The Healing Arts Clinic at Multnomah Village

An Association of Independent Practitioners

Joyce D. McClure, DC, DACRB – Don Fuegy, DC
3644 SW Troy St. Suite 200 – Portland, Oregon 97219

Patient Name ____ Date ____________________

CONFIDENTIAL PATIENT INFORMATION / MVC

Address ____________________________________ City ____________ State ____ Zip ________

Home Phone ________________ Work Phone ________________ Mobile ____________________

Email _____________________________ Driver license/ID #: _____________________________

Birth date _________ Age ____ Height ____ Weight ____ Spouse/Partner Name_________________

Purpose for Visit ______________________________ Referred by: _________________________

AUTOMOBILE INSURANCE INFORMATION

Who owns the vehicle in which you were hit? ____

Do you or someone else have insurance coverage for the vehicle you were in? ☐ YES ☐ NO

How is this person related to you? ☐ Self ☐ Parent ☐ Friend ☐ Other

Have you reported this injury to your insurance carrier? ☐ YES ☐ NO

Name of *your* Auto Insurance Carrier ____

Adjuster's Name ________________________________ **Phone** ____________________________

Claim Number _______________________________

Name **of *other party's* Insurance Carrier, if known:** _______________________________________

Do you have an attorney representing you? ☐ YES ☐ NO

If yes, please indicate name, address and telephone number of your retained attorney:

Attorney's Name _______________________________ Phone ____________________________

Address ____

Doctor's Notes:

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Patient Name ____ Date ____________________

Date of collision: __________________ **Time of collision:** ____________ ☐ AM ☐`PM

Estimated damage to your vehicle? $ ___________ ☐ Unknown ☐ Estimate not done yet

Street/intersection where collision occurred ____

Did the police come to the scene? ☐ YES ☐ NO Report written? ☐ YES ☐ NO

Was the street wet or dry? ☐ Wet☐ Dry **Where were you seated?** ________________________

Number of vehicles involved? __________ **Number of *other* occupants** (your car)? __________

Make/Model/Year of your car: ____ ☐ Unknown

Make/Model/Year of other car(s): ______________________________________ ☐ Unknown

Type of accident: ***check all that apply:***

☐ Single-vehicle collision ☐ Two-vehicle collision ☐ Three-or-more vehicles

☐ Rear-end collision ☐ Head-on collision ☐ Side collision ___________

☐ Rollover ☐ Ran off road ☐ Hit guard rail, tree, or object

Please draw and describe what happened:

____

____

____

____

____

At the moment of impact:

Were you aware of the impending collision? ☐ YES ☐ NO

If YES, were you able to brace yourself? ☐ YES ☐ NO

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Patient Name ____ Date ____________________

Were you wearing a seatbelt? ☐ YES ☐ NO Type: ☐ Lap Belt only ☐ Lap/Shoulder harness

Position of headrest: __________ None ________ Integrated or adjusted in ___________ position.

What direction were you looking?__________________ **Body position?** ______________________

Were you holding onto the steering wheel? ☐ YES ☐ NO Both hands? ☐ YES ☐ NO

Was your foot on the brake? ☐ YES ☐ NO ☐ Unknown

Did airbags deploy? ______ If yes, location of airbags deployed: _____________________________

Did you hit anything inside your vehicle (Describe)? _______________________________________

Did you lose consciousness? ☐ YES ☐ NO

If YES, for how long? ____________________________

Were you transported to hospital via ambulance? ☐ YES ☐ NO

If YES, name of Hospital: _________________________

At the moment of impact your vehicle was:

☐ Slowing down ☐ Speeding up ☐ Stopped ☐ Moving at constant speed

At the moment of impact the other vehicle was:

☐ Slowing down ☐ Speeding up ☐ Stopped ☐ Moving at constant speed

During and after the collision, your vehicle:

☐ Continued forward, not hitting anything
☐ Continued forward, hitting car/object in front
☐ Was hit by another vehicle
☐ Spun around, not hitting anything
☐ Spun around, hitting another car
☐ Spun around, hitting object/curb

If moving, please describe direction/speed: _____________________________________

Was there more than one impact? ☐ YES ☐ NO

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Patient Name ____ Date ____________________

Describe how you felt immediately after the accident: _____________________________________

____

Describe how you felt that night: ____

____

Describe how you felt the next day: ____

____

Did you have any areas of bruising after the collision? If yes please describe below. □ YES □ NO

____

Have you missed work as a result? _________ **Dates missed:** _________________________

Have you taken medications to manage symptoms related to these injuries? □ YES □ NO

What medications/timing/amounts? ____

When was the last time you had treatment prior to the Motor Vehicle Accident? ______________

List any physical complaints prior to the accident? (When did they start, and cause?)

____

____

Have you ever experienced similar symptoms to what you're experiencing now? ______________

____

Have you seen any other doctors for this injury? Please list:

Doctor #1 __________________________ X-Ray? __________ Date of 1st visit: ______________

Medications/Therapy prescribed: ____

Doctor #2 __________________________ X-Ray? __________ Date of 1st visit: ______________

Medications/Therapy prescribed: ____

Doctor #3 __________________________ X-Ray? __________ Date of 1st visit: ______________

Medications/Therapy prescribed: ____

Date of last visit: _____________ Treatment: ____

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Patient Name ____ Date ____________________

PLEASE DESCRIBE YOUR <u>MOST BOTHERSOME</u> COMPLAINT/SYMPTOM:

____

ONSET: Describe what caused these symptoms: (did you strike any object/item upon impact?)

____

PROVOKING: What activities/positions aggravate this condition? (**please circle**)

sitting / standing / lying down / sleeping / walking / reaching / bending / other

PALLIATIVE: Does anything make it feel better? (**please circle**)

ice / heat / sleeping / lying down / pain relievers / stretching / other

QUALITY: How would you describe the pain? (**please circle**)

sharp / electric / tingling / burning / stabbing / grabbing / aching / deep / other

Please circle areas you have sensations radiating into:

shoulder blade / arm / forearm / hand / buttock / thigh / leg / foot / other ______

Please circle the way you would describe these radiating sensations:

sharp / electric / tingling / burning / stabbing / grabbing / aching / deep / other

SEVERITY: Rate your level of pain on a scale of 0 – 10 with 0 being no pain and 10 being constant pain that prevents all activities. (**please circle**)

0 1 2 3 4 5 6 7 8 9 10

FREQUENCY: How often are your symptoms present?

Constant all day / Intermittent throughout day / Occasionally

PATTERN: Do you notice any particular pattern of pain? (**please circle**)

Most painful: in the morning / in the evening / after work / other ______________

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Patient Name ____ Date ____________________

PLEASE DESCRIBE ANY ADDITIONAL COMPLAINT(S) / SYMPTOM(S):

____

ONSET: Describe what caused these symptoms: (did you strike any object/item upon impact?)

____

PROVOKING: What activities/positions aggravate this condition? (**please circle**)

sitting / standing / lying down / sleeping / walking / reaching / bending / other

PALLIATIVE: Does anything make it feel better? (**please circle**)

ice / heat / sleeping / lying down / pain relievers / stretching / other

QUALITY: How would you describe the pain? (**please circle**)

sharp / electric / tingling / burning / stabbing / grabbing / aching / deep / other

Please circle areas you have sensations radiating into:

shoulder blade / arm / forearm / hand / buttock / thigh / leg / foot / other ______

Please circle the way you would describe these radiating sensations:

sharp / electric / tingling / burning / stabbing / grabbing / aching / deep / other

SEVERITY: Rate your level of pain on a scale of 0 – 10 with 0 being no pain and 10 being constant pain that prevents all activities. (**please circle**)

0 1 2 3 4 5 6 7 8 9 10

FREQUENCY: How often are your symptoms present?

Constant all day / Intermittent throughout day / Occasionally

PATTERN: Do you notice any particular pattern of pain? (**please circle**)

Most painful: in the morning / in the evening / after work / other ______________

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Patient Name ____ Date ____________________

Previous auto accidents (dates): ____

Any physical residuals from previous auto accidents?_____________________________________

Date of last physical exam ________________ **Date of last laboratory screening** ______________

Any unusual findings? ____

List any medications/supplements you are currently taking: _______________________________

____

Other doctors consulted for above condition? (dates) ____________________________________

Have you had previous chiropractic care? □ YES □ NO

If YES, when was the last time you were adjusted? ______________________________

Do you have a past history of injuries involving: (dates)

ankles ____________________ knees ____________________ hips ____________________

wrists ____________________ elbows___________________ shoulders_________________

Surgical operations (dates and description):

____

____

Have you had X-rays taken of your spine within the last 10 years? _________________________

Location and date of X-rays ____

Location and date of MRIs ____

MEN: Date of last prostate exam ________________ Date of last colon exam ________________

Any unusual findings? ____

WOMEN: Date of last pap smear _______________ Date of last mammogram _______________

Any unusual findings? ____

Do you have breast implants? _________________ Date implanted ________________________

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Patient Name ____ Date ____________________

Do you exercise regularly? ☐ YES ☐ NO If yes, how many times per week? _____________

If yes, what activities? ____

When you engage in the physical activity noted above, **what is the average duration of activity?**

☐ Less than 10 minutes ☐ 10 – 20 mins ☐ 20 – 30 mins ☐ 30 – 60 mins ☐ over 60 mins

When you engage in the physical activity noted above, **what do you feel the level of effort is?** ____________

____

At work, how many days per week do you engage in tasks that are intense enough to cause sweating and a rapid heart rate?____

Please rate your level of fitness (0 = very poor, 5 = average, 10 = excellent) __________________________

PLEASE CHECK ANY OF THE FOLLOWING YOU ARE CURRENTLY EXPERIENCING

HEAD

_____ Headache
_____ Loss of balance
_____ Dizziness
_____ Deafness
_____ Ringing in ear(s)
_____ Jaw pain
_____ Fainting
_____ Eye Pain
_____ Failing Vision
_____ Frequent nosebleeds
_____ Sinus Infection(s)

CHEST

_____ Chest Pain
_____ Difficulty breathing
_____ Asthma
_____ Other

ABDOMEN

_____ Difficult digestion
_____ Abdominal cramps
_____ Diarrhea
_____ Constipation
_____ Nausea
_____ Change in urinary function
_____ Change in bowel function
_____ Hemorrhoids

OTHER

_____ Fatigue
_____ Loss of sleep/insomnia
_____ Nervousness
_____ Fever
_____ Change in menstrual cycle
_____ Hot flashes
_____ Numbness/tingling

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Patient Name ____ Date ____________________

Do you or other family members have a history of any of the following?

Condition				
Arthritis	☐ Family member	☐ Self	☐ Medications	____________________
Asthma	☐ Family member	☐ Self	☐ Medications	____________________
Autoimmune	☐ Family member	☐ Self	☐ Medications	____________________
Cancer	☐ Family member	☐ Self	☐ Medications	____________________
Depression	☐ Family member	☐ Self	☐ Medications	____________________
Diabetes	☐ Family member	☐ Self	☐ Medications	____________________
Fibromyalgia	☐ Family member	☐ Self	☐ Medications	____________________
Heart Disease	☐ Family member	☐ Self	☐ Medications	____________________
High Cholesterol	☐ Family member	☐ Self	☐ Medications	____________________
Hypertension	☐ Family member	☐ Self	☐ Medications	____________________
Kidney Disease	☐ Family member	☐ Self	☐ Medications	____________________
Mental Illness	☐ Family member	☐ Self	☐ Medications	____________________
Migraines	☐ Family member	☐ Self	☐ Medications	____________________
Stroke/TIA	☐ Family member	☐ Self	☐ Medications	____________________

PLEASE GIVE DATES FOR ANY OF THE FOLLOWING YOU HAVE HAD PREVIOUSLY:

_____ Alcoholism
_____ Allergies
_____ Anemia
_____ Arteriosclerosis
_____ Appendectomy
_____ Chemical dependency
_____ Chicken Pox
_____ Colitis
_____ Concussion/head injury
_____ Diphtheria
_____ Eating disorder
_____ Eczema
_____ Emphysema
_____ Epilepsy
_____ Fractures
_____ Glaucoma
_____ Goiter
_____ Gout
_____ Gall bladder problems
_____ HIV/AIDS
_____ Hepatitis
_____ Herniated disc
_____ Irritable Bowel Syndrome
_____ Kidney stone or infection
_____ Liver problems
_____ Measles
_____ Mumps
_____ Malaria
_____ Multiple sclerosis
_____ Numbness in hands/feet
_____ Osteoporosis
_____ Pacemaker
_____ Pinched nerve
_____ Polio
_____ Pneumonia
_____ Prostate problems
_____ Pleurisy
_____ Scarlet Fever
_____ Scoliosis
_____ Small Pox
_____ Tuberculosis
_____ Thyroid trouble
_____ Ulcers
_____ Whooping cough
_____ Weakness in arms or legs

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Please list any allergies that you have

____

____

PLEASE MARK ALL THAT APPLY:

_____ Avoid dairy

_____ Avoid wheat

_____ Avoid corn

_____ Avoid sugar

_____ Avoid night snacks

_____ Avoid nuts

_____ Drink alcohol _____ per week

_____ History of smoking ☐ current ☐ past

_____ Recreational drugs ________________

_____ Caffeinated drinks ________ cups/day

_____ Soda _________ cans/day

_____ Anabolic steroids / EPO / Other

Any other health conditions you currently have? (Please list condition and any medications)

____

____

____

____

What medications, vitamins, supplements, herbs do you take?

Name	Reason

Do you have any other concerns?_______________________________

____

____

____

______________________	______________
Patient Signature	**Date**

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INFORMED CONSENT TO CHIROPRACTIC CARE

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy, on me (or on the patient named below, for whom I am legally responsible) by the above named doctors of chiropractic.

Though chiropractic treatments are usually beneficial and rarely cause any problem, I understand that, like many other forms of health care, there are some risks. These can include but are not limited to fractures, disc injuries, strokes, dislocations, and sprains.

Alternatives to chiropractic treatment for common musculoskeletal conditions may include physical therapy, medications such as muscle relaxers and anti-inflammatory drugs, and acupuncture.

I have had the opportunity to discuss with the doctor the purpose, benefits, and risks of the recommended chiropractic care, and alternatives to chiropractic treatment have been reviewed.

I further understand that health care providers cannot guarantee the results of treatment. I acknowledge that no guarantee of the outcome of the chiropractic care I have requested has been made. I have had ample opportunity to ask questions, and my questions have been answered to my satisfaction.

____

Patient's name (printed) Today's Date

____

Signature of patient or parent/guardian (if patient is a minor)

*******STOP HERE*******

Portion Below Used If Additional Information Requested and Received

I requested and received, in substantial detail, further explanation of the procedure or treatment. I was also given information about material risks of the procedure or treatment and other alternative procedures or methods. I give my permission and consent to the procedure or treatment.

____

Signature Today's Date

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YF FORM

NAME ______________________________ **Primary complaint** ______________________________

1. Please indicate your usual level of pain during **the past week**:
No pain 0 1 2 3 4 5 6 7 8 9 10 Worst possible pain

2. Does pain, numbness, tingling or weakness extend into your leg (from the low back) &/or arm (from the neck)?
None of the time 0 1 2 3 4 5 6 7 8 9 10 All of the time

3. How would you **rate your general health**? (10-x)
Poor 0 1 2 3 4 5 6 7 8 9 10 Excellent

4. If you had to spend the rest of your life with your condition as it is right now, how would you feel about it?
Delighted 0 1 2 3 4 5 6 7 8 9 10 Terrible

5. How anxious (eg. tense, uptight, irritable, fearful, difficulty in concentrating / relaxing) you have been feeling during **the past week:**
Not at all 0 1 2 3 4 5 6 7 8 9 10 Extremely anxious

6. How much you have been able to control (i.e., reduce/help) your pain/complaint on your own during **the past week:**
I can reduce it 0 1 2 3 4 5 6 7 8 9 10 I can't reduce it at all

7. Please indicate how depressed (eg. Down-in-the-dumps, sad, downhearted, in low spirits, pessimistic, feelings of hopelessness) you have been feeling in **the past week:**
Not depressed at all 0 1 2 3 4 5 6 7 8 9 10 Extremely depressed

8. On a scale of 0 to 10, how certain are you that you will be doing normal activities or working in **six months**?
Very certain 0 1 2 3 4 5 6 7 8 9 10 Not certain at all

9. I can do light work for an hour?
Completely agree 0 1 2 3 4 5 6 7 8 9 10 Completely disagree

10. I can sleep at night
Completely agree 0 1 2 3 4 5 6 7 8 9 10 Completely disagree

11. An increase in pain is an indication that I should stop what I am doing until the pain decreases.
Completely disagree 0 1 2 3 4 5 6 7 8 9 10 Completely agree

12. Physical activity makes my pain worse?
Completely disagree 0 1 2 3 4 5 6 7 8 9 10 Completely agree

13. I should not do my normal activities including work with my present pain.
Completely disagree 0 1 2 3 4 5 6 7 8 9 10 Completely agree

Please sign your name ____________________________________ **Date** ______________

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Effective Date: September 21, 2013

Health Insurance Portability and Accountability Act (HIPAA)
Notice of Patient Privacy Policy

Joyce D. McClure DC PC, The Healing Arts Clinic, an association of independent practitioners, and its staff are dedicated to preserving your personal health information. We are required by law to protect your personal medical information and to provide you with a notice describing how your medical information may be used and disclosed as well as how you can access this information.

Under HIPAA, we are able to use or disclose to others your medical information for purposes of providing or arranging for your healthcare, the payment for or reimbursement of the care that we provide to you, and the related administrative activities supporting your treatment.

We may be required by law to use and disclose your medical information for other purposes without your consent or authorization.

You are provided the right to inspect and receive a copy of your medical information that we maintain, amending or correcting that information, obtaining an accounting of or disclosures of your medical information, requesting that we communicate with you confidentially, requesting that we restrict certain uses and disclosures of your health information, and complaining if you think your rights have been violated. We in turn reserve our legal right of having 30 days to produce such information.

We have available a detailed **NOTICE OF PRIVACY PRACTICES** which fully explains your rights and our obligations under the law. We may revise our NOTICE from time to time. The Effective Date at the top right hand side of this page indicates the date of the most current NOTICE in effect.

You have the right to receive a copy of our most current NOTICE in effect. If you have not yet received a copy of our current NOTICE, please ask at the front desk and we will provide you with a copy.

If you have any questions, concerns or complaints about the NOTICE or your medical information, please contact Jennifer DeChane, Office Manager/Compliance Officer at (503) 293-3001.

I acknowledge that I have read the above and understand I may request a detailed version of privacy practices at this clinic.

____________________________________ ____________
Printed Name Date

____
Signature

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Financial Policy

1) All payments, including co-pays, are due at the time of service, unless special arrangements have been agreed upon prior to visit.
2) We accept cash, checks, Visa, and MasterCard.
3) As a courtesy to our patients, we will bill your insurance company for you. However, an insurance contract is between you, the patient, and your insurance company, therefore,
you are financially responsible for anything your insurance does not cover.
4) All supplements/vitamins, supports and other supplies ***must*** be paid for at the time they are received.
5) You are responsible for timely payment of your account.

Workers Compensation Claims

6) All workers' compensation cases will be billed directly to the insurance company, providing the appropriate paperwork has been filled out and a claim is filed with your employer. If the claim is denied, we will bill your private insurance carrier, if you have applicable coverage. Please keep in mind that if your claim is denied, you are responsible for prompt payment of your account.

Personal Injury/Motor Vehicle Accidents

7) Personal injury and auto accident cases will be billed to your auto insurance company, providing a claim has been filed and the appropriate paperwork has been completed. This includes a Personal Injury Protection (PIP) form, and any other forms required by your insurance company.
8) We do not do third party billings to other insurance companies.
9) If you choose not to file a claim with your auto insurance company, or are uninsured, your account will be treated as a cash account, and all fees will be due at the time of service.
10) Supplements/vitamins, supports, and other supplies may not be covered by insurance companies, and must be paid for at the time they are received. Should the insurance company cover the cost of these items, we will reimburse you for the amount paid by your insurance.

Missed Appointments

We request at least a 24-hour notice when appointments must be cancelled or rescheduled, except in the case of illness or family emergency. There is a charge of $40 for no-shows or cancellations with less than 24-hour notice.

I have read, understand, and agree to Dr. McClure's financial policy. In addition, I authorize the payment of benefits to Joyce D. McClure, D.C., P.C.

____ ____________

Patient/Guardian Signature Date

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Joyce D. McClure, DC, DACRB – Don Fuegy, DC

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NECK PAIN DISABILITY INDEX QUESTIONNAIRE

PLEASE READ*: This questionnaire is designed to enable us to understand how much your neck pain has affected your ability to manage your everyday activities. Please answer each section by circling the ONE CHOICE that most applies to you. We realize that 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 NOW.

SECTION 1 - Pain Intensity

A I have no pain at the moment.
B The pain is very mild at the moment.
C The pain is moderate at the moment.
D The pain is fairly severe at the moment.
E The pain is very severe at the moment.
F The pain is the worst imaginable at the moment.

SECTION 2 -Personal Care (Washing,Dressing,etc.)

A I can look after myself normally without causing extra pain.
B I can look after myself normally, but it causes extra pain.
C It is painful to look after myself and I am slow and careful.
D I need some help, but manage most of my personal care.
E I need help every day in most aspects of self care.
F I do not get dressed, I wash with difficulty and stay in bed.

SECTION 3 - Lifting

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

SECTION 4 - Reading

A I can read as much as I want to with no pain in my neck.
B I can read as much as I want to with slight pain in my neck.
C I can read as much as I want to with moderate pain in my neck.
D I cannot read as much as I want because of moderate pain in my neck.
E I cannot read as much as I want because of severe pain in my neck.
F I cannot read at all.

SECTION 5 - Headaches

A I have no headaches at all.
B I have slight headaches which come infrequently.
C I have moderate headaches which come infrequently.
D I have moderate headaches which come frequently.
E I have severe headaches which come frequently.
F I have headaches almost all the time.

SECTION 6 - Concentration/

A I can concentrate fully when I want to with no difficulty.
B I can concentrate fully when I want to with slight difficulty.
C I have a fair degree of difficulty in concentrating when I want to.
D I have a lot of difficulty in concentrating when I want to.
E I have a great deal of difficulty in concentrating when I want to.
F I cannot concentrate at all.

SECTION 7 - Work

A I can do as much work as I want to.
B I can only do my usual work, but no more.
C I can do most of my usual work, but no more.
D I cannot do my usual work.
E I can hardly do any work at all.
F I cannot do any work at all.

SECTION 8 - Driving

A I can drive my car without any neck pain.
B I can drive my car as long as I want with slight pain in my neck.
C I can drive my car as long as I want with moderate pain in my neck.
D I cannot drive my car as long as I want because of moderate pain in my neck.
E I can hardly drive at all because of severe pain in my neck.
F I cannot drive my car at all.

SECTION 9 - Sleeping

A I have no trouble sleeping.
B My sleep is slightly disturbed (less than 1 hour sleepless).
C My sleep is mildly disturbed (1-2 hours sleepless).
D My sleep is moderately disturbed (2-3 hours sleepless).
E My sleep is greatly disturbed (3-5 hours sleepless).
F My sleep is completely disturbed (5-7 hours)

SECTION 10 - Recreation

A I am able to engage in all of my recreational activities with no neck pain at all.
B I am able to engage in all of my recreational activities with some pain in my neck.
C I am able to engage in most, but not all of my recreational activities because of pain in my neck.
D I am able to engage in a few of my recreational activities because of pain in my neck.
E I can hardly do any recreational activities because of pain in my neck.
F I cannot do any recreational activities at all.

Patient name ____________________________ Patient signature _________________________ Date ______

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Upper Extremity Functional Scale

We are interested in knowing whether you are having any difficulty at all with the activities listed below because of your upper limb problem for which you are currently seeking attention.
Please check (√) 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
Any of your usual work, household, or school activities					
Your usual hobbies, recreational or sporting activities					
Lifting a bag of groceries to waist level					
Lifting a bag of groceries above your head					
Grooming your hair					
Pushing up on your hands (e.g., from bathtub or chair)					
Preparing food (e.g., peeling, cutting)					
Driving					
Vacuuming, sweeping, or raking					
Dressing					
Doing up buttons					
Using tools or appliances					
Opening doors					
Cleaning					
Tying or lacing shoes					
Sleeping					
Laundering clothes (e.g., washing, ironing, folding)					
Opening a jar					
Throwing a ball					
Carrying a small suitcase with your affected limb)					

Stratford P, Binkley JM, Stratford POW. Development and initial validation of the upper extremity functional index. Physiotherapy Canada Fall 2001;259-266, 281.

Patient name: ____________________________ Signature: ______________________________ Date: ______________

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Score ______________________/80 MDC (minimum detectable change) = 9 pts Error +/- 5 scale points

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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 check (√) 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
Any of your usual work, household, or school activities					
Your usual hobbies, recreational or sporting activities					
Getting into or out of the bath					
Walking between rooms					
Putting on your shoes or socks					
Squatting					
Lifting an object, like a bag of groceries from the floor					
Performing light activities around your Home					
Performing heavy activities around your Home					
Getting into or out of a car					
Walking 2 blocks					
Walking a mile					
Going up or down 10 stairs (about 1 flight of stairs)					
Standing for 1 hour					
Sitting for 1 hour					
Running on even ground					
Running on uneven ground					
Making sharp turns while running fast					
Hopping					
Rolling over in bed					

Binkley JM, Stratford POW, Lott SA, Riddle DL. The lower extremity functional scale (LEFS): Scale development, measurement properties, and clinical application. Physical Therapy 1999;79:371-383.

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Patient name: ____________________________ Signature: ______________________________ Date: ______________

Score _____________________/80 MDC (minimum detectable change) = 9 pts Error +/- 5 scale points

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Low Back Pain and Disability Questionnaire (Roland-Morris)

Patient Name:____ Date:_____________________

Instructions: When your back hurts, you may find it difficult to do some of the things you normally do. **Mark only the sentences that describe you today.**

- ☐ I stay at home most of the time because of my back.
- ☐ I change position frequently to try and get my back comfortable.
- ☐ I walk more slowly than usual because of my back.
- ☐ Because of my back, I am not doing any jobs that I usually do around the house.
- ☐ Because of my back, I lie down to rest more often.
- ☐ Because of my back, I have to hold on to something to get out of an easy chair.
- ☐ Because of my back, I try to get other people to do things for me.

- ☐ I get dressed more slowly than usual because of my back.
- ☐ I only stand up for short periods of time because of my back.
- ☐ Because of my back, I try not to bend or kneel down.
- ☐ My back is painful almost all of the time.
- ☐ I find it difficult to turn over in bed because of my back.
- ☐ My appetite is not very good because of my back pain.
- ☐ I have trouble putting on my socks (stockings) because of the pain in my back.

- ☐ I only walk short distances because of my back pain.
- ☐ I sleep less well because of my back.
- ☐ Because of my back pain, I get dressed with help from someone else.
- ☐ I sit down for most of the day because of my back.
- ☐ I avoid heavy jobs around the house because of my back.
- ☐ Because of back pain, I am more irritable and bad tempered with people than usual.
- ☐ Because of my back I go upstairs more slowly than usual.
- ☐ I stay in bed most of the time because of my back.

Pain Scale: Rate the severity of your pain by checking one box on the following scale;

No Pain	1	2	3	4	5	6	7	8	9	10	Worst Pain

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REVISED OSWESTRY LOW BACK PAIN DISABILITY QUESTIONNAIRE

PLEASE READ*: This questionnaire is designed to enable us to understand how much your low back/leg pain is affecting your ability to manage everyday activities. Please answer each section by circling the ONE CHOICE that best applies to you today. We realize that 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 NOW.

SECTION 1 – Pain Intensity

A. I have no pain
B. The pain is mild
C. The pain comes and goes and is moderate
D. The pain does not vary much and is moderate
E. The pain comes and goes and is severe
F. The pain does not vary much and is severe

SECTION 2 - Personal Care

A I would not have to change my way of washing or dressing to avoid pain.
B I do not normally change my way of washing or dressing even though it causes some pain.
C Washing and dressing increases the pain, but I manage not to change my way of doing it.
D Washing and dressing increases the pain and I find it necessary to change my way of doing it.
E Because of the pain, I am unable to do some washing and dressing without help.
F Because of the pain, I am unable to do any washing or dressing without help.

SECTION 3 - Lifting

A I can lift heavy weights without extra pain.
B I can lift heavy weights, but it causes extra pain.
C Pain prevents me from lifting heavy weights from any height.
D Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned, (eg. on a table)
E Pain prevents me from lifting heavy weights off the floor, but I can manage medium weights if they are conveniently positioned.
F I can only lift very light weights at the most.

SECTION 4 - Walking

A I can walk as long as I want without getting pain.
B Walking gives me pain which does not increase with time.
C Walking gives me pain which I can relieve by varying my pace.
D I get pain only when I walk long distances.
E I get pain when I walk short distances.
F I avoid walking because it gives me pain straight away.

SECTION 5 - Sitting

A I can sit in any chair as long as I like without pain.
B I can sit in some types of chairs as long as I like without getting pain.
C I get pain only when I get out of some seats.
D I get pain after sitting in most seats.
E I get pain soon on sitting in most seats.
F Sitting in most seats gives me pain straight away.

SECTION 6 - Standing

A I can stand as long as I want without pain.
B Standing eventually causes some pain, but it does not increase with time.
C Standing eventually gives me pain which I can relieve by shifting my weight.
D Standing eventually gives me pain which I can not relieve by shifting my weight.
E I get pain soon on standing.
F I avoid standing because I get pain straight away.

SECTION 7 - Sleeping

A I get no pain in bed.
B I get some pain in bed but it does not disturb my sleep.
C I get some pain in bed which sometimes disturbs my sleep.
D I get pain in bed which often disturbs my sleep.
E I get pain in bed which always disturbs my sleep.
F Pain prevents me from sleeping at all.

SECTION 8 - Social Life

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

SECTION 9 - Traveling

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

SECTION 10 - Changing Degree of Pain

A My pain has gone.
B My pain is rapidly getting better.
C My pain varies but is slowly getting better.
D My pain is getting neither better nor worse.
E My pain is slowly worsening.
F My pain is rapidly worsening.

Patient name ______________________________ Patient signature ___________________________ Date ______

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Physical Activity Readiness Questionnaire (Par-Q)

Name ______________________ SS# ______________

Contact Phone ______________________ Occupation ______________

Date of Birth ____________ Which Preventive Health activities do you plan to participate in? ______________

For most people physical activity should not pose any problem or hazard. The Par-Q has been designed to identify the small number of adults for whom physical activity might be inappropriate or those who should have medical advice concerning the type of activity most suitable for them.

Common sense is your best guide in answering these questions. Please read them carefully and check **YES** or **NO** if it applies to you. If a question is answered with **YES**, **please use the available space to explain your answer and give additional details.**

1. Has a doctor ever said that you have a heart condition and that you should only do physical activity recommended by a doctor? ☐YES ☐NO

2. Do you feel pain in your chest when you do physical activity? ☐YES ☐NO

3. In the past month, have you had chest pain when you were not doing physical activity? ☐YES ☐NO

4. Do you lose your balance because of dizziness or do you ever lose consciousness? ☐YES ☐NO

5. Do you have a bone or joint problem that could be made worse by a change in your physical activity? ☐YES ☐NO

6. Is your doctor currently prescribing drugs (for example, water pills) for your blood pressure or heart condition? ☐YES ☐NO

7. Do you know of any other reason why you should not do physical activity? ☐YES ☐NO

8. Do you currently participate in any regular activity program designed to improve or maintain your physical fitness? ☐YES ☐NO
   If yes, what activity program do you participate in?________________________________
   ____

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Medical History

Cardiovascular Disease Risk Factor
Has a doctor or health professional ever told you that you have any of the following conditions?
☐Heart Disease
☐Family history of heart disease
☐High Blood Pressure
☐High Cholesterol
☐Obesity
☐Lack of physical activity
☐Diabetes
☐Impaired fasting glucose
☐High HDL (negative risk factor)

Medication Use
Are you currently taking any of the following medications:
☐Blood Pressure Medication
☐Cholesterol Medication
☐Blood Sugar Medication
☐Heart Medication
☐Other medication(s)
Please list:

Do you have any of the following?
☐Back Pain
☐Joint, tendon, or muscular pain
☐Lung disease (asthma, emphysema, etc.)
Please explain:

Which best describes your current smoking status?
☐I have NEVER smoked or quit more than 6 months ago.
☐I CURRENTLY smoke or quit within the last 6 months.

Cardiovascular Disease Risk Factor
How would you rate your overall state of health?
☐Poor ☐Good
☐Fair ☐Excellent

Patient Signature ____________________ Date ____________

For Medical Use Only

Cleared to Participate ☐with ☐without restriction
Based on review of ☐Par-Q ☐Chart ☐Discussion with patient ☐Exam

Restriction: ____

Certified Chiropractic Assistant's Signature ____________________ Date ____________

Physician's Signature ____________________ Date ____________