVERE	EXTREME
24. Arm, shoulder or hand pain.	1	2	3	4	5
25. Arm, shoulder or hand pain when you performed any specific activity.	1	2	3	4	5
26. Tingling (pins and needles) in your arm, shoulder or hand.	1	2	3	4	5
27. Weakness in your arm, shoulder or hand.	1	2	3	4	5
28. Stiffness in your arm, shoulder or hand.	1	2	3	4	5

	NO DIFFICULTY	MILD DIFFICULTY	MODERATE DIFFICULTY	SEVERE DIFFICULTY	SO MUCH DIFFICULTY THAT I CAN'T SLEEP
29. During the past week, how much difficulty have you had sleeping because of the pain in your arm, shoulder or hand? ( <i>circle number</i> )	1	2	3	4	5

	STRONGLY DISAGREE	DISAGREE	NEITHER AGREE NOR DISAGREE	AGREE	STRONGLY AGREE
30. I feel less capable, less confident or less useful because of my arm, shoulder or hand problem. ( <i>circle number</i> )	1	2	3	4	5

**DASH DISABILITY/SYMPTOM SCORE** = \_\_\_\_\_ ( [(sum of n responses / n) - 1] x 25, where n is the number of completed responses.)

A DASH score may not be calculated if there are greater than 3 missing items.

## Low Back Pain and Disability Questionnaire (Revised Oswestry)

Patient Name: \_\_\_\_\_ File # \_\_\_\_\_ Date: \_\_\_\_\_

This questionnaire has been designed to give the doctor information as to how your back pain has affected your ability to manage everyday life. Please answer every section and mark in each section only the 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

- 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 very severe.
- The pain is severe and does not vary much.

### SECTION 2 - PERSONAL CARE

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

### SECTION 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.
- Pain prevents me from lifting heavy weights off the floor, but I manage if they are conveniently positioned (e.g. on a table).
- 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.

### SECTION 4 - WALKING

- I have no pain on walking.
- I have some pain on walking but it does not increase with distance.
- I cannot walk more than one mile without increasing pain.
- I cannot walk more than 1/2 mile without increasing pain.
- I cannot walk more than 1/4 mile without increasing pain.
- I cannot walk at all without increasing pain.

### SECTION 5 - SITTING

- I can sit in any chair as long as I like.
- I can only sit in my favorite chair as long as I like.
- Pain prevents me from sitting more than one hour.
- Pain prevents me from sitting more than half hour.
- Pain prevents me from sitting more than 10 minutes.
- I avoid sitting because it increases pain straight away.

### SECTION 6 - STANDING

- I can stand as long as I want without pain.
- I have some pain on 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.
- I cannot stand for longer than 10 minutes without increasing pain.
- I avoid standing because it increases the pain straight away.

### SECTION 7 - SLEEPING

- I get no pain in bed.
- I get pain in bed but it does not prevent me from sleeping well.
- Because of pain my normal night's sleep is reduced by less than 1/4.
- Because of pain my normal night's sleep is reduced by less than 1/2.
- Because of pain my normal night's sleep is reduced by less than 3/4.
- Pain prevents me from sleeping at all.

### SECTION 8 - SOCIAL LIFE

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

### SECTION 9 - TRAVELLING

- I get no pain whilst traveling.
- I get some pain whilst traveling but none of my usual forms of travel make it any worse.
- I get extra pain whilst traveling but it does not compel me to seek alternative forms of travel.
- I get extra pain whilst 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.

### SECTION 10 - CHANGING DEGREE OF PAIN

- 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.

### Pain Severity Scale:

Rate the Severity of your pain by checking one box on the following scale

No pain	0	1	2	3	4	5	6	7	8	9	10	Excruciating Pain
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## THE LOWER EXTREMITY FUNCTIONAL SCALE

We are interested in knowing whether you are having any difficulty at all with the activities listed below because of your lower limb problem for which you are currently seeking attention. Please provide an answer for each activity.

**Today, do you or would you have any difficulty at all with:**

	Activities	Extreme Difficulty or Unable to Perform Activity	Quite a Bit of Difficulty	Moderate Difficulty	A Little Bit of Difficulty	No Difficulty
1	Any of your usual work, housework, or school activities.	0	1	2	3	4
2	Your usual hobbies, recreational or sporting activities.	0	1	2	3	4
3	Getting into or out of the bath.	0	1	2	3	4
4	Walking between rooms.	0	1	2	3	4
5	Putting on your shoes or socks.	0	1	2	3	4
6	Squatting.	0	1	2	3	4
7	Lifting an object, like a bag of groceries from the floor.	0	1	2	3	4
8	Performing light activities around your home.	0	1	2	3	4
9	Performing heavy activities around your home.	0	1	2	3	4
10	Getting into or out of a car.	0	1	2	3	4
11	Walking 2 blocks.	0	1	2	3	4
12	Walking a mile.	0	1	2	3	4
13	Going up or down 10 stairs (about 1 flight of stairs).	0	1	2	3	4
14	Standing for 1 hour.	0	1	2	3	4
15	Sitting for 1 hour.	0	1	2	3	4
16	Running on even ground.	0	1	2	3	4
17	Running on uneven ground.	0	1	2	3	4
18	Making sharp turns while running fast.	0	1	2	3	4
19	Hopping.	0	1	2	3	4
20	Rolling over in bed.	0	1	2	3	4
	<b>Column Totals:</b>					

**Minimum Level of Detectable Change (90% Confidence): 9 points**

**Please submit the sum of responses to ASH**

**SCORE: \_\_\_\_\_ / 80**

*Reprinted from Binkley, J., Stratford, P., Lott, S., Riddle, D., & The North American Orthopaedic Rehabilitation Research Network, The Lower Extremity Functional Scale: Scale development, measurement properties, and clinical application, Physical Therapy, 1999, 79, 4371-383, with permission of the American Physical Therapy Association.*