CONFIDENTIAL HEALTH INFORMATION

Robert A. Nab, D.C.
11960 West 119th Street
Overland Park, KS 66213
www.nabchiro.com
913-345-9229

Please allow our staff to photocopy your driver's license and insurance details.
All information you supply is confidential. We comply with all federal privacy standards.
Please print clearly.

Today's Date (MM/DD/YYYY) ______

Have you consulted a chiropractor before? ○ No ○ Yes

When? ______

If so, whom? ______

Patient Number (office use only) ______

Whom may we thank for referring you? ______

Age ______

Gender ○ Male ○ Female

Race ○ American Indian ○ Alaskan Native ○ Asian ○ Black or African American ○ Native Hawaiian ○ Other Pacific Islander ○ Other ○ White ○ Decline to answer

Ethnicity ○ Hispanic or Latino ○ Not Hispanic or Latino ○ Decline to specify

Birth Date (MM/DD/YYYY) ______

Your Last Name ______

Your Social Security Number ______

Your First Name ______

Your Middle Name (or Initial) ______

Smoking Status (age 13 and over) ○ Never A Smoker ○ Former Smoker ○ Current Every Day Smoker ○ Current Some Day Smoker ○ Heavy Smoker ○ Light Smoker

Address ______

Marital Status ○ Married ○ Single ○ Divorced ○ Widowed ○ Separated

City ______ State/Province ______ ZIP/Postal Code ______

Preferred Language ______

Home Phone ______ Cell Phone ______

Spouse's Name ______

Email Address ______

Child's Name and Age ______

Emergency Contact ______ Emergency Contact's Phone ______

Child's Name and Age ______

Your Occupation ______

Child's Name and Age ______

Your Employer ______

Work Phone ______

Address ______

May we contact you at work? ○ Yes ○ No

City ______ State/Province ______ ZIP/Postal Code ______

Preferred method of contact? ○ Home Phone ○ Cell Phone ○ Work Phone ○ Email

Primary Care Provider's Name ______

Insurance Carrier ______ Policy Number ______

Insured's Last Name ______ Birth Date (MM/DD/YYYY) ______

Who carries this policy? ○ Self ○ Spouse ○ Parent

Insured's First Name ______ Insured's Middle Name (or Initial) ______

Insured's Employer ______

Address ______

City ______ State/Province ______ ZIP/Postal Code ______ Employer's Phone ______

CONFIDENTIAL HEALTH INFORMATION

Version No. 210256226
© 2015 Paperwork Project. All rights reserved.

Please describe your Primary Complaint in the space below. Use the Secondary and Additional Complaint boxes if they apply.

Primary Complaint
The primary symptom that prompted me to seek care today is: ______________________________

And are the result of (darken circle):
- ◯ An accident or injury
  - ◯ Work ◯ Auto ◯ Other ________
- ◯ A worsening long-term problem
- ◯ An interest in: ◯ Wellness ◯ Other ______

Onset (When did you first notice your current symptoms?) ______________________________

Prior interventions (What have you done to relieve the symptoms?)
- ◯ Prescription medication ◯ Acupuncture
- ◯ Over-the-counter drugs ◯ Chiropractic
- ◯ Homeopathic remedies ◯ Massage
- ◯ Physical therapy ◯ Ice
- ◯ Surgery ◯ Heat
- ◯ Other ______________________________

Secondary Complaint
The secondary symptom that prompted me to seek care today is: ______________________________

And are the result of (darken circle):
- ◯ An accident or injury
  - ◯ Work ◯ Auto ◯ Other ________
- ◯ A worsening long-term problem
- ◯ An interest in: ◯ Wellness ◯ Other ______

Onset (When did you first notice your current symptoms?) ______________________________

Prior interventions (What have you done to relieve the symptoms?)
- ◯ Prescription medication ◯ Acupuncture
- ◯ Over-the-counter drugs ◯ Chiropractic
- ◯ Homeopathic remedies ◯ Massage
- ◯ Physical therapy ◯ Ice
- ◯ Surgery ◯ Heat
- ◯ Other ______________________________

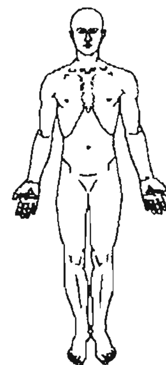
Additional Complaint
The additional symptom that prompted me to seek care today is: ______________________________

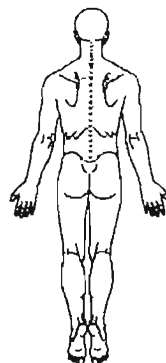
And are the result of (darken circle):
- ◯ An accident or injury
  - ◯ Work ◯ Auto ◯ Other ________
- ◯ A worsening long-term problem
- ◯ An interest in: ◯ Wellness ◯ Other ______

Onset (When did you first notice your current symptoms?) ______________________________

Prior interventions (What have you done to relieve the symptoms?)
- ◯ Prescription medication ◯ Acupuncture
- ◯ Over-the-counter drugs ◯ Chiropractic
- ◯ Homeopathic remedies ◯ Massage
- ◯ Physical therapy ◯ Ice
- ◯ Surgery ◯ Heat
- ◯ Other ______________________________

Location
(Where does it hurt?)
Circle the area(s) on the illustration.
"O" for current condition
"X" for conditions experienced in the past





1. What else should Dr. Nab know about your current condition? ______________________________

2. How does your current condition interfere with your:

Work or career: ______________________________

Recreational activities: ______________________________

Household responsibilities: ______________________________

Personal relationships: ______________________________

3. Review of Systems
Chiropractic care focuses on the integrity of your nervous system, which controls and regulates your entire body. Please darken the circle beside any condition that you've **Had** or currently **Have** and initial to the right.

a. Musculoskeletal

Had	Have	Condition	Had	Have	Condition	Had	Have	Condition	Had	Have	Condition	Had	Have	Condition	Had	Have	Condition	
◯	◯	Osteoporosis	◯	◯	Arthritis	◯	◯	Scoliosis	◯	◯	Neck pain	◯	◯	Back problems	◯	◯	Hip disorders	NONE ◯
◯	◯	Knee injuries	◯	◯	Foot/ankle pain	◯	◯	Shoulder problems	◯	◯	Elbow/wrist pain	◯	◯	TMJ issues	◯	◯	Poor posture	Initials ____

b. Neurological

Had	Have	Condition	Had	Have	Condition	Had	Have	Condition	Had	Have	Condition	Had	Have	Condition	Had	Have	Condition	
◯	◯	Anxiety	◯	◯	Depression	◯	◯	Headache	◯	◯	Dizziness	◯	◯	Pins and needles	◯	◯	Numbness	NONE ◯ Initials ____

c. Cardiovascular

Had	Have	Condition	Had	Have	Condition	Had	Have	Condition	Had	Have	Condition	Had	Have	Condition	Had	Have	Condition	
◯	◯	High blood pressure	◯	◯	Low blood pressure	◯	◯	High cholesterol	◯	◯	Poor circulation	◯	◯	Angina	◯	◯	Excessive bruising	NONE ◯ Initials ____

d. Respiratory

Had	Have	Condition	Had	Have	Condition	Had	Have	Condition	Had	Have	Condition	Had	Have	Condition	Had	Have	Condition	
◯	◯	Asthma	◯	◯	Apnea	◯	◯	Emphysema	◯	◯	Hay fever	◯	◯	Shortness of breath	◯	◯	Pneumonia	NONE ◯ Initials ____

e. Digestive

Had	Have	Condition	Had	Have	Condition	Had	Have	Condition	Had	Have	Condition	Had	Have	Condition	Had	Have	Condition	
◯	◯	Anorexia/bulimia	◯	◯	Ulcer	◯	◯	Food sensitivities	◯	◯	Heartburn	◯	◯	Constipation	◯	◯	Diarrhea	NONE ◯ Initials ____

f. Sensory

Had	Have	Condition	Had	Have	Condition	Had	Have	Condition	Had	Have	Condition	Had	Have	Condition	Had	Have	Condition	
◯	◯	Blurred vision	◯	◯	Ringing in ears	◯	◯	Hearing loss	◯	◯	Chronic ear infection	◯	◯	Loss of smell	◯	◯	Loss of taste	NONE ◯ Initials ____

g. Skin

Had	Have	Condition	Had	Have	Condition	Had	Have	Condition	Had	Have	Condition	Had	Have	Condition	Had	Have	Condition	
◯	◯	Skin cancer	◯	◯	Psoriasis	◯	◯	Eczema	◯	◯	Acne	◯	◯	Hair loss	◯	◯	Rash	NONE ◯ Initials ____

____
Patient name

____
Patient Number
(office use only)

____
Doctor's Initials

Robert A. Nab, D.C.

Version No. 52548617
© 2015 Paperwork Project. All rights reserved.

(Continued from previous page)

h. Endocrine

Had Have ○ ○ Thyroid issues | Had Have ○ ○ Immune disorders | Had Have ○ ○ Hypoglycemia | Had Have ○ ○ Frequent infection | Had Have ○ ○ Swollen glands | Had Have ○ ○ Low energy | NONE ○ Initials ____

i. Genitourinary

Had Have ○ ○ Kidney stones | Had Have ○ ○ Infertility | Had Have ○ ○ Bedwetting | Had Have ○ ○ Prostate issues | Had Have ○ ○ Erectile dysfunction | Had Have ○ ○ PMS symptoms | NONE ○ Initials ____

j. Constitutional

Had Have ○ ○ Fainting | Had Have ○ ○ Low libido | Had Have ○ ○ Poor appetite | Had Have ○ ○ Fatigue | Had Have ○ ○ Sudden weight gain/loss (circle one) | Had Have ○ ○ Weakness | NONE ○ Initials ____

Patient name ____

Patient Number (office use only) ____

○ All other systems negative

Past Personal, Family and Social History

Please identify your past health history, including accidents, injuries, illnesses and treatments. Please complete each section fully.

PERSONAL

4. Illnesses

Check the illnesses you have **Had** in the past or **Have** now.

Had	Have	
○	○	AIDS
○	○	Alcoholism
○	○	Allergies
○	○	Arteriosclerosis
○	○	Cancer
○	○	Chicken pox
○	○	Diabetes
○	○	Epilepsy
○	○	Glaucoma
○	○	Goiter
○	○	Gout
○	○	Heart disease
○	○	Hepatitis
○	○	HIV Positive
○	○	Malaria
○	○	Measles
○	○	Multiple Sclerosis
○	○	Mumps
○	○	Polio
○	○	Rheumatic fever
○	○	Scarlet fever
○	○	Sexually transmitted disease
○	○	Stroke
○	○	Tuberculosis
○	○	Typhoid fever
○	○	Ulcer
○	○	Other: ____

5. Operations

Surgical interventions, which may or may not have included hospitalization.

- ○ Appendix removal
- ○ Bypass surgery
- ○ Cancer
- ○ Cosmetic surgery
- ○ Elective surgery: ____
- ○ Eye surgery
- ○ Hysterectomy
- ○ Pacemaker
- ○ Spine ____
- ○ Tonsillectomy
- ○ Vasectomy
- ○ Other: ____

6. Treatments

Check the ones you've received in the **Past** or are receiving **Currently**.

Past	Currently	
○	○	Acupuncture
○	○	Antibiotics
○	○	Birth control pills
○	○	Blood transfusions
○	○	Chemotherapy
○	○	Chiropractic care
○	○	Dialysis
○	○	Herbs
○	○	Homeopathy
○	○	Hormone replacement
○	○	Inhaler
○	○	Massage therapy
○	○	Physical therapy
○	○	Medications

(Please list below all prescription, over-the-counter, natural supplements, enzymes, vitamins and minerals): ____

7. Allergies

Are you allergic to any medications?

Yes ○ No ○ If Yes please list: ____

8. Injuries

Have you ever...

- ○ Had a fractured or broken bone
- ○ Had a spine or nerve disorder
- ○ Been knocked unconscious
- ○ Been injured in an accident
- ○ Used a crutch or other support
- ○ Used neck or back bracing
- ○ Received a tattoo
- ○ Had a body piercing

Consultation Notes

FAMILY

9. Family History

Some health issues are hereditary. Tell Dr. Nab about the health of your immediate family members.

Relative	Age (If living)	State of health: Good	State of health: Poor	Illnesses	Age at death	Cause of death: Natural	Cause of death: Illness
Mother	____	○	○	____	____	○	○
Father	____	○	○	____	____	○	○
Sister 1	____	○	○	____	____	○	○
Sister 2	____	○	○	____	____	○	○
Brother 1	____	○	○	____	____	○	○
Brother 2	____	○	○	____	____	○	○
____	____	○	○	____	____	○	○

10. Are there any other hereditary health issues that you know about? ____

SOCIAL

11. Social History

Tell Dr. Nab about your health habits and stress levels.

Alcohol use	○ Daily	○ Weekly	How much? ____
Coffee use	○ Daily	○ Weekly	How much? ____
Tobacco use	○ Daily	○ Weekly	How much? ____
Exercising	○ Daily	○ Weekly	How much? ____
Pain relievers	○ Daily	○ Weekly	How much? ____
Soft drinks	○ Daily	○ Weekly	How much? ____
Water intake	○ Daily	○ Weekly	How much? ____

Prayer or meditation?	○ Yes	○ No
Job pressure/stress?	○ Yes	○ No
Financial peace?	○ Yes	○ No
Vaccinated?	○ Yes	○ No
Mercury fillings?	○ Yes	○ No
Recreational drugs?	○ Yes	○ No

Hobbies: ____

Doctor's Initials ____

Robert A. Nab, D.C.

Version No. 52548617
© 2015 Paperwork Project. All rights reserved.

12. Activities of Daily Living

How does this condition currently interfere with your life and ability to function?

Activity	No Effect	Mild Effect	Moderate Effect	Severe Effect
Sitting	○	○	○	○
Rising out of chair	○	○	○	○
Standing	○	○	○	○
Walking	○	○	○	○
Lying down	○	○	○	○
Bending over	○	○	○	○
Climbing stairs	○	○	○	○
Using a computer	○	○	○	○
Getting in/out of car	○	○	○	○
Driving a car	○	○	○	○
Looking over shoulder	○	○	○	○
Caring for family	○	○	○	○
Grocery shopping	○	○	○	○
Household chores	○	○	○	○
Lifting objects	○	○	○	○
Reaching overhead	○	○	○	○
Showering or bathing	○	○	○	○
Dressing myself	○	○	○	○
Love life	○	○	○	○
Getting to sleep	○	○	○	○
Staying asleep	○	○	○	○
Concentrating	○	○	○	○
Exercising	○	○	○	○
Yard work	○	○	○	○

13. What is the major stressor in your life? ____________________

14. How much sleep do you average per night? ______ **Hours**

15. What is the type and approximate age of your mattress and pillow? ________

16. What is your preferred sleeping position? ____________

17. Describe your typical eating habits: ○ Skip breakfast ○ Two meals a day ○ Three meals a day ○ Snacking between meals

18. What would be the most significant thing that you could do to improve your health? ____________________

____

19. In addition to the main reason for your visit today, what additional health goals do you have? ____________________

____

Acknowledgements

To set clear expectations, improve communications and help you get the best results in the shortest amount of time, please read each statement and initial your agreement.

Initials ____ **I instruct the chiropractor to deliver the care that, in his or her professional judgement, can best help me in the restoration of my health. I also understand that the chiropractic care offered in this practice is based on the best available evidence and designed to reduce or correct vertebral subluxation. Chiropractic is a separate and distinct healing art from medicine and does not proclaim to cure any named disease or entity.**

Initials ____ **I may request a copy of the Privacy Policy and understand it describes how my personal health information is protected and released on my behalf for seeking reimbursement from any involved third parties.**

Initials ____ **I realize that an X-ray examination may be hazardous to an unborn child and I certify that to the best of my knowledge I am not pregnant. Date of last menstrual period (MM/DD/YYYY):** ____________

Initials ____ **I grant permission to be called to confirm or reschedule an appointment and to be sent occasional cards, letters, emails or health information to me as an extension of my care in this office.**

Initials ____ **I acknowledge that any insurance I may have is an agreement between the carrier and me and that I am responsible for the payment of any covered or non-covered services I receive.**

Initials ____ **To the best of my ability, the information I have supplied is complete and truthful. I have not misrepresented the presence, severity or cause of my health concern.**

______________________________ Patient (or Guardian's) signature

______________________________ Date (MM/DD/YYYY)

Patient name ____________

Patient Number (office use only) ____________

Consultation Notes

____________ **Doctor's Initials**

Robert A. Nab, D.C.

Version No. 52548617
© 2015 Paperwork Project. All rights reserved.

VEHICLE ACCIDENT INFORMATION

CONFIDENTIAL

PATIENT INFORMATION

Date________________

Patient Name____

Date of Accident____________________ Time of Accident____________________ ☐ a.m. ☐ p.m.

Please describe the accident in your own words:____

____

____

____

Were you the: ☐ Driver ☐ Rear Passenger ☐ Front Passenger ☐ Pedestrian

How many people were in the accident vehicle?________

ACCIDENT SITE

Road/Street Name____________________

City/State____________________

Nearest intersection with road/street____________________

Driving conditions ☐ Dry ☐ Wet ☐ Icy ☐ Other ________

Which direction were you headed?____________________

Speed you were traveling?____________________

VEHICLE

Make and model of vehicle you were in:

____

Were you wearing a seatbelt? ☐ Yes ☐ No

If yes, what type? ☐ Lap ☐ Shoulder

Was vehicle equipped with airbags? ☐ Yes ☐ No

If yes, did it/they inflate properly? ☐ Yes ☐ No

Did your seat have a headrest? ☐ Yes ☐ No

If yes, what was the position of the headrest?

☐ Low ☐ Midposition ☐ High

OTHER VEHICLE

(If applicable)

Make and model of other vehicle____________________

Which direction was other vehicle headed?____________________

Speed other vehicle was traveling____________________

IMPACT

Did your car impact another vehicle? ☐ Yes ☐ No

Did your car impact a structure? ☐ Yes ☐ No

If yes, explain____________________

____

Did any part of your body strike anything in the vehicle?

☐ Yes ☐ No If yes, explain____________________

Was impact from :

☐ Front ☐ Rear ☐ Left ☐ Right ☐ Other____________

At the time of impact were you:

☐ Looking straight ahead ☐ Looking to the right
☐ Looking to the left ☐ Looking down
☐ Looking up

Were both hands on the steering wheel? ☐ Yes ☐ No

If no, which hand was on the wheel? ☐ Right ☐ Left

Was your foot on the brake? ☐ Yes ☐ No

If yes, which foot was on the brake? ☐ Right ☐ Left

Were you: ☐ Surprised by impact ☐ Braced for impact

POLICE

Did the police come to the accident site? ☐ Yes ☐ No

Were there any witnesses? ☐ Yes ☐ No

Was a police report filed? ☐ Yes ☐ No

Was a traffic violation issued? ☐ Yes ☐ No

If yes, to whom?____________________

#20546 – Medical Arts Press 1-800-328-2179

CONFIDENTIAL

PATIENT CONDITION

Were you unconscious immediately after the accident? ☐ Yes ☐ No If yes, for how long?________________

Please describe how you felt immediately after the accident:

____

____

____

TREATMENT

Did you go to the hospital? ☐ Yes ☐ No

When did you go? ☐ Immediately after accident ☐ Next day ☐ 2 days or more after the accident

How did you get to the hospital? ☐ Ambulance ☐ Private transportation

Name of hospital________________________ Name of doctor________________________

Diagnosis____

____

Treatment received____

____

X-rays taken____

SYMPTOMS/INJURIES

Have you been able to work since this injury? ☐ Yes ☐ No How many work days have you missed?____________

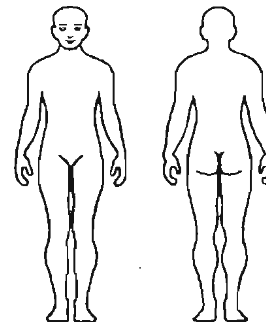
Prior to the injury were you able to work on an equal basis with others your age? ☐ Yes ☐ No

If you have had any of the following symptoms since your injury, please ☑ check:

- ☐ Arm/shoulder pain
- ☐ Back pain
- ☐ Back stiffness
- ☐ Chest pain
- ☐ Dizziness
- ☐ Ear buzzing
- ☐ Ear ringing
- ☐ Fatigue
- ☐ Feet/toe numbness
- ☐ Hand/finger numbness
- ☐ Headaches
- ☐ Irritability
- ☐ Jaw problems
- ☐ Leg pain
- ☐ Memory loss
- ☐ Nausea
- ☐ Neck pain
- ☐ Neck stiff
- ☐ Shortness of breath
- ☐ Sleep difficulty
- ☐ Stomach upset
- ☐ Tension
- ☐ Vision blurred

Is this condition getting progressively worse? ☐ Yes ☐ No ☐ Unknown

Mark an X on the picture where you continue to have pain, numbness, or tingling.



Rate the severity of your pain on a scale from 1 (least pain) to 10 (severe pain)_____

Type of pain: ☐ Sharp ☐ Dull ☐ Throbbing ☐ Numbness ☐ Aching ☐ Shooting ☐ Burning ☐ Tingling ☐ Cramps ☐ Stiffness ☐ Swelling ☐ Other____________

How often do you have this pain?____

Is it constant or does it come and go?____

Does it interfere with your: ☐ Work ☐ Sleep ☐ Daily Routine ☐ Recreation

Activities or movements that are painful to perform: ☐ Sitting ☐ Standing ☐ Walking ☐ Bending ☐ Lying Down

I certify that the above information is correct to the best of my knowledge.

Patient Signature________________________________ Date________________

CONFIDENTIAL

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
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 causes extra pain.
C. Pain prevents me from lifting heavy weights off of the floor, but I can manage if they are conveniently positioned, e.g., 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 infrequently.
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 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.

Total Score: __________ Signature: ______________________________ Date: ______________

CONFIDENTIAL

Rowland-Morris Acute Low Back Pain Disability Questionnaire

When your back hurts, you may find it difficult to do some of the things you normally do. This list contains some sentences that people have used to describe themselves when they have back pain. When you read them, you may find that some stand out because they describe you today.

As you read the list, think of yourself today. Check the box next to any sentence that describes you today. If the sentence does not describe you, then leave the space blank and go on to the next one. Remember, only check the sentence if you are sure that it describes you today.

1. _____ I stay at home most of the time because of my back.
2. _____ I change position frequently to try and get my back comfortable
3. _____ I walk more slowly than usual because of my back.
4. _____ Because of my back, I am no doing any of the jobs that I usually do around the house.
5. _____ Because of my back, I use a handrail to get upstairs.
6. _____ Because of my back, I lie down to rest more often.
7. _____ Because of my back, I have to hold on to something to get out of an easy chair.
8. _____ Because of my back, I try to get other people to do things for me.
9. _____ I get dressed more slowly than usual because of my back.
10. _____ I only stand up for short periods of time because of my back.
11. _____ Because of my back, I try not to bend or kneel down.
12. _____ I find it difficult to get out of a chair because of my back.
13. _____ My back is painful almost all the time.
14. _____ I find it difficult to turn over in bed because of my back.
15. _____ My appetite is not very good because of my back pain.
16. _____ I have trouble putting on my socks (or stockings) because of the pain in my back.
17. _____ I only walk short distances because of my back pain.
18. _____ I sleep less well because of my back pain.
19. _____ Because of my back pain, I get dressed with help from someone else.
20. _____ I sit down for most of the day because of my back.
21. _____ I avoid heavy jobs around the house because of my back.
22. _____ Because of my back pain, I am more irritable and bad tempered with people than usual.
23. _____ Because of my back pain, I go upstairs more slowly than usual.
24. _____ I stay in bed most of the time because of my back.

Total Score:__________ Signature:____________________________________ Date:______________

CONFIDENTIAL

RAND 36 ITEM HEALTH SURVEY 1.0

Patient Name: ______________________________

1. In general, would you say your health is:
(Circle One Number)

Excellent	1
Very Good	2
Good	3
Fair	4
Poor	5

2. **Compared to one year ago**, how would you rate your: general health right **now** ?
(Circle One Number)

Much better than one year ago	1
Somewhat better than one year ago	2
About the same	3
Somewhat worse now than one year ago	4
Much worse now than one year ago	5

The following items are about activities you might do during a typical day: Does **your health now limit you** in these activities ? If so, how much ? **(Circle One Number on Each Line)**	Yes, Limited A Lot	Yes, Limited A Little	No, Not Limited at All
3. **Vigorous activities**, such as running, lifting heavy objects, participating in strenuous sports	1	2	3
4. **Moderate activities**, such as moving a table pushing a vacuum cleaner, bowling or playing golf	1	2	3
5. Lifting or carrying groceries	1	2	3
6. Climbing **several** fights of stairs	1	2	3
7. Climbing **one** flight of stairs	1	2	3
8. Bending, kneeling or stooping	1	2	3
9. Walking **more than a mile**	1	2	3
10. Walking **several blocks**	1	2	3
11. Walking **one block**	1	2	3
12. Bathing or dressing yourself	1	2	3

During the **past 4 weeks**, have you had any of the following problems with your work or other regular daily activities **as a result of your physical health** ?: **(Circle One Number on Each Line)**	Yes	No
13. Cut down the amount of time you spend on work or other activities	1	2
14. Accomplish less than you would like	1	2
15. Were limited in the kind of work or other activities	1	2
16. Had difficulty performing the work or other activities (for example, took extra effort)	1	2

During the **past 4 weeks**, have you had any of the following problems with your work or other regular daily activities **as a result of any emotional problems** ?: (depressed, anxious) **(Circle One Number on Each Line)**	Yes	No
17. Cut down the amount of time you spend on work or other activities	1	2
18. Accomplish less than you would like	1	2
19. Didn't do work or other activities as carefully as usual	1	2

20. During the **past 4 weeks**, to what extent has your physical health or emotional: problems interfered with your normal social activities with family, friends, neighbors or groups?
(Circle One Number)

Not at all	1
Slightly	2
Moderate	3
Quite a bit	4
Good	5

21. How much **bodily** pain have you had during the **past 4 weeks**:
(Circle One Number)

None 1
Very Mild 2
Mild 3
Moderate 4
Severe 5
Very Severe 6

22. During the **past 4 weeks**, how much did pain interfere with your normal work (including both work outside the home and housework ?
(Circle One Number)

Not at all 1
Slightly 2
Moderately 3
Quite a bit 4
Extremely 5

These questions are about how you feel and how things have been with you **during the past 4 weeks**.
For each question, please give the one answer that comes closest to the way you have been feeling.

How much of the time during the past 4 weeks . . . **(Circle One Number on Each Line)**	All of the Time	Most of the Time	A Good Bit of the Time	Some of the Time	A Little of the Time	None of the Time
23. Did you feel full of pep ?	1	2	3	4	5	6
24. Have you been a very nervous person ?	1	2	3	4	5	6
25. Have you felt so down in the dumps that nothing could cheer you up ?	1	2	3	4	5	6
26. Have you felt calm and peaceful ?	1	2	3	4	5	6
27. Do you have a lot of energy ?	1	2	3	4	5	6
28. Have you felt downhearted and blue ?	1	2	3	4	5	6
29. Did you feel worn out ?	1	2	3	4	5	6
30. Have you been a happy person ?	1	2	3	4	5	6
31. Did you feel tired ?	1	2	3	4	5	6

32. During the **past 4 weeks,** to what extent has your **physical health or emotional problems** interfered with your normal social activities like visiting with family, friends, relatives, etc.?
(Circle One Number)

All of the time 1
Most of the time 2
Some of the time 3
A little of the time 4
None of the time 5

How TRUE or FALSE is each of the following statements for you ? **(Circle One Number on Each Line)**	Definitely True	Mostly True	Don't Know	Mostly False	Definitely False
33. I seem to get sick a little easier than other people	1	2	3	4	5
34. I am as healthy as anybody I know	1	2	3	4	5
35. I expect my health to get worse	1	2	3	4	5
36. My health is excellent	1	2	3	4	5

Comments: ______________________________

____

Patient Signature: ______________________ Date ____________

CONFIDENTIAL

Doctor's Lien

To: ______________________________

____

____

____

RE: Medical Reports and Doctor's Lien

Doctor: ______________________________
11960 West 119th Street
Overland Park, KS 66213

I do hereby authorize the above doctor to furnish you with a report of his examination, diagnosis, treatment, prognosis, etc., of myself in regard to the accident in which I was involved.

I hereby authorize and direct you to pay directly to said doctor such sums as may be due and owing him for medical services rendered me both by reason of this accident and by reason of any other bills that are due his office and to withhold such sums from settlement, judgment or verdict as may be necessary to adequately protect said doctor. And I hereby further give a lien on my case to said doctor against any and all proceeds of any settlement, judgment or verdict which may be paid to you or myself as the result of the injuries for which I have been treated or injuries in connection therewith.

I fully understand that I am directly and fully responsible to said doctor for all medical bills submitted by him for service rendered me and that this agreement is made solely for said doctor's additional protection and in consideration of his awaiting payment. And I further understand that such payment is not contingent on any settlement judgment or verdict by which I may eventually recover said fee.

Date: ____________________ Patient's Signature ______________________________

The undersigned does hereby agree to observe all the terms of the above and agrees to withhold such sums from any settlement, judgment or verdict as may be necessary to adequately protect said doctor above named.

Date: ____________________ Signature ______________________________

Please date, sign and return a copy to doctor's office at once.
Keep one copy for your records.