Florida Functional Neurology Group
WWW.FFNG.ORG
4076 E. FL-44 Ste. 4 Wildwood, FL. 34785
P: 352-571-5155 info@FFNG.org F: 352-877-9637

Confidential Patient Information

Patients Name:_____ Chief Complaint:_____

Address:_____ Home Phone:_____

_____ Cell: _____

Email:_____ Marital Status: M S W D

Date of Birth:_____ Employer:_____

Occupation:_____ Previous Chiropractic Care: No / Yes

Referred by:_____

Are your present systems or condition related to, or the result of an auto collision, work-related injury or other personal injury? (Someone else might be responsible for payment?) ___Yes___No

Surgeries:

- ☐ Tonsillectomy
- ☐ Gall bladder removal
- ☐ Appendectomy
- ☐ Hernia repair
- ☐ Breast implant surgery
- ☐ Cesarean Section
- ☐ Thyroid surgery
- ☐ Stomach surgery
- ☐ Rectal surgery
- ☐ Abdominal surgery
- ☐ Tubes in ears
- ☐ Knee/hip replacement L / R L / R Shoulder L R
- ☐ Neurosurgery
- ☐ Spinal surgery
- ☐ Cardiac surgery
- ☐ Orthopedic surgery
- ☐ Female surgery
- ☐ Male Surgery

Other: _____ When_____

Recent Illness? _____ _____

Cancer? Y/ Diabetes? High Blood Pressu Thyroid Issues Psychological Tremors? Falls/Balance

Autoimmunity: N/ Y:_____ **Allergies** N / Y:_____

Sensitivities? Chemical ☐ Scent ☐ Metal ☐ WiFi ☐ Other**:**_____ **Memory/Recall/Word Retrieval:** Y/ N

Bowels Regular Irregular Constipation ☐ Diarrhea ☐ **Bladder**: Regular Incontinence Trouble starting Trouble stopping ☐

Smoke: Never Quit a long time ago Current Trying to Quit **Soda** Y/N **Coffee** Y/N **Card Accident(s)**: N/Y: how many?_____ **Concussion** _____?

Sleep: Easily fall asleep Y/N **S**tay asleep? Y/N why? pain urinate **A**waken feeling rested? Y/N Average hours of sleep: _____ Nap during day Y/N

Pacemaker? N/Y **Ur/Col Ostomy?** N/Y **Spinal Stimulator** N/Y Hardware: Cervical Lumbar Joint: Shoulder Hip Knee Other:_____

Previous Care for this(ese) Complaint(s): Medical ☐ Medication ☐ Physical Therapy ☐ Chiropractic ☐ Past Care: Helped Transient Relief Did not Help

Previous Imaging? N / Y; location : Lake Medical Imaging (LMI) Sharon Morse Hospital Medical Imaging & Therapeutics (MIT) Sandlake Imaging Other:_____

Neck: Xray ☐ MRI ☐ CT ☐ Year:_____ Low Back: Xray ☐ MRI ☐ CT ☐ Year:_____ Other:_____

Please included a list of all current medications and/or supplements; their dosages and brand (see back of form)

_____ _____

Signature of Patient/Parent /Guardian **Date**

Your last office visit from your medical physician SHOULD contain all your current medications. Make sure to sign the Records Requestso that we can request these documents

Dosage and Prescribing Physician

Medication Name	Dosage	Physician
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		
Medical Physicians	Conditions	Contact Info
1.		
2.		
3.		
4.		
5.		
6.		
7.		

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EXPLANTATION OF CHIROPRACTIC MEDICARE BENEFITS

A. Medicare Part B does cover chiropractic care! However, the only portion of care provided by a chiropractic physician/office that Medicare **COVERS is** the *manipulation of the spine**; the neck , mid-back, low back, pelvis, and sacrum** (chiropractic adjustment**) when a patient has documented pain.*** Medicare will pay for services that it determines to be "reasonable and necessary" under section 1862 (a)(1) of the Medicare law. If Medicare determines that a particular service (spinal manipulation), although it would be otherwise covered, is "not reasonable and necessary", Medicare will deny payment for that service.

A. Please initial here_____

B. Medicare Part B ***DOES NOT COVER* *DOES NOT COVER* *DOES NOT COVER* *DOES NOT**

1. The cost of the initial examination and reevaluations every 30 days. **These are required by Medicare.** 1. Please initial here_____
2. X-rays, MRIs, or other testing ordered by a chiropractic physician. 2. Please initial here_____
3. Chiropractic treatment to any body part other than the neck, mid back, low back, and pelvis. (i.e . shoulder, elbow, wrist, hand, knee, ankle, feet, jaw, cranium, viscera, etc. **are excluded by Medicare** 3. Please initial here_____
4. The use of any therapy such as: spinal decompression table, photomedicine (LASER or LED), Physical Therapies (Electrical therapies, Heat/Ice, Ultrasound, Traction, etc.) supplements, ice packs, or other therapies offered at this office, **to any and all body parts.** 4. Please initial here_____
5. Functional Neurology, Health, and Medicine 5. Please initial here_____
6. Recommendations/Review of testing and/or results 6. Please initial here_____

MEDICARE Part B covers spinal manipulation(s) when the patient is experiencing achenes, stiffness, burning pain, sharp pain, numbness & tingling, pins & needles, when these dysfunctions are interfering with their "daily living activities". Patients will be placed on a treatment plan to alleviate pain, with a goal of improving the patient's condition, and to return them to their "activities of daily living". Often it is in the best interest of patients to continue **TREATMENT ON A MONTHLY BASIS** to prevent an exacerbation (worsening) of their condition(s). Medicare **WILL NOT PAY FOR THIS CARE**. However, if at *any time after being released from care*, you experience an exacerbation **(worsening of condition)**, your visits **WILL BE COVERED** by Medicare, after an examination. It is important that you DO NOT DISCONTINUE CARE BASED ON WHAT MEDICARE WILL PAY.

C. Medicare Part B requires a brief inventory at each office visit of your current pain level in regard to your current condition(s). If you mark "**0 out of 10** on the **intake**/iPad, **YOU WILL BE FINANCIALLY RESPONSIBLE for all services rendered** to you on that day, even those that would be normally covered (spinal manipulation). C. Please initial here:_____

I,_____,
(PRINT NAME) HAVE READ AND UNDERSTAND THE ABOVE STATEMENT. I AM AWARE THAT I AM FINANCIALLY RESPONSIBLE FOR ANY SERVICE(S) NOT COVERED BY MEDICARE PART B. I AM AWARE THAT MEDICARE PART B DOES NOT PAY FOR MAINTANENCE CARE.

SIGANATURE DATE

4076 East FL-44 #14, Wildwood, FL. 34785 P: (352) 571-5155 F: (352) 877-9637 info@ffng.org

PATIENT OPTIONS ACCESS PROGRAM

FREE PATIENT ENROLLMENT AGREEMENT

As a patient, you are a participant in a Discount Managed Care Organization provided by Patient Options. There is NO FEE for patients to participate, and it is provided free to the public for those who are uninsured or otherwise underinsured. This Agreement and its terms and conditions, is between you and Patient Options. This Agreement is effective as of the date you sign below and are electronically enrolled at www.PatientOptions.org by your Provider and shall continue for a period of exactly one year (12 months) from the date of signature below. You will automatically be reenrolled for successive one year (12 month) periods unless request in writing.

There are no fees, dues, charges or other consideration required for participation.

DISCLOSURES:

· The Program provides discounts to you from contracted healthcare providers for services rendered;

· The Program participant is obligated to pay for all healthcare services directly as de facto 3rd party to provider but will receive a contractual discount from healthcare providers who have contracted with Patient Options;

·This is NOT insurance or a qualified policy under the Affordable Care Act or any state regulated program. Patient agrees this program and the discounts offered by contracted Providers are not available in instances where another third party insurance company is responsible for charges.

· Patient absolves provider of wrongdoing in the event the patient chooses to bill insurance for discounted services rendered under this Agreement;

· The name and address of the Discount Managed Care Organization is: Patient Options; 9435 Waterstone Blvd., Suite #140, Cincinnati, Ohio 45249. (866) 275-5633

This Disclosure and its Benefit descriptions represent the entire agreement between you and Patient Options and supersedes all other prior representations, statements, or written agreements between you and Patient Options.

I have read and agree to the terms and conditions set forth above:

Name:_____ Signature:_____

Address:_____ Date:_____

_____

_____

**Additional Household participants may be enrolled free of charge under the same terms of this Agreement. To activate, please write their names below:

1._____ 2._____

3._____ 4._____

5._____ 6._____

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A patient, in coming to the chiropractic physician, gives the doctor permission and authority to care for the patient in accordance with the chiropractic tests, diagnosis, and analysis. The chiropractic adjustment or other clinical procedures are usually beneficial and seldom cause any problems. In rare cases, underlying physical defects, deformities or pathologies may render the patient susceptible to injury. The doctor, of course will not give any treatment or care if he is aware that such care may be contra-indicated. Again, it is the responsibility of the patient to make it known that he/she is suffering from: latent pathological defects, illnesses or deformities which would otherwise not come to the attention of the chiropractic physician. The board certified chiropractic neurologist provides a specialized, non-duplicating health care service. Your doctor of chiropractic is licensed in a special practice and is available to work with other types of providers in your health care regimen. I understand that if I am accepted as a patient, I am authorizing FFNG and its' staff to proceed with any treatment that may be necessary. Furthermore, any risk involved, regarding chiropractic treatment, will be explained to me upon my request.

To the best of my knowledge I am pregnant_____ I am NOT pregnant_____

I give my permission to X-ray_____ I DO NOT give my permission to x-ray me for diagnostic interpretation. _____

Missed Appointments:

There is a possible $25 fee charged for all appointments that are not canceled prior to scheduled visit.

Consent to Evaluate and Treat a Minor:

_____being the parent or legal guardian of_____, have read and fully understand the above terms of acceptance and hereby grant permission for my child to receive chiropractic care.

Communications:

In the event that we would need to communicate your healthcare information, to whom may we do so?

Spouse: _____

Children: _____

Others: _____

_____ None

May we mail postcards or leave messages on any answering device, i.e. home answering machines or voicemails? Yes_____ No_____

Acknowledgement:

I have reviewed the notice of privacy practices (HIPAA) and have been provided an opportunity to discuss my right to privacy. Upon reques I will be given a copy.

I, _____ , have read and fully understand the above statements.

Signature:_____ Date_____

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Alexander C. Frank, D.C., D.A.C.N.B., F.A.B.E.S.
Board Certified Chiropractic Neurologist
Diplomate, American Chiropractic Neurology Board
Fellow, Electrodiagnostic Specialties

Please describe in your own words the condition(s) you are seeking evaluation for. When did it start? What makes it better? What makes it worse? Information such as "pain is worse in the morning", or "the pain reduces when I lay on my left side". What has/has not helped?

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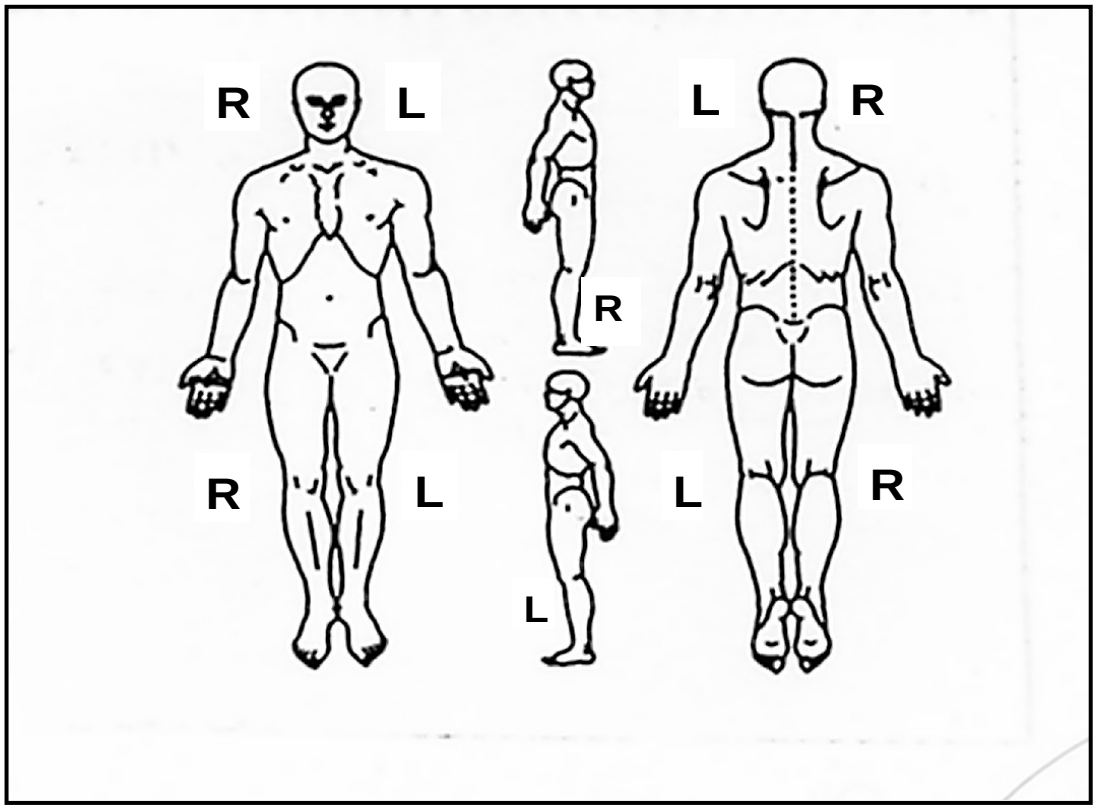
Name: _____

SYMPTOM CHART: *[If you are currently experiencing symptoms, on the chart below place an **X** on **all** the area(s) where symptom(s) are present.]*



Rate your pain levels on a scale of 0-10

0 = There are times, when I am awake, that I do not notice pain.
9 = I almost pass out because of pain and I cannot get out of bed.
10 = I pass out because of pain.

Neck Pain:

This pain when at its ***worst*** = 0
This pain when at its ***best*** = 0

I notice my **neck** pain this % of the day
Select one

☐ Stiff ☐ Pressure ☐ Dull ☐ Numbness ☐ Pulling ☐ Sharp
☐ Pins/Needles ☐ Burning ☐ Tingling ☐ Ache ☐ Other_____ __ Other_____

Where does the pain radiate to? _____
How long after the accident did you begin to feel **neck** related symptoms? _____

Upper / Mid Back:

This pain when at its ***worst*** = 0
This pain when at its ***best*** = 0

I notice my pain this % of the day
Select one

Check all that apply ☐ Upper Back ☐ Goes into my neck ☐ Mid Back ☐ Shoulder Blades
☐ Goes in to lower back ☐ Other _____ ____ Other _____

Check all that apply for the quality of your **upper / mid back** symptoms:
☐ Stiff ☐ Pressure ☐ Dull ☐ Numbness ☐ Pulling ☐ Sharp
☐ Pins/Needles ☐ Burning ☐ Tingling ☐ Ache ☐ Other_____ __ Other_____

Where does the pain radiate to? _____
How long after the accident did you begin to feel **upper / mid back** related symptoms? _____

Cont.

Name: _____

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Rate your pain levels on a scale of 0-10

0 = There are times when I am awake that I do not notice pain.
9 = I almost pass out because of pain and I cannot get out of bed.
10 = I pass out because of pain.

Low Back Pain:

My **back** pain when at its ***worst*** = select one
My **back** pain when at its ***best*** = select one

I notice my **back** pain this % of the day
Select one

Check all that apply for the quality of your **low back** symptoms:

☐ Stiff ☐ Pressure ☐ Dull ☐ Numbness ☐ Pulling ☐ Sharp
☐ Pins/Needles ☐ Burning ☐ Tingling ☐ Ache ☐ Other_____ __ Other_____

Where does your pain radiate to? _____

How long after the accident did you begin to feel **low back** related symptoms? _____

Headaches:

My **headaches** when at its ***worst*** = select one
My **headaches** when at its ***best*** = select one

I notice my **headaches** % of the day
Select one

How many days a week do you have **headaches**? select one 7 How many headaches do you have a day? 0

Check all that apply for the quality of your **headache** symptoms:

☐ Throbbing ☐ Pulsating ☐ Pounding ☐ Constant ☐ Tight
☐ Squeezing ☐ Pressure ☐ Sharp ☐ Grinding ☐ Tender

Please mark symptoms that are associated with your **headaches:**

☐ Loss of consciousness ☐ Light sensitivity ☐ Nausea or vomiting ☐ Noise sensitivity ☐ Dizziness
☐ Neck stiffness ☐ Numbness in face/arm/hand ☐ Visual disturbances ☐ Other _____

How long after the accident did you begin to feel your **headaches**? _____

Arm, Leg, Hand, etc.: SIDE select one

This pain when at its ***worst*** = select one
This pain when at its ***best*** = select one

I notice my pain this % of the day
Select one

Check all that apply for the quality of these symptoms:

☐ Stiff ☐ Pressure ☐ Dull ☐ Numbness ☐ Pulling ☐ Sharp
☐ Pins/Needles ☐ Burning ☐ Tingling ☐ Ache ☐ Pinching ☐ Throbbing
☐ Nagging ☐ Other_____

How long after the accident did you begin to feel **these** symptoms? _____

Arm, Hand,Leg, etc: _____ SIDE select one

This pain when at its ***worst*** = select one
This pain when at its ***best*** = select one

I notice my pain this % of the day
Select one

Check all that apply for the quality of these symptoms:

☐ Stiff ☐ Pressure ☐ Dull ☐ Numbness ☐ Pulling ☐ Sharp
☐ Pins/Needles ☐ Burning ☐ Tingling ☐ Ache ☐ Pinching ☐ Throbbing
☐ Nagging ☐ Other_____

How long after the accident did you begin to feel **these** symptoms? _____

Please provide any additional symptoms / information here: _____

_____

_____

_____

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Patient:_____

Date:_____

Review of Systems

Please check all that apply

General-
□ Weight loss or gain
□ Fatigue
□ Fever or chills
□ Weakness
□ Trouble sleeping

Skin-
□ Rashes
□ Lumps
□ Itching
□ Dryness
□ Color changes
□ Hair and nail changes

Head-
□ Headache
□ Head injury
□ Neck Pain

Ears-
□ Decreased hearing
□ Ringing in ears
□ Earache
□ Drainage

Eyes-
□ Vision Loss/Changes
□ Glasses or contacts
□ Pain
□ Redness
□ Blurry or double vision
□ Flashing lights
□ Specks
□ Glaucoma
□ Cataracts
□ Last eye exam

Nose-
□ Stuffiness
□ Discharge
□ Itching
□ Hay fever
□ Nosebleeds
□ Sinus pain

Throat-
□ Bleeding
□ Dentures
□ Sore tongue
□ Dry mouth
□ Sore throat
□ Hoarseness
□ Thrush
□ Non-healing sores

Neck-
□ Lumps
□ Swollen glands
□ Pain
□ Stiffness

Breasts-
□ Lumps
□ Pain
□ Discharge
□ Self-exams
□ Breast-feeding

Respiratory-
□ Cough
□ Sputum
□ Coughing up blood
□ Shortness of breath
□ Wheezing
□ Painful breathing

Cardiovascular-
□ Chest pain or discomfort
□ Tightness
□ Palpitations
□ Shortness of breath with activity
□ Difficulty breathing lying down
□ Swelling
□ Sudden awakening from sleep with shortness of breath

Gastrointestinal-
□ Swallowing difficulties
□ Heartburn
□ Change in appetite
□ Nausea
□ Change in bowel habits
□ Rectal bleeding
□ Constipation
□ Diarrhea
□Yellow eyes or skin

Urinary-
□ Frequency
□ Urgency
□ Burning or pain
□ Blood in urine
□ Incontinence
□ Change in urinary strength

Vascular-
□ Calf pain with walking
□ Leg cramping

Musculoskeletal-
□ Muscle or joint pain
□ Stiffness
□ Back pain
□ Redness of joints
□ Swelling of joints
□ Trauma

Neurologic-
□ Dizziness
□ Fainting
□ Seizures
□ Weakness
□ Numbness
□ Tingling
□ Tremor

Hematologic-
□ Ease of bruising
□ Ease of bleeding

Endocrine-
□ Head or cold intolerance
□ Sweating
□ Frequent urination
□ Thirst
□ Change in appetite

Psychiatric-
□ Nervousness
□ Stress
□ Depression
□ Memory loss

Signature _____

P: (352) 571-5155 F: (352) 877-9637 info@ffng.org

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AUTHORIZATION TO RELEASE & RECEIVE X-RAYS & INFORMATION

To:_____
(NAME OF HEALTH CARE PROVIDER, CLINIC, HOSPITAL, ETC.)

For:_____

_____

_____

_____

_____

_____

_____

I, _____ DOB:_____
(PATIENT'S NAME)

REQUEST THE FOLLOWING INFORMATION:

☐ X-RAYS ☐ HISTORY ☐ RECORDS ☐ DIAGNOSIS ☐ REPORTS ☐ TREATMENT

CONCERNING MY: ☐ ILLNESS ☐ ACCIDENT ☐ INJURY ☐ OTHER_____

To be released to To be released from

ALEXANDER C. FRANK, DC, DACNB

Florida Functional Neurology Group

4076 East FL-44 #4, Wildwood, FL. 34785

Fax 352.877.9637 Email: info@FFNG.org Phone: 352.571.5155

I UNDERSTANT THAT I HAVE A RIGHT TO RECEIVE A COPY OF THIS AUTHORIZATION UPON MY REQUEST.

SIGNATURE:_____DATE: _____

◯ PATIENT ◯ PARENT ◯ GUARDIAN

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This form is utilized along with examination findings to determine if your care is warranted, as defined by Medicare, and thus may be covered by Medicare

Neck Disability Index (Vernon-Mior)

Patient Name: _____

This questionnaire has been designed to enable us to understand **how much your neck pain has affected your ability to manage your everyday activities**. Please answer every section by circling the **ONE CHOICE** that most applies to you. We realize that you may feel that two of the statements in any one section relate to you, but PLEASE circle **ONE CHOICE** only per section.

SECTION 1--Pain Intensity
- A. I have no pain at the moment
- B. The pain is mild at the moment.
- C. The pain comes and goes and is moderate.
- D. The pain is moderate and does not vary much.
- E. The pain is severe but comes and goes.
- F. The pain is severe and does not vary much.

SECTION 2--Personal Care (Washing, Dressing etc.)
- A. I can look after myself 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 the floor but I can 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 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--Headache
- A. I have no headaches at all.
- B. I have slight headaches which come infrequently.
- C. I have moderate headaches which come in-frequently.
- 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 concentrating when I want to.
- D. I have a lot of difficulty concentrating when I want to.
- E. I have a great deal of difficulty 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 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 my car 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 engage in all recreational activities with no pain in my neck at all.
- B. I am able engage in all recreational activities with some pain in my neck.
- C. I am able engage in most, but not all recreational activities because of pain in my neck.
- D. I am able 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.

Patient Signature _____

Date

THE FAILURE TO FILL OUT THIS DOUCMENT AS INSTRUCTED, AND COMPLETLEY, WILL BE CONSTRUED AS YOU WANTING MAINTENANCE CARE, WHICH IS ***NOT COVERED BY MEDICARE*** **YOU AGREE TO BE FINANCIALLY RESPONSIBLE FOR CARE AT THIS OFFICE.**

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This form is utilized along with examination findings to determine if your care is warranted, as defined by Medicare, and thus may be covered by Medicare

Revised Oswestry Pain Questionnaire

Patient Name: _____

This questionnaire has been designed to enable us to understand how much your **low back pain** has affected your ability to manage your everyday activities. Please answer every section by circling the ONE CHOICE that most applies to you. We realize that you may feel that two of the statements in any one section relate to you, but PLEASE circle ONE CHOICE only per section.

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.

SECTION 2--Personal Care (Washing, Dressing etc.)
A. I do 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. 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 me extra pain.
C. Pain prevents me from lifting weights off the floor.
D. Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently placed, e.g., on a table.
E. Pain prevents me from lifting heavy weights off the floor, but I can manage light to medium weights if they are conveniently placed.
F. I can only lift very light weights at the most.

SECTION 4 --Walking
A. I have no pain walking.
B. I have some pain on walking, but it does not increase with distance.
C. I cannot walk more than one mile without increased pain.
D. I cannot walk more than ½ mile without increased pain
E. I cannot walk more than ¼ mile without increasing pain.
F. I cannot walk at all without increasing pain.

SECTION 5--Sitting
A. I can sit in any chair as long as I like.
B. I can sit only 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 ½ hour.
E. Pain prevents me from sitting more than 10 minutes.
F. I avoid sitting because it increases pain immediately.

SECTION 6--Standing
A. I can stand as long as I want without pain
B. I have some pain on standing, but it does not increase with time.
C. I cannot stand for longer than one hour without increase pain
D. I cannot stand longer than ½ hour without increasing pain.
E. I cannot stand longer than 10 minutes without increased pain.
F. I avoid standing because increases pain immediately.

SECTION 7--Sleeping
A. I have no pain in bed.
B. I have pain in bed, but it does not prevent me from sleeping well.
C. Because of my pain my sleep is reduced by less than ¼
D. Because of my pain my sleep s reduces by less than ½
E. Because of my pain my sleep is reduced by less than ¾
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 my pain.
C. Pain has no significant effect on my social life, apart from limiting my more energetic interests, e.g., dancing, ect.
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 my 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 from traveling, but it does not compel me to seek alternative forms of travel.
D. I get extra pain from 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.

Patient Signature

Date

THE FAILURE TO FILL OUT THIS DOUCMENT AS INSTRUCTED, AND COMPLETLEY, WILL BE CONSTRUED AS YOU WANTING MAINTENANCE CARE, WHICH IS ***NOT COVERED BY MEDICARE.*** **YOU AGREE TO BE FINANCIALLY RESPONSIBLE FOR CARE AT THIS OFFICE.**

SUBMIT FORMS