Berkeley Chiropractic Center

2902 Central Heights Rd. Suite E

Goldsboro, NC 27534

Proper First Name: ______________________ Last Name: ______________________ Middle Initial: ________

Home Phone: ________________ Work Phone: ________________ Cell Phone: ________________

Street Address & Number: ______________________ City: ________________ State: ______ Zip: ________

Mailing Address (if different): ____________________________________________

Email Address: ______________________ Date of Birth: ____________ Age: ________ Sex: ☐ Male ☐ Female

Social Security Number: ________________ Marital Status: (circle one) Single Married Divorced Widowed # of Children: ______

Spouse's Name: ______________________ Spouse's Occupation: ______________________

Occupation: ________________ Employer: ________________ Work Status: ☐ Full Time ☐ Part Time
Student: ☐ Full Time ☐ Part Time

Drivers License #: ________________ State: ______ How were you referred to our office? ________________

Emergency Contact: ______________________ Phone Number: ________________

- Are today's problems related to: ☐ Auto Injury ☐ Workman's Compensation ☐ Neither

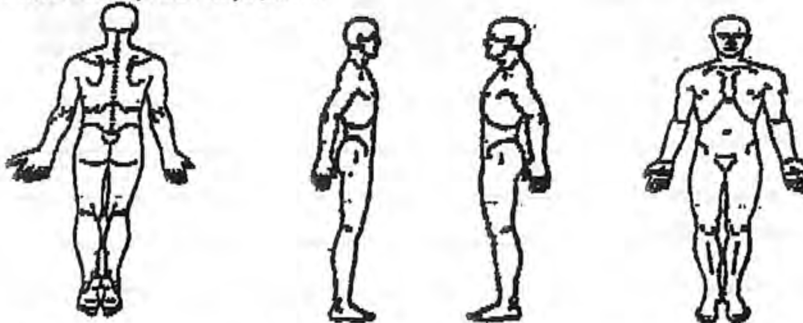
- Describe your condition(s) beginning with the most severe. Please rate each condition on a scale of 1 to 10 (10 being worst)

1. ______________________ (____ / 10) 2. ______________________ (____ / 10)

3. ______________________ (____ / 10) 4. ______________________ (____ / 10)

5. ______________________ (____ / 10) 6. ______________________ (____ / 10)

- How often do you experience pain? ☐ Constantly (75-100%) ☐ Frequently (50-75%) ☐ Occasionally (25-50%) ☐ Intermittently (1-25%)
- How would you describe the type of pain? ☐ Ache ☐ Dull ☐ Burn ☐ Sharp ☐ Shooting ☐ Numb ☐ Other
- Please indicate on the diagram below where you have symptoms:



- How are your symptoms changing with time? ☐ Getting Worse ☐ Not Changing ☐ Getting Better
- How much has your problem interfered with your work? ☐ Not At All ☐ A Little Bit ☐ Moderately ☐ Quite A Bit ☐ Extremely
- How much has the problem interfered with your social activities? ☐ Not At All ☐ A Little Bit ☐ Moderately ☐ Quite A Bit ☐ Extremely
- Who else have you seen for your problem?
  ☐ Chiropractor ☐ Neurologist ☐ Primary Care Physician ☐ ER Physician ☐ No One
  ☐ Orthopedist ☐ Massage Therapist ☐ Physical Therapist ☐ Other: ________________

Who? ________________ Treatment? ________________ Results: ________________

- Who is your family physician? ______________________
- How long have you had this problem? ______________________
- How do you think your problem began? ______________________
- Do you consider this problem to be severe? ☐ Yes ☐ Yes, At Times ☐ No
- What aggravates your problem? ______________________
- What makes your problem better? ______________________

- What concerns you the most about your problem what does it prevent you from doing? ______
- What is your: Height: ______ ft. ______ in. Weight: ______ lbs.
- How would you rate your overall health? ☐ Excellent ☐ Very Good ☐ Good ☐ Fair ☐ Poor
- What type of exercise do you do on a regular basis? ☐ Strenuous ☐ Moderate ☐ Light ☐ None
- Family History: Place an (X) if any family member has suffered from:

| | | | | |
|---|---|---|---|---|
| ☐ Rheumatoid Arthritis | ☐ Diabetes | ☐ Lupus | ☐ Tuberculosis | ☐ Heart Attacks |
| ☐ Cancer | ☐ ALS | ☐ Mental Illness | ☐ Gout | ☐ High Blood Pressure |
| ☐ Kidney Disease | ☐ Epilepsy | ☐ Allergies | ☐ Spinal Disorder | ☐ Arthritis |

- For each of the conditions listed below, place a check in the "past" column if you have had the condition in the past. If you presently have a condition listed below, place a check in the "present" column.

| PAST | PRESENT | PAST | PRESENT | PAST | PRESENT | PAST | PRESENT |
|---|---|---|---|---|---|---|---|
| ☐ | ☐ Headaches | ☐ | ☐ High Blood Pressure | ☐ | ☐ Diabetes | ☐ | ☐ Neck Pain |
| ☐ | ☐ Heart Attack | ☐ | ☐ Excessive Thirst | ☐ | ☐ Upper Back Pain | ☐ | ☐ Chest Pains |
| ☐ | ☐ Frequent Urination | ☐ | ☐ Mid Back Pain | ☐ | ☐ Stroke | ☐ | ☐ Smoking/Tobacco Use |
| ☐ | ☐ Low Back Pain | ☐ | ☐ Angina | ☐ | ☐ Drug/Alcohol Dependence | ☐ | ☐ Shoulder Pain |
| ☐ | ☐ Kidney Stones | ☐ | ☐ Allergies | ☐ | ☐ Elbow/Upper Arm Pain | ☐ | ☐ Kidney Disorders |
| ☐ | ☐ Depression | ☐ | ☐ Wrist Pain | ☐ | ☐ Bladder Infection | ☐ | ☐ Systemic Lupus |
| ☐ | ☐ Hand Pain | ☐ | ☐ Painful Urination | ☐ | ☐ Epilepsy | ☐ | ☐ Hip Pain |
| ☐ | ☐ Loss of Bladder Control | ☐ | ☐ Dermatitis/Eczema/Rash | ☐ | ☐ Upper Leg Pain | ☐ | ☐ Prostate Problems |
| ☐ | ☐ HIV/AIDS | ☐ | ☐ Knee Pain | ☐ | ☐ Abnormal Weight Gain/Loss | ☐ | ☐ Ankle/Foot Pain |
| ☐ | ☐ Loss of Appetite | ☐ | ☐ Jaw Pain | ☐ | ☐ Abdominal Pain | ☐ | ☐ Joint Pain/Stiffness |
| ☐ | ☐ Ulcer | ☐ | ☐ Arthritis | ☐ | ☐ Hepatitis | ☐ | ☐ Rheumatoid Arthritis |
| ☐ | ☐ Liver/Gall Bladder Disorders | ☐ | ☐ Cancer | ☐ | ☐ General Fatigue | ☐ | ☐ Tumor |
| ☐ | ☐ Muscular Coordination | ☐ | ☐ Asthma | ☐ | ☐ Visual Disturbances | ☐ | ☐ Chronic Sinusitis |
| ☐ | ☐ Dizziness | ☐ | ☐ Other: ______ | | | | |
| For Females Only: | | ☐ | ☐ Birth Control | ☐ | ☐ Hormonal Replacement | ☐ | ☐ Pregnancy |

- What activities do you do at work?

| | | | |
|---|---|---|---|
| Sit: | ☐ Most Of The Day | ☐ Half The Day | ☐ A Little Of The Day |
| Stand: | ☐ Most Of The Day | ☐ Half The Day | ☐ A Little Of The Day |
| Computer Work: | ☐ Most Of The Day | ☐ Half The Day | ☐ A Little Of The Day |
| On The Phone: | ☐ Most Of The Day | ☐ Half The Day | ☐ A Little Of The Day |
| Driving: | ☐ Most Of The Day | ☐ Half The Day | ☐ A Little Of The Day |
| Manual Labor: | ☐ Most Of The Day | ☐ Half The Day | ☐ A Little Of The Day |

- What activities do you do outside of work? ______
- List all prescription medications you are currently taking: ______
- List all over-the-counter medications you are currently taking: ______
- List al surgical procedures you have had: ______
- Have you ever been hospitalized? ☐ No ☐ Yes
  If Yes, what were you hospitalized for? ______
- Have you seen a Chiropractor before? ☐ No ☐ Yes
  If Yes, who? ______ When was your last visit? ______
- Have you had any other significant past trauma? ☐ No ☐ Yes
- Anything else pertinent to your visit today? ______

I herby authorize Sylvia Chiropractic Center to examine me, including x-rays if indicated by my exam, and to release my records to anyone I designate. I further authorize treatments deemed necessary by the findings, and wish all my chiropractic records to be held in strict secret confidence and not to be given to anyone without my written consent. I authorize payment directly to the doctor from my insurance company and I clearly understand that I am totally responsible for payment should my insurance company deny payments, or make payment directly to me. First day's fees are due and payable at the time of service.
BY SIGNING YOUR NAME BELOW, YOU CERTIFY THE ACCURACY OF YOUR MEDICAL AND/OR ACCIDENT HISTORY AND FURTHER CERTIFY THAT YOU PRESENT TO DR. SYLVIA FOR EVALUATION AND TREATMENT OF A HEALTH RELATED CONDITION AND FOR NO OTHER PURPOSE.

______ Signature of Patient, or of Guardian authorizing care

______ Date

Berkeley Chiropractic Center

2902 Central Heights Rd. Suite E

Goldsboro, NC 27534

# PERSONAL INJURY QUESTIONAIRE

(PLEASE BE VERY SPECIFIC WITH YOUR ANSWERS...THANK YOU!)

**NAME:** ______________________________ **DATE:** ______________________

## CHIEF COMPLAINT:

1. Describe your current complaint that you are requesting evaluation and treatment for from this office. Please check the symptoms that you have since the accident: ______________________________

| | | | |
|---|---|---|---|
| ☐ Headaches | ☐ Numbness in toes | ☐ Loss of Memory | ☐ Pain Behind Eyes |
| ☐ Neck Pain/Stiffness | ☐ Arm/ Leg Weakness | ☐ Dizziness | ☐ Clicking/Popping Jaw |
| ☐ Mid Back Pain | ☐ Sleeping Problems | ☐ Numbness in fingers | ☐ Facial Pain |
| ☐ Low Back Pain | ☐ Eyes Light Sensitive | ☐ Fainting | ☐ Irritability |
| ☐ Arm Pain | ☐ Fatigue | ☐ Breath Shortness | ☐ Loss of Balance |
| ☐ Leg Pain | ☐ Depression | ☐ Ringing/Buzzing | ☐ Cold Feet |
| ☐ Muscle Spasm/Cramping | ☐ Cold hands | ☐ Chest Pain | |
| ☐ Pain across Shoulder Blades | ☐ Diarrhea | ☐ Constipation | |

2. Do you have any prior history of any of the symptoms you checked above? ☐ Yes ☐ No If yes explain: ______________________________

3. Have you ever had any prior automobile accidents or ever had any serious falls/injuries? If yes, please give dates and treatments: ______________________________

4. Please describe your accident in your own words: ______________________________

## HISTORY:

5. What was the Date of the Accident? __________ Time: __________ AM/PM ______
6. How many vehicles were involved in the accident? ______________________
7. What was the estimated damage to the vehicle you were in? ______________________
8. What street or intersection were you on when the accident occurred? ______________________
9. What city did the accident occur in? ______________________ State: __________
10. What direction were you traveling in? North ______ South ______ East ______ West ______
11. What type of impact was the auto accident? (check all that apply) ☐ Head-on Collision ☐ Front Impact ☐ Broad-side Collision ☐ Rear-end car in front of you ☐ Rear Impact ☐ Non-collision
12. Did your vehicle hit anything following the accident? ______________________
13. Where were you sitting in the vehicle during the accident? ______________________
14. Who was the driver of your car? ______________________
15. Did you know the accident was coming? ______________________
16. What type of vehicle were you in? (Year & Model) ______________________
17. What type of vehicle impacted yours? (Year & Model of other car) ______________________
18. Was your vehicle....slowing down__ Speeding up___ Moving at a steady speed___ Stopped__ Other__________
19. Was the other car... slowing down__ speeding up___ Moving at a steady speed___ Stopped__ Other__________
20. At the time of impact, how fast would you estimate the other vehicle was moving? ______
21. During and after the crash what happened to your vehicle? (check all that apply)
    ____Kept going straight ____spun around ____kept going straight hitting a car in front ____hit a stationary object ____spun around & hit a stationary object ____was hit by another vehicle
22. Did you lose consciousness during the accident? ☐ Yes ☐ No
23. How was your head positioned during the accident? ______________________
24. How was your body positioned during the accident? ______________________

*over please*

25. Where were your feet positioned during the accident? ____________________
26. Did your face hit anything during the accident? ☐ No ☐ Yes, please describe: ____________________
27. Did your shoulders hit anything during the accident? ☐ No ☐ Yes, please describe: ____________________
28. Did your neck hit anything during the accident? ☐ No ☐ Yes, please describe: ____________________
29. Did your chest hit anything during the accident: ☐ No ☐ Yes, please describe: ____________________
30. Did your hips hit anything during the accident? ☐ No ☐ Yes, please describe: ____________________
31. Did your knees hit anything during the accident? ☐ No ☐ Yes, please describe: ____________________
32. Did your feet hit anything during the accident? ☐ No ☐ Yes, please describe: ____________________
33. What kind of headrest was in your vehicle? ____movable fixed headrest ____non-movable fixed headrest ____no headrest
34. Where was the headrest positioned on your head? ____________________
35. Did you have your seatbelt on during the accident? ☐ No ☐ Yes
36. Did you slide out of your seatbelt during the accident? ☐ No ☐ Yes
37. What was damaged in your vehicle: (Check all that apply)

__windshield __rear bumper __mirror __steering wheel __front bumper __knee bolster
__dashboard __trunk __back right door __seat frame __front left door
__side window __rear window __back left door __front right door __completely totaled

38. Choose the items that dented inward: __floorboards __side door __dashboard
39. Choose the doors that would not open as a result of the accident:

____front left ____front right ____rear left ____rear right

40. Did you go to the hospital? No__ Yes__
41. How did you get to the hospital? __Ambulance __drove self __someone else drove
42. What was the name of the hospital? ____________________
43. Did you stay overnight? ___Yes ___No
44. Did you receive any of the following at the hospital:

____pain medication ____muscle relaxer ____neck brace ____stitches
____MRI ____examination ____x-rays ____CAT scan ____cast

45. Did you receive any stitches for any cuts at the hospital? ____________________.
46. Were x-rays taken at the hospital? If yes, which area was taken? ____________________
47. Who was the 1st Doctor that treated you?

Name: ____________________
Date seen: ____________________
Were you examined? ☐ Yes ☐ No
Were X-rays taken? ☐ Yes ☐ No Were you: ☐ Sitting or ☐ Standing
Did you receive treatment? ☐ Yes ☐ No ☐ Medications ☐ Braces ☐ Collars
If yes, what kind of treatment did you receive? ____________________
What benefits did you receive from the treatment? ____________________

48. What relieves your symptoms? ____________________
49. What aggravates your symptoms? ____________________
50. Road conditions at time of accident: ☐ Icy ☐ Rainy ☐ Wet ☐ Clear ☐ Dark ☐ Other (describe): ____________
51. Visibility at the time of the accident? ☐ Poor ☐ Fair ☐ Good ☐ Other: ____________
52. Where was your car struck? ____________________
53. Were you wearing a hat or glasses? ☐ Yes ☐ No

If yes, where were they located after the accident? ____________________

54. Did you get any bleeding cuts? ☐ Yes ☐ No If yes, where? ____________________
55. Did you get any bruises? ☐ Yes ☐ No If yes, where? ____________________
56. As a result of the accident you were: ☐ Rendered unconscious ☐ In shock ☐ Dazed, circumstances vague

☐ Other: ____________________

57. Are you pregnant? ____NO ____Yes If yes, how far along? ____________
58. Do you have an attorney representing you for this claim? ☐ Yes ☐ No

If yes, who? ____________________

SIGNATURE OF PATIENT: ____________________ DATE: ____________

# BERKELEY CHIROPRACTIC CENTER

## ACTIVITIES OF DAILY LIVING

Patient Name:____________________ Date:__________ File #:________

**Activities of Daily Living:** The things we normally do in daily living including any daily activity we perform for self-care (such as feeding ourselves, bathing, dressing, grooming), work, homemaking, and leisure. The ability or inability to perform ADL's can be used as a very practical measure of ability/disability in many disorders.

Please place a check beside any/all of the following activities that you are **having trouble performing** on a normal daily basis **without pain.**

___Dressing ___Bathing
___Lifting ___Grooming
___Walking ___Oral Care
___Sitting comfortably ___Toileting
___Sleeping through the night ___Climbing Stairs
___Having energy ___Eating
___Driving ___Shopping
___Reading ___Cooking
___Working ___Housework
___Running ___Doing Laundry
___Bending ___Playing with Children

OTHER:______________________________________________________

____________________________________________________________

____________________________________________

# WELCOME

# TO

# BERKELEY CHIROPRACTIC CENTER

DO YOU HAVE A MEDICAL DOCTOR?

**PLEASE CIRCLE**

**YES NO**

IF NO, WOULD YOU LIKE TO BE CONTACTED FOR AN APPOINTMENT AT THE MEDICAL CLINIC?

**PLEASE CIRCLE**

**YES NO**

For re-ordering information, contact:
ACTIVATOR METHODS, INC., P.O. Box 80317, Phoenix, AZ 85060-0317
Phone: (602) 224-0220; Facsimile (602) 224-0230

## NECK PAIN DISABILITY INDEX QUESTIONNAIRE

NAME (Please Print): ______________________ DATE: __________

AGE: ______ DATE OF BIRTH: __________ OCCUPATION: ______________

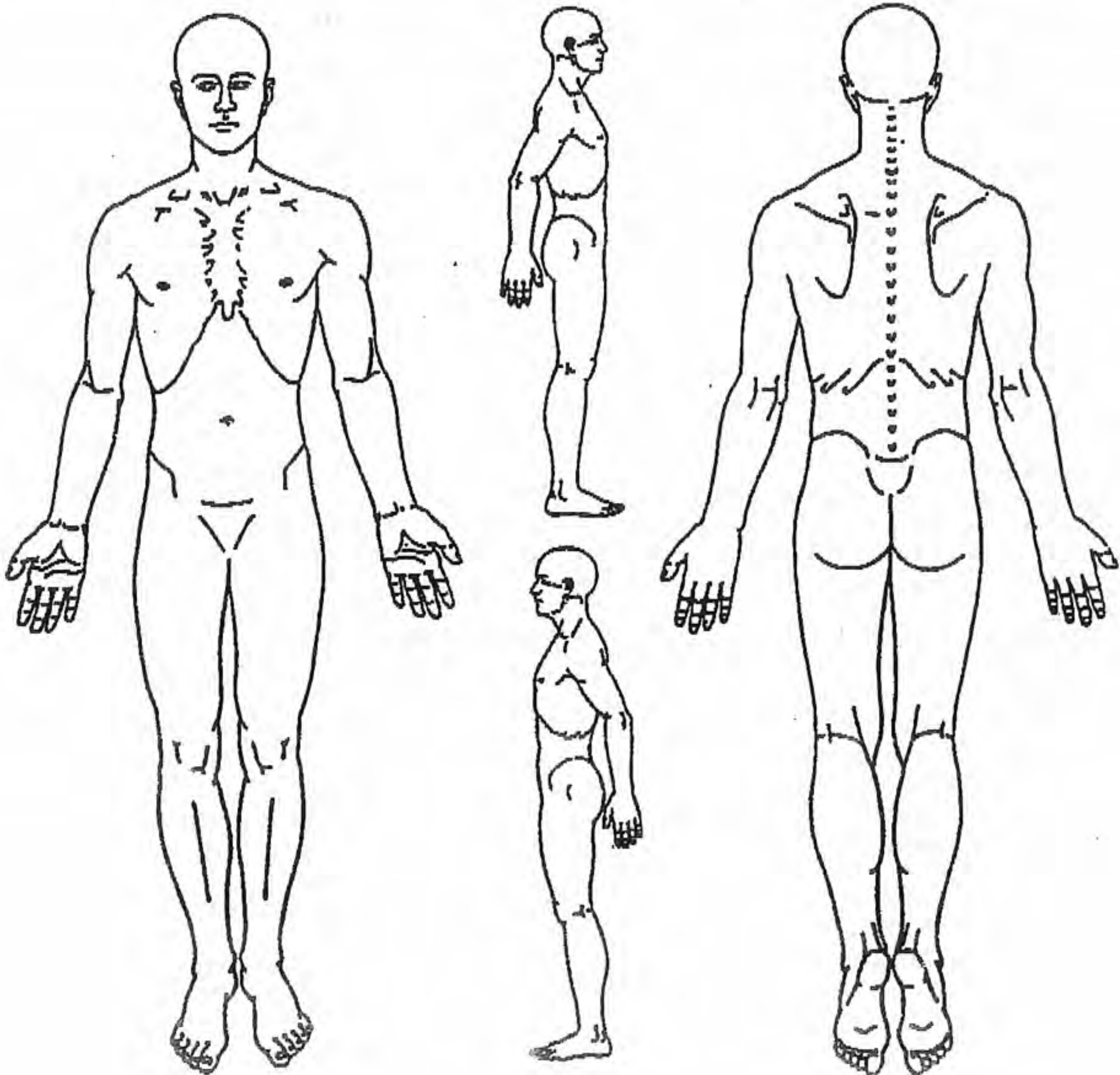
HOW LONG HAVE YOU HAD NECK PAIN? __YEARS __MONTHS __WEEKS

IS THIS YOUR FIRST EPISODE OF NECK PAIN? __YES __NO

**USE THE LETTERS BELOW TO INDICATE THE TYPE AND LOCATION OF YOUR SENSATIONS RIGHT NOW**

(Please remember to complete both sides of this form.)

| KEY: | A=ACHE | B=BURNING | N=NUMBNESS |
|---|---|---|---|
| | P=PINS & NEEDLES | S=STABBING | O=OTHER |



OVER PLEASE

For re-ordering information, contact:
ACTIVATOR METHODS, INC., P.O. Box 80317, Phoenix, AZ 85060-0317
Phone: (602) 224-0220; Facsimile (602) 224-0230

# 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 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.

*After Vernon & Mior, 1991*
*Reprinted by permission of the Journal of Manipulative and Physiological Therapeutics*

## 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 sleepless).

## 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 usual recreational activities because of pain in my neck.
D I am able to engage in a few of my usual 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.

REVISED January 1, 1996

Comments: ______________________________

Patient Signature: ______________________________ Date: __________

ACTIVATOR METHODS, INC., P.O. Box 80317, Phoenix, AZ 85060-0317
(602) 224-0220 Fax: (602) 224-0230

## REVISED OSWESTRY CHRONIC LOW BACK PAIN DISABILITY QUESTIONNAIRE

NAME (Please Print): ______________________________ DATE: __________

AGE: ______ DATE OF BIRTH: __________ OCCUPATION: ______________________

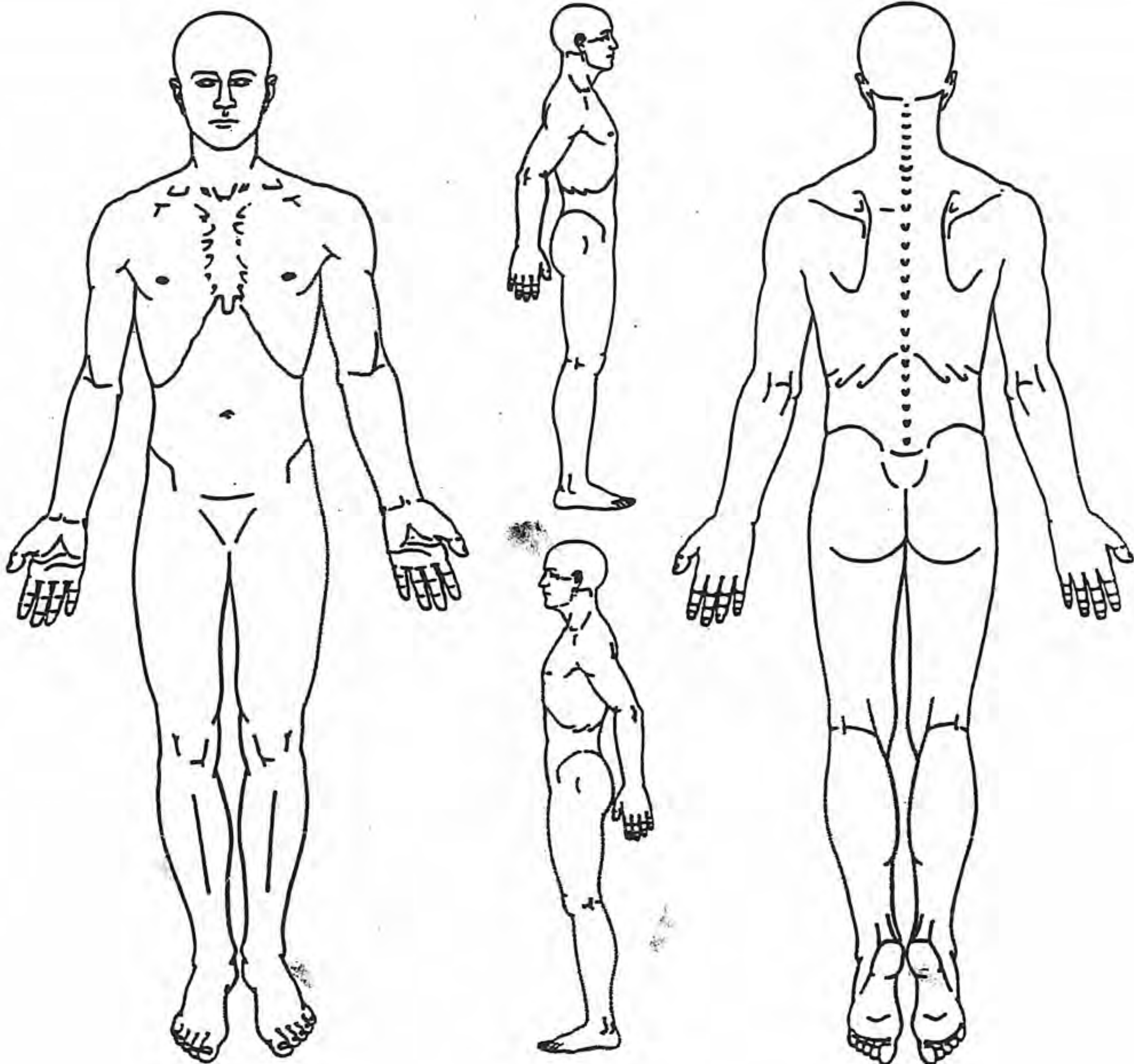
HOW LONG HAVE YOU HAD LOW BACK PAIN? ___YEARS ___MONTHS ___WEEKS

IS THIS YOUR FIRST EPISODE OF LOW BACK PAIN? ___YES ___NO

**USE THE LETTERS BELOW TO INDICATE THE TYPE AND LOCATION OF YOUR SENSATIONS RIGHT NOW**

(Please remember to complete both sides of this form.)

KEY: **A**=ACHE **B**=BURNING **N**=NUMBNESS
**P**=PINS & NEEDLES **S**=STABBING **O**=OTHER



OVER PLEASE

# REVISED OSWESTRY CHRONIC LOW BACK PAIN DISABILITY QUESTIONNAIRE

**Please Read:** This questionnaire is designed to enable us to understand how much your low back 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 The pain comes and goes and is very mild.
B The pain is mild and does not vary much.
C The pain comes and goes and is moderate.
D The pain is moderate and does not vary much.
E The pain comes and goes and is severe.
F The pain is severe and does not vary much.

**SECTION 2 – Personal Care**

A I would not have to change my way of washing or dressing in order 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 off the floor.
D Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned, e.g., on a table.
E Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
F I can only lift very light weights, at the most.

**SECTION 4 – Walking**

A Pain does not prevent me from walking any distance.
B Pain prevents me from walking more than one mile.
C Pain prevents me from walking more than 1/2 mile.
D Pain prevents me from walking more than 1/4 mile.
E I can only walk while using a cane or on crutches.
F I am in bed most of the time and have to crawl to the toilet.

**SECTION 5 – Sitting**

A I can sit in any chair as long as I like without pain.
B I can only sit in my favorite chair as long as I like.
C Pain prevents me from sitting more than one hour.
D Pain prevents me from sitting more than 1/2 hour.
E Pain prevents me from sitting more than ten minutes.
F Pain prevents me from sitting at all.

*From: N. Hudson, K. Tome-Nicholson, A. Breen; 1989*

REVISED 9/11/92

**SECTION 6 – Standing**

A I can stand as long as I want without pain.
B I have some pain while standing, but it does not increase with time.
C I cannot stand for longer than one hour without increasing pain.
D I cannot stand for longer than 1/2 hour without increasing pain.
E I cannot stand for longer than ten minutes without increasing pain.
F I avoid standing, because it increases the pain straight away.

**SECTION 7 – Sleeping**

A I get no pain in bed.
B I get pain in bed, but it does not prevent me from sleeping well.
C Because of pain, my normal night's sleep is reduced by less than one-quarter.
D Because of pain, my normal night's sleep is reduced by less than one-half.
E Because of pain, my normal night's sleep is reduced by less than three-quarters.
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 degree of my pain.
C Pain has no significant effect on my social life apart from limiting my more energetic interests, e.g., dancing, etc.
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 is rapidly getting better.
B My pain fluctuates, but overall is definitely getting better.
C My pain seems to be getting better, but improvement is slow at present.
D My pain is neither getting better nor worse.
E My pain is gradually worsening.
F My pain is rapidly worsening.

**Comments:** ______________________________

**Patient Signature:** ______________________________ **Date:** ______________