Cynthia Smith Chiropractic and Acupuncture

- Auto Accident Questionnaire -

- Patient Information -

Name: _____
First Middle Last

Mailing Address: _____ Apt:_____ City:_____ State:_ Zip:_____

Email Address: _____

Phone #: (H)_____ (W)_____(C)_____

Date of Birth: _____ Age:_____ Sex: ☐ Male ☐ Female

☐ Marital Status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed ☐ Minor

Occupation: _____ Employer:_____

How did you hear about our office? _____

Emergency Contact/Relation: _____ Phone #:_____

- Auto Insurance Information -

	At Fault Party/Other Vehicle	**Your Car Insurance**
Name of Insurance Company Or Law Firm Name:	_____	_____
Insurance Claim Number Or Case Number:	_____	_____
Adjuster or Lawyer Name:	_____	_____
Phone Number:	_____	_____

- Benefits Assignment

(Insured Patients Only)

I certify that my (or my dependent) have insurance coverage with_____and I AUTHORIZE, REQUEST AND ASSIGN MY INSURANCE COMPANY TO PAY DIRECTLY TO THE PHYSICIAN/MEDICAL PRACTICE, INSURANCE PAYMENTS OTHERWISE PAYABLE TO ME. I hereby authorize the doctor to release all information necessary, including diagnosis and records of any exam or treatment rendered to me, in order to secure the payment of benefits. I authorize the use of this signature on all insurance claims, excluding electronic submissions.

Notice: Having insurance information is not a guarantee that they will cover your fees in full. Whatever your insurance provider does not pay will be your responsibility. If you fail to keep in contact with the insurance company and your case closes before our bill is paid in full, you will be responsible for your balance.

Signature:_____ Date: _____

- Accidents and Injuries -

Date of Accident: _____ Time of Accident: _____ ☐ am. ☐ pm.

City, street(s) and location of the accident:

_____

What type of vehicle were you in (make, model, year): _____

What type of vehicle was the other driver in (make, model, year): _____

Please describe in the accident in detail:

_____

_____

_____

_____

Please describe your position at the time of impact (e.g. seated in the passenger seat with my head turned):

_____

_____

_____

Please describe if you made any contact with interior surfaces of your car at the time of impact (e.g. knee hit dashboard, head hit window, etc.):

_____

_____

_____

When did you first notice your symptoms?

_____

_____

Were you taken to the Emergency Room or any other Healthcare Professional? ☐ Yes ☐ No

Were X-Rays taken? ☐ Yes ☐ No If yes, what was X-Rayed? ☐ Head ☐ Neck ☐ Upper Back ☐ Mid-Back ☐ Lower Back ☐ Other

_____

_____

- Medications -

Are you taking any medications (prescription or over-the-counter)? ☐ Yes ☐ No

If yes, please explain the reason: _____

- Health History -

Do you have any of the following conditions?

☐ Contagious Disease
☐ Infection
☐ Circulatory Problems
☐ Stroke/Heart Disease
☐ High Blood Pressure

☐ Arthritis
☐ Headaches
☐ Muscle Spasms
☐ Diabetes or Cancer
☐ Kidney Disease

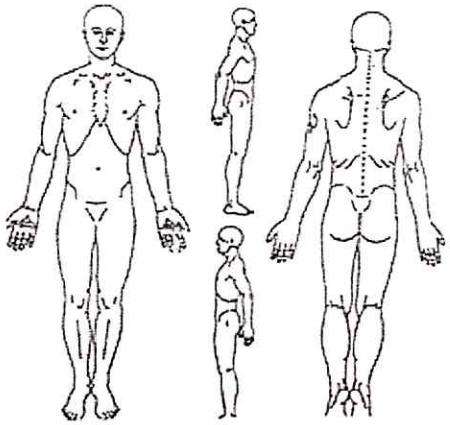
☐ Skin Problems
☐ Inflammation
☐ Flu or Cold
☐ Pinched Nerve

☐ Smoker
_ ___packs/day
☐ Low Blood Pressure
☐ Varicose Veins
☐ Lung Disease

☐ Allergies (including Oils/creams)
☐ Epilepsy/Seizures

- Current Health Condition -

Please indicate on the diagrams below your areas of pain or discomfort:



How long have you been experiencing your primary complaint? _____

Is your pain: ☐ Dull ☐ Achy ☐ Sharp ☐ Numb ☐ Tingling ☐ Burning ☐ Throbbing

Does your pain radiate down your arms and/or legs? ☐ Yes ☐ No If yes, please describe:_____

_____

Do you know what caused your current condition? ☐ Yes ☐ No If yes, please describe_____

_____

Is the pain: ☐ Constant ☐ Frequent ☐ Intermittent ☐ Occasional

Are you experiencing any headaches, dizziness, or blurry vision since the accident, please describe:

_____

What makes the pain feel better? _____

What makes the pain feel worse? _____

Use the scale below to rate the pain of your primary complaint:

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

Were there bleeding cuts caused by the accident? ☐ Yes ☐ No Where: _____

Did the accident cause any bruises? ☐ Yes ☐ No Where: _____

- Neurological/MRI Vascular Patient Questionnaire -

NAME: _____ DATE: _____

For any YES answer please include details:

1. Do you suffer from neck pain in your shoulders, arms or hands? NO YES

   Comments: _____

2. Do you have weakness, numbness or burning in your shoulders, arms or hands? NO YES

   Comments: _____

3. Do your hands or arms fall asleep regularly? NO YES

   Comments: _____

4. Do you have reduced feeling (sensation) or swelling in your arms or hands? NO YES

   Comments: _____

5. Do you suffer from loss of handgrip strength? NO YES

   Comments: _____

6. Do you suffer from back pain with pain in your buttocks, legs or feet? NO YES

   Comments: _____

7. Do you have weakness, numbness or burning in your buttocks, legs or feet? NO YES

   Comments: _____

8. Do your feet fall asleep regularly? NO YES

   Comments: _____

9. Do you have reduced feeling (sensation) or swelling in your legs or feet? NO YES

   Comments: _____

10. Do you suffer from cold hands or feet? NO YES

    Comments: _____

11. Do you have frequent falls or find that you trip over your feet while walking? NO YES

    Comments: _____

12. Do you suffer from headaches? If yes, how often, how severe and what have you tried for them? NO YES

    Comments: _____

13. Have you tried taking any medications such as anti-inflammatory? NO YES

    Comments: _____

14. Have you tried Physical Therapy, Chiropractic or Acupuncture treatments before? What kind? When? How long? NO YES

    Comments: _____

15. Have you had an MRI? If yes? Who ordered it? What was it ordered for? NO YES

    Comments: _____

16. Have you used any splint, braces or other prescribed treatment by an MD? What type? NO YES

    Comments: _____

17. If you tried any treatment or medication, did this make your problem better? NO YES

    Comments: _____

- Severity Rater -

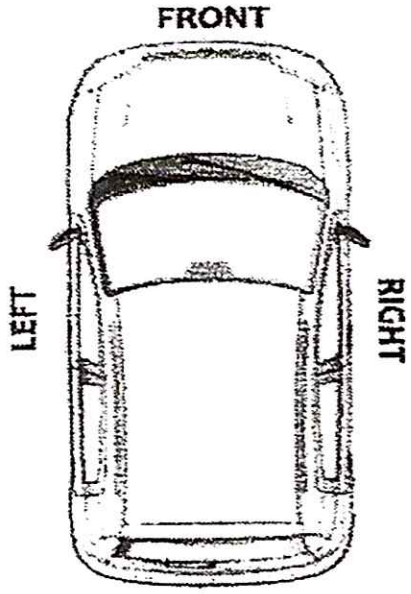
My pain is:

- ☐ Minimal and easily forgotten
- ☐ Mild and I feel it during activity but it does not interfere with my activities
- ☐ Slight and interferes only with strenuous activities
- ☐ Slight to moderate and interferes with light activities and strenuous activities
- ☐ Moderate and prevents light activities
- ☐ Moderate to severe and interferes with moderate activities ☐ Severe and prevents all activities

My vehicle status:

- ☐ My vehicle damage was minimal
- ☐ My vehicle suffered $0-$500 in damage
- ☐ My vehicle suffered $501-$1000 in damage
- ☐ My vehicle suffered $1001-$ 2000 in damage
- ☐ My vehicle suffered more than $2000 in damage
- ☐ My vehicle was totaled

Damage was to the: ☐ Front ☐ Rear ☐ Left side ☐ Right side



The following questions pertain to the other vehicle involved in the accident:

Other Vehicle Year:_____ Make:_____ Model:_____

Was the other car moving or stopped? ☐ Moving ☐ Stopped

If the other car was moving: How fast was it going? Approximately _____ m.p.h

Just before impact, the other car was: ☐ Slowing Down ☐ Speeding Up ☐ Constant Speed

Informed Consent

A patient coming to the doctor gives him/her permission and authority to care for them in accordance with appropriate test, diagnosis and analysis. The clinical procedures performed are usually beneficial and seldom cause any problem. In rare cases, the underlying physical defects, deformities or pathologies may render the patient susceptible for injury. The doctor, of course, will not provide specific healthcare, if he/she is aware that such care may be contraindicated. It is the responsibility of the patient to make it known or to learn through health care procedures from whatever he/she is suffering from: latent pathological defects, illnesses, or deformities which would otherwise not come to the attention of the physician.

I agree to settle any claim or dispute I may have against or with any of these persons or entities, whether related to the prescribed care or otherwise, will be resolved by binding arbitration under the current malpractice terms which can be obtained by written request.

_____ _____

Patients Signature Date

Chiropractic care, like all forms of health care, while offering considerable benefit may also provide some level of risk. This level of risk is most often very minimal, yet in rare cases injury has been associated with chiropractic care. The types of complications that have been reported secondary to chiropractic care include sprain/strain injuries, irritation of a disc condition, and rarely, fractures. One of the rarest complications associated with chiropractic care, occurring at a rate between one instance per million to one per two million cervical spine (neck) adjustments may be a vertebral artery injury that could lead to stroke.

Prior to receiving chiropractic care at this Chiropractic office, a health history and physical examination will be completed. These procedures are performed to assess your specific condition, your overall health and, in particular, your spine health. These procedures will assist us in determining if chiropractic care is needed or if any further examinations or studies are needed. In addition, they will help us determine if there is any reason to modify your care or provide you with a referral to another health care provider. All relevant findings will be reported to you along with a care plan prior to beginning care. I understand and accept that there are risks associated with chiropractic care and give consent to the examinations that the doctor deems necessary, and to the chiropractic care including spinal adjustments, as reported following my assessment.

I have had an opportunity to discuss with the doctor of chiropractic named below and/or with other office or clinic personnel the nature of my condition and diagnoses and purpose of chiropractic adjustments and other procedures. I understand the results are not guaranteed.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its content, and by signing below, I agree to the above named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

This notice is effective as of _____ and will expire 7 years after the date on which you last received services from us.
date

Patients Signature: _____ Date:_____

Printed Name: _____

CYNTHIA SMITH CHIROPRACTIC AND ACUPUNCTURE

Cynthia Smith
Chiropractic & Acupuncture
Newport Beach, CA
949-565-5015

NOTICE OF DOCTOR'S LIEN

PATIENT: _____ DATE OF ACCIDENT: _____

I do hereby authorize Cynthia Smith, D.C. to furnish you, my attorney, with a full 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, my attorney, to pay directly to said doctor such sums as may be due and owing him for the medical service rendered to me both by reason of this accident and by reason of any other bills that are due her office and to withhold such sums from any settlement, judgment, or verdict as may be necessary to adequately protect and fully compensate said doctor. And I hereby further give a Lien on my case to said doctor against any and all proceeds of my settlement, judgment, or verdict which may be paid to you, my attorney, or myself as a 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 her for services rendered to me and that this agreement is made solely for said doctor's additional protection and in consideration of her 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.

I agree to promptly notify said doctor of any change or addition of attorney(s) used by me in connection with this accident, and I instruct my attorney to do the same and to promptly deliver a copy of this lien to any such substituted attorney(s).

Please acknowledge this letter by signing below and returning it to the doctor's office. I have been advised that if my attorney does not wish to cooperate in protecting the doctor's interest, the doctor will not await payment and may declare the entire balance due and payable.

_____ _____

DATE PATIENT NAME PATIENT SIGNATURE

The undersigned, being attorney of record for the above named patient, 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 and fully compensate said doctor above-named. Attorney further agrees that in the event this lien is litigated, that the prevailing party will be awarded attorney fees and costs.

_____ _____

DATE ATTORNEY SIGNATURE

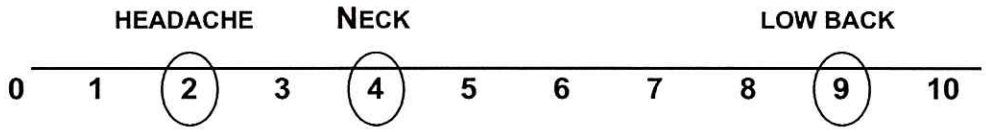
QUADRUPLE VISUAL ANALOGUE SCALE

Name _____ Number _____ Date _____

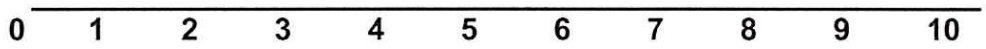
INSTRUCTIONS: Please circle the number that best describes the question being asked.

NOTE: If you have more than one complaint, please answer each question for each Individual complaint and indicate which score is for which complaint.

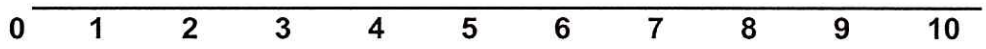
EXAMPLE:



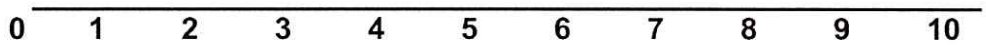
1. What is your pain RIGHT NOW?



2. What is your TYPICAL or AVERAGE pain?

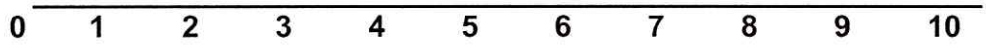


3. What is your pain AT ITS BEST (How close to "0" does your pain get at its best)?



What percentage of your awake hours is your pain at its best? _____%

4. What is your pain AT ITS WORST (How close to "10" does your pain get at its worst)?



What percentage of your awake hours is your pain at its worst? _____%

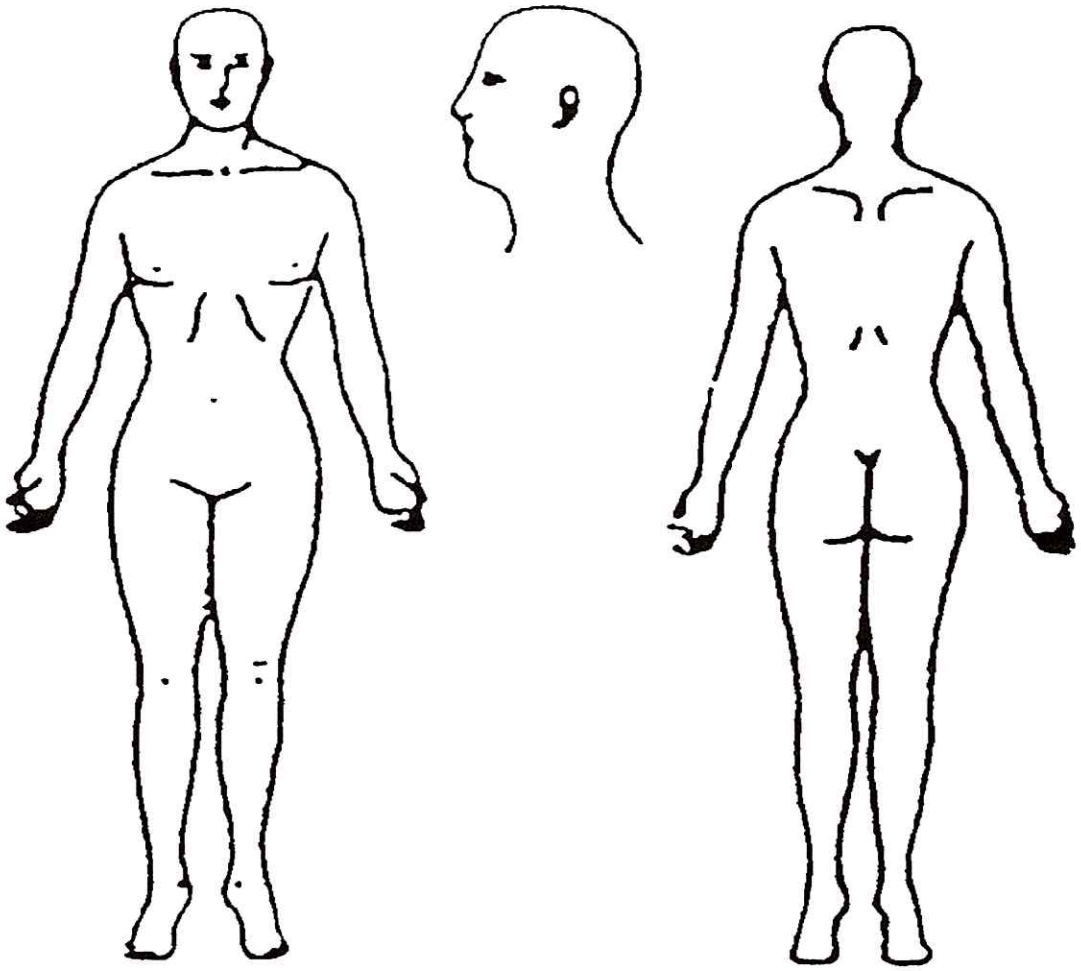
Reference: Thomeé R., Grimby G., Wright B.D., Linacre J.M. (1995) Rasch analysis of Visual Analog Scale. *Scandinavian Journal of Rehabilitation Medicine* 27, 145-151.

SYMPTOM DIAGRAM

Name _____ Number _____ Date _____

Please be sure to fill this form out extremely accurately. Mark the area(s) on your body where you feel the described sensation(s). Use the appropriate symbol(s). Mark areas of radiating pain, and include all affected areas. You may draw on the face as well.

Aches ΛΛΛΛ Numbness oooo Pins/Needles ●●●● Burning xxxx Stabbing ////



Reference: Randsford. Spine, Vol. 1, No 2, June 1976

HEADACHE DISABILITY INDEX

NAME: _____ DATE: _____ AGE: ____ SCORES TOTAL: ____; E____; F____
(100) (52) (48)

INSTRUCTIONS: Please CIRCLE the correct response:

1. I have headache: [1] 1 per month [2] more than but less than 4 per month [3] more than one per week.
2. My headache is: [1] mild [2] moderate [3] severe

INSTRUCTIONS: ***PLEASE READ CAREFULLY:*** The purpose of the scale is to identify difficulties that you may be experiencing because of your headache. Please check off "YES", "SOMETIMES", or "NO" to each item. Answer each item as it pertains to your headache only.

	YES	SOMETIMES	NO
E1. Because of my headaches I feel handicapped.	☐	☐	☐
F2. Because of my headaches I feel restricted in performing my routine daily activities.	☐	☐	☐
E3. No one understands the effect my headaches have on my life.	☐	☐	☐
F4. I restrict my recreational activities (e.g. sports, hobbies) because of my headaches.	☐	☐	☐
E5. My headaches make me angry.	☐	☐	☐
E6. Sometimes I feel that I am going to lose control because of my headaches	☐	☐	☐
F7. Because of my headaches I am less likely to socialize.	☐	☐	☐
E8. My spouse/significant other, or family and friends have no idea what I am going through because of my headaches.	☐	☐	☐
E9. My headaches are so bad that I feel I am going to go insane.	☐	☐	☐
E10. My outlook on the world is affected by my headaches.	☐	☐	☐
E11. I am afraid to go outside when I feel a headache is starting.	☐	☐	☐
E12. I feel desperate because of my headaches.	☐	☐	☐
F13. I am concerned that I am paying penalties at work or at home because of my headaches.	☐	☐	☐
E14. My headaches place stress on my relationships with family or friends.	☐	☐	☐
F15. I avoid being around people when I have a headache.	☐	☐	☐
F16. I believe my headaches are making it difficult for me to achieve my goals in life.	☐	☐	☐
F17. I am unable to think clearly because of my headaches.	☐	☐	☐
F18. I get tense (e.g. muscle tension) because of my headaches.	☐	☐	☐
F19. I do not enjoy social gatherings because of my headaches.	☐	☐	☐
E20. I feel irritable because of my headaches.	☐	☐	☐
F21. I avoid traveling because of my headaches.	☐	☐	☐
E22. My headaches make me feel confused.	☐	☐	☐
E23. My headaches make me feel frustrated.	☐	☐	☐
F24. I find it difficult to read because of my headaches.	☐	☐	☐
F25. I find it difficult to focus my attention away from my headaches and on other things.	☐	☐	☐

Reference: Jacobson Gary P., Ramadan NM, et al., The Henry Ford Hospital Headache Disability Inventory (HDI). Neurology 1994; 44:837-842

Patient's Name_____ Number_____ Date_____

NECK DISABILITY INDEX

This questionnaire has been designed to give the doctor information as to how your neck pain has affected your ability to manage in everyday life. **Please answer every section and mark in each section only ONE box** which applies to you. We realize you may consider that two of the statements in any one section relate to you, but **please just mark the box which MOST CLOSELY describes your problem.**

Section 1 - Pain Intensity

☐ I have no pain at the moment.
☐ The pain is very mild at the moment.
☐ The pain is moderate at the moment.
☐ The pain is fairly severe at the moment.
☐ The pain is very severe at the moment.
☐ The pain is the worst imaginable at the moment.

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

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

Section 3 – Lifting

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

Section 4 – Reading

☐ I can read as much as I want to with no pain in my neck.
☐ I can read as much as I want to with slight pain in my neck.
☐ I can read as much as I want with moderate pain.
☐ I can't read as much as I want because of moderate pain in my neck.
☐ I can hardly read at all because of severe pain in my neck.
☐ I cannot read at all.

Section 5-Headaches

☐ I have no headaches at all.
☐ I have slight headaches which come infrequently.
☐ I have slight headaches which come frequently.
☐ I have moderate headaches which come infrequently.
☐ I have severe headaches which come frequently.
☐ I have headaches almost all the time.

Scoring: Questions are scored on a vertical scale of 0-5. Total scores and multiply by 2. Divide by number of sections answered multiplied by 10. A score of 22% or more is considered a significant activities of daily living disability.
(Score___ x 2) / (____Sections x 10) = _____ %ADL_____

Section 6 – Concentration

☐ I can concentrate fully when I want to with no difficulty.
☐ I can concentrate fully when I want to with slight difficulty.
☐ I have a fair degree of difficulty in concentrating when I want to.
☐ I have a lot of difficulty in concentrating when I want to.
☐ I have a great deal of difficulty in concentrating when I want to.
☐ I cannot concentrate at all.

Section 7—Work

☐ I can do as much work as I want to.
☐ I can only do my usual work, but no more.
☐ I can do most of my usual work, but no more.
☐ I cannot do my usual work.
☐ I can hardly do any work at all.
☐ I can't do any work at all.

Section 8 – Driving

☐ I drive my car without any neck pain.
☐ I can drive my car as long as I want with slight pain in my neck.
☐ I can drive my car as long as I want with moderate pain in my neck.
☐ I can't drive my car as long as I want because of moderate pain in my neck.
☐ I can hardly drive my car at all because of severe pain in my neck.
☐ I can't drive my car at all.

Section 9 – Sleeping

☐ I have no trouble sleeping.
☐ My sleep is slightly disturbed (less than 1 hr. sleepless).
☐ My sleep is moderately disturbed (1-2 hrs. sleepless).
☐ My sleep is moderately disturbed (2-3 hrs. sleepless).
☐ My sleep is greatly disturbed (3-4 hrs. sleepless).
☐ My sleep is completely disturbed (5-7 hrs. sleepless).

Section 10 – Recreation

☐ I am able to engage in all my recreation activities with no neck pain at all.
☐ I am able to engage in all my recreation activities, with some pain in my neck.
☐ I am able to engage in most, but not all of my usual recreation activities because of pain in my neck.
☐ I am able to engage in a few of my usual recreation activities because of pain in my neck.
☐ I can hardly do any recreation activities because of pain in my neck.
☐ I can't do any recreation activities at all.

Comments_____
%ADL

Reference: Vernon, Mior. JMPT 1991; 14(7): 409-15

Patient's Name_____ Number_____ Date_____

LOW BACK DISABILITY QUESTIONNAIRE (REVISED OSWESTRY)

This questionnaire has been designed to give the doctor information as to how your back pain has affected your ability to manage in everyday life. **Please answer every section and mark in each section only ONE box** which applies to you. We realize you may consider that two of the statements in any one section relate to you, but **please just mark the box which MOST CLOSELY describes your problem.**

Section 1 - Pain Intensity

☐ I can tolerate the pain without having to use painkillers.
☐ The pain is bad but I can manage without taking painkillers.
☐ Painkillers give complete relief from pain.
☐ Painkillers give moderate relief from pain.
☐ Painkillers give very little relief from pain.
☐ Painkillers have no effect on the pain and I do not use them.

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

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

Section 3 – Lifting

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

Section 4 – Walking

☐ Pain does not prevent me from walking any distance.
☐ Pain prevents me from walking more than one mile.
☐ Pain prevents me from walking more than one-half mile.
☐ Pain prevents me from walking more than one-quarter mile
☐ I can only walk using a stick or crutches.
☐ I am in bed most of the time and have to crawl to the toilet.

Section 5 -- Sitting

☐ I can sit in any chair as long as I like
☐ I can only sit in my favorite chair as long as I like
☐ Pain prevents me from sitting more than one hour.
☐ Pain prevents me from sitting more than 30 minutes.
☐ Pain prevents me from sitting more than 10 minutes.
☐ Pain prevents me from sitting almost all the time.

Scoring: Questions are scored on a vertical scale of 0-5. Total scores and multiply by 2. Divide by number of sections answered multiplied by 10. A score of 22% or more is considered significant activities of daily living disability.
(Score___ x 2) / (____Sections x 10) = _____ %ADL

Section 6 – Standing

☐ I can stand as long as I want without extra pain.
☐ I can stand as long as I want but it gives extra pain.
☐ Pain prevents me from standing more than 1 hour.
☐ Pain prevents me from standing more than 30 minutes.
☐ Pain prevents me from standing more than 10 minutes.
☐ Pain prevents me from standing at all.

Section 7 -- Sleeping

☐ Pain does not prevent me from sleeping well.
☐ I can sleep well only by using tablets.
☐ Even when I take tablets I have less than 6 hours sleep.
☐ Even when I take tablets I have less than 4 hours sleep.
☐ Even when I take tablets I have less than 2 hours sleep.
☐ Pain prevents me from sleeping at all.

Section 8 – Social Life

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

Section 9 – Traveling

☐ I can travel anywhere without extra pain.
☐ I can travel anywhere but it gives me extra pain.
☐ Pain is bad but I manage journeys over 2 hours.
☐ Pain is bad but I manage journeys less than 1 hour.
☐ Pain restricts me to short necessary journeys under 30 minutes.
☐ Pain prevents me from traveling except to the doctor or hospital.

Section 10 – Changing Degree of Pain

☐ My pain is rapidly getting better.
☐ My pain fluctuates but overall is definitely getting better.
☐ My pain seems to be getting better but improvement is slow at the present.
☐ My pain is neither getting better nor worse.
☐ My pain is gradually worsening.
☐ My pain is rapidly worsening.

Comments_____

Reference: Fairbank, Physiotherapy 1981; 66(8): 271-3, Hudson-Cook. In Roland, Jenner (eds.), Back Pain New Approaches To Rehabilitation & Education. Manchester Univ Press, Manchester 1989: 187-204

LOW BACK PAIN DISABILITY QUESTIONNAIRE
(ROLAND-MORRIS)

Name _____ Number _____ Date _____

SCORE: _____

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 use a handrail to get upstairs.**
- ☐ **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 stand up only for short periods of time because of my back.**
- ☐ **Because of my back, I try not to bend or kneel down.**
- ☐ **I find it difficult to get out of a chair because of my back.**
- ☐ **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 (or stockings) because of pain in my back.**
- ☐ **I sleep less well because of my back.**
- ☐ **Because of 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 pain, I go upstairs more slowly than usual.**
- ☐ **I stay in bed most of the time because of my back.**

Reference: Roland, Morris. A Study of the Natural History of Back Pain Part 1: Development of a Reliable and Sensitive Measure of Disability in Low-Back Pain. Spine 1983; 8(2): 141-144

Medical Records Release Form

Patient Name: _____ Date of Birth: _____

By signing this form, I authorize you to release confidential health information about me, by releasing a copy of my medical records, or a summary or narrative of my protected health information, from the physician/person/facility/entity listed below.

Physician/Person/Facility/Entity:_____

Address:	Phone Number:
Fax Number:	Email:

The information you may release subject to this signed release form is as follows:

☐ Complete Records	☐ Care Plan	☐ Progress Notes
☐ History and Physical	☐ Lab Reports	☐ Radiology Reports
☐ Pathology Reports	☐ Treatment Record	☐ Operative Reports
☐ Hospital Reports	☐ Medication Record	☐ Other

Release my protected health information to the following:

Physician/Person/Facility/Entity: **Cynthia Smith Chiropractic and Acupuncture**

Cynthia Smith **Chiropractic & Acupuncture** **Newport Beach, CA** **949-565-5015**	Phone Number: **(949) 565 - 5015**
	Email: **hello@drcynthiasmith.com**

If the patient's request cannot be honored within 30 days, please notify us via fax within 10 days at the fax number listed above.

Patient's Signature: _____