Chiropractic Case History/Patient Information

Name: _____ Social Security #_____Home Phone: _____

Address: _____ City: _____ State: _____ Zip: _____

E-mail address: _____Fax # _____Cell Phone: _____

Age: _____ Birth Date: _____ Marital: M S W D Cell Service Provider: _____ Text: Y / N

Occupation: _____ Employer: _____

Employer's Address:_____ Office Phone:_____

Spouse:_____ Occupation:_____ Employer:_____

How many children? _____Names and Ages of Children: _____

_____

Name of Nearest Relative: _____ Address: _____Phone: _____

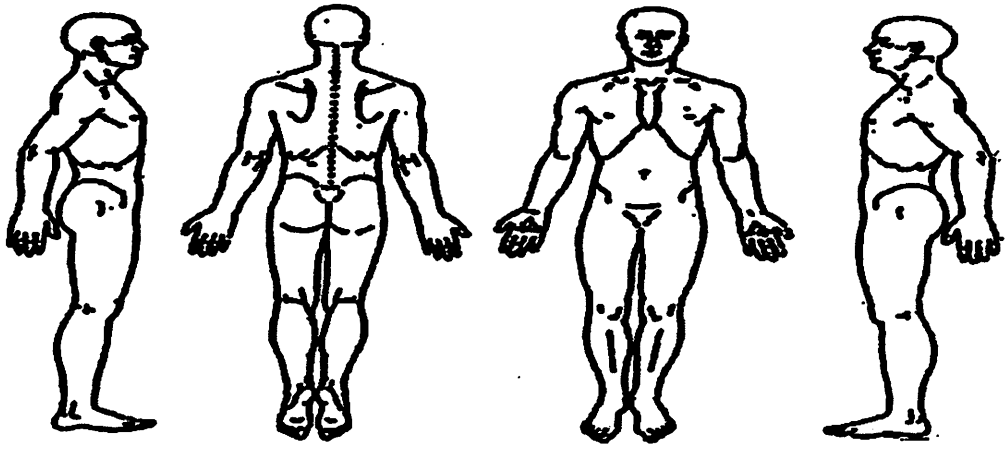
How were you referred to our office? _____

Family Medical Doctor: _____

When doctors work together it benefits you. May we have your permission to update your medical doctor regarding your care at this office? _____

1. Is today's problem caused by: □ Auto Accident □ Workman's Compensation

2. Indicate on the drawings below where you have pain/symptoms



3. How often do you experience your symptoms?

□ Constantly (76-100% of the time) □ Occasionally (26-50% of the time)
□ Frequently (51-75% of the time) □ Intermittently (1-25% of the time)

4. How would you describe the type of pain?

□ Sharp □ Numb
□ Dull □ Tingly
□ Diffuse □ Sharp with motion
□ Achy □ Shooting with motion
□ Burning □ Stabbing with motion
□ Shooting □ Electric like with motion
□ Stiff □ Other: _____

5. How are your symptoms changing with time?

□ Getting Worse □ Staying the Same □ Getting Better

6. Using a scale from 0-10 (10 being the worst), how would you rate your problem?

0 1 2 3 4 5 6 7 8 9 10 (*Please circle*)

7. How much has the problem interfered with your work?

□ Not at all □ A little bit □ Moderately □ Quite a bit □ Extremely

8. How much has the problem interfered with your social activities?

□ Not at all □ A little bit □ Moderately Quite a bit □ Extremely

9. Who else have you seen for your problem?

□ Chiropractor □ Neurologist □ Primary Care Physician
□ ER physician □ Orthopedist □ Other: _____
□ Massage Therapist □ Physical Therapist □ No one

10. How long have you had this problem? _____

11. How do you think your problem began?

_____

12. Do you consider this problem to be severe?
□ Yes □ Yes, at times □ No

13. What aggravates your problem?

_____

14. What concerns you the most about your problem; what does it prevent you from doing?

_____

15. What is your: Height_____ **Weight** _____

16. How would you rate your overall Health?
□ Excellent □ Very Good □ Good □ Fair □ Poor

17. What type of exercise do you do?
□ Strenuous □ Moderate □ Light □ None

18. Indicate if you have any immediate family members with any of the following:
□ Rheumatoid Arthritis □ Diabetes □ Lupus
□ Heart Problems □ Cancer □ ALS

19. 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
□	□ 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	**For Females Only**	
□	□ Jaw Pain	□	□ Abdominal Pain	□	□ Birth Control Pills
□	□ Joint Pain/Stiffness	□	□ Ulcer	□	□ Hormonal Replacement
□	□ Arthritis	□	□ Hepatitis	□	□ Pregnancy
□	□ Rheumatoid Arthritis	□	□ Liver/Gall Bladder Disorder		
□	□ Cancer	□	□ General Fatigue		
□	□ Tumor	□	□ Muscular Incoordination		
□	□ Asthma	□	□ Visual Disturbances		
□	□ Chronic Sinusitis	□	□ Dizziness		
□	□ Other: _____				

20. List all prescription medications you are currently taking:

_____

21. List all the over-the-counter medications you are currently taking:

_____

22. List all surgical procedures you have had:

_____

23. 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 of the day	□ A little of the day

24. What activities do you do outside of work?

_____

25. Have you ever been hospitalized? □ No □ Yes
if yes, why _____

26. Have you had significant past trauma? □ No □ Yes

27. Anything else pertinent to your visit today? _____

Please check any and all insurance coverage that may be applicable in this case:
□ Major Medical □Worker's Compensation □Medicaid □ Medicare □ Auto Accident
□Medical Savings Account & Flex Plans □ Other

Name of Primary Insurance Company: _____

Name of Secondary Insurance Company (if any): _____

AUTHORIZATION AND RELEASE: I authorize payment of insurance benefits directly to the chiropractor or chiropractic office. I authorize the doctor to release all information necessary to communicate with personal physicians and other healthcare providers and payors and to secure the payment of benefits. I understand that I am responsible for all costs of chiropractic care, regardless of insurance coverage. I also understand that if I suspend or terminate my schedule of care as determined by my treating doctor, any fees for professional services will be immediately due and payable.

The patient understands and agrees to allow this chiropractic office to use their Patient Health Information for the purpose of treatment, payment, healthcare operations, and coordination of care. We want you to know how your Patient Health Information is going to be used in this office and your rights concerning those records. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your Patient Health Information we encourage you to read the HIPAA NOTICE that is available to you at the front desk before signing this consent. If there is anyone you do not want to receive your medical records, please inform our office.

Patient's Signature: _____ Date: _____

Guardian's Signature Authorizing Care: _____ Date: _____

Insurance Information

We will make a copy of your insurance card/s; however, please complete the following information as well.

Please check any and **all** insurance coverage that may be applicable in your case:

_____ Major Medical _____ Worker's Compensation _____ Medicare _____Medicaid

_____ Auto Accident _____ Medical Savings Account & Flex Plans _____ Other

Name of Primary Insurance Company: _____

_____

Policy Number: _____ Group Number: _____

Are you the policy holder? Yes / No If not, who is the policy holder? Spouse Parent Employer Other

Policy Holder's First Name: _____ MI _____ Last Name: _____

Policy Holder's Date of Birth: _____ Policy Holder's Social Security #: _____

Policy Holder's Employer: _____

Do you have secondary insurance coverage? Yes / No If yes, please complete the following information:

Name of Secondary Insurance Company: _____

_____

Policy Number: _____ Group Number: _____

Policy Holder's First Name: _____ MI _____ Last Name: _____

Policy Holder's Date of Birth: _____ Policy Holder's Social Security #: _____

Policy Holder's Employer: _____

AUTHORIZATION AND RELEASE: I authorize payment of insurance benefits directly to the chiropractor or chiropractic office. I authorize the doctor to release all information necessary to communicate with personal physicians, other healthcare providers, and payors in order to secure, as a courtesy to me, the payment of benefits.

I understand and agree that health and accident insurance policies are an agreement between me and an insurance carrier. I clearly understand that I am responsible for all costs of chiropractic care, regardless of insurance coverage. I also understand that if I suspend or terminate my schedule of care and treatment as determined by my treating doctor, any fees or outstanding balances for services I have received will be immediately due and payable.

Date: _____

Patient's Signature Authorizing Care: _____

Parent's / Guardian's Authorizing Signature: _____

TO OUR VALUED PATIENTS

[Please Read!]

Continued issues and discrepancies in the information we are given by your insurance company regarding your chiropractic benefits have necessitated this notice to re/emphasize some things to you:

1. As a courtesy to you, we make every attempt, by utilizing online insurance websites as well as calling your insurance company, to verify as accurately as we can up front what your chiropractic benefits are and whether a preauthorization is required for care.

2. When we call your insurance company, however, we are immediately given a benefit disclaimer that the information they are about to tell us is "not a guarantee of coverage or payment either in part or in whole."

3. In fact, we are routinely given inaccurate and misinformation by your insurance company as to what they will and will not cover as well as what your financial responsibility is and is not.

4. This misinformation by your insurance company means that despite our best efforts, we may not always accurately collect your financial responsibility at the time your services are rendered.

5. Consequently, we may end up owing you a refund or **you may have additional financial responsibility to pay.**

6. It is only when we receive payment/non-payment from your insurance company with the accompanying Explanation of Benefits – the same ones they send to you – that we truly find out what your coverage / financial responsibility is.

7. **Please keep in mind, and we say this most respectfully, it is not our fault what your insurance covers and does not cover or what your financial responsibility is. Your benefit plan with your insurance company is one that you have chosen and is an arrangement, agreement, and relationship between you and your insurance company. We cannot influence or change what your benefits are or what your financial responsibility is.**

8. **Therefore, please understand that regardless of your coverage or our initial understanding of your benefits, the cost of the valuable care you receive here is ultimately your responsibility.**

9. To minimize surprises, we ask that you do your part. Call your insurance company yourself to ask specifically about your chiropractic benefits. We can even give you a list of our commonly used codes/services about which to inquire directly. Your calls as a member are routed to a completely different call center than ours are as a provider, and you are often treated differently (meaning better) than we are when you call.

10. Whenever you call your insurance company, make sure you ask for and obtain a call reference number! This is the "proof" you'll need of the information you were given on that particular call.

11. Be diligent about looking at your Explanation of Benefits (EOBs) when you receive them and bring to our attention immediately if you have any questions or see any discrepancies from the initial understanding of your coverage/responsibility. Being proactive about paying any additional financial responsibility would also be greatly appreciated.

12. You have come to us seeking relief from your body's pain and dysfunctions – without the use of unhealthy drugs and invasive and expensive surgery – through safe, effective, and comparatively affordable chiropractic care. While Dr. Jay is loosely aware of our initial understanding of your benefits, he would be doing you a disservice if he let your benefits or lack thereof dictate his prescribed plan of treatment for you. **Our mission is TO GET YOU BETTER**, and Dr. Jay makes his professional, experienced, treatment decisions based on this goal – not on your insurance coverage.

13. Insurance companies are not doctors; they are profit-centered businesses whose CEOs make tens of MILLIONS of dollars a year. It has been our experience that they try to pay as little as possible and often make it as difficult as possible for you to use your benefits and for us to be fairly compensated for our services. As patient and provider, we must work together to hold insurance companies accountable.

14. Regardless of your benefits, it is imperative to us that you see the VALUE in the care that you receive here. Compared to all other alternatives for treatment – certainly compared to the even greater long-term cost (in time, money, and quality of life) of doing nothing about your current pain and dysfunction – chiropractic care offers the best value for most people. Your health is important to us, but you must likewise realize that you are worth the investment of time, energy, and money to improve your health and make it a priority. It is then that you will fully discover what chiropractic can do for you.

15. Lastly, all of us at Forever Young Chiropractic pride ourselves on exceeding your expectations of your chiropractic healthcare experience, and we TRULY appreciate you entrusting us with your spinal health.

Please acknowledge that you have received this notice.

_____	_____	_____
Printed Name	**Signature**	**Date**

Consent to Care

A patient coming to the doctor gives him / her permission and authority to care for the patient in accordance with appropriate tests, diagnosis, and analysis. The clinical procedures performed are usually beneficial and seldom cause any problem. In rare cases, 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 – latent pathological defects, illnesses, or deformities – which would otherwise not come to the attention of the physician.

I have read and understand the foregoing. Date: _____

Print Name _____ Signature _____

X-Ray Questionnaire

(For WOMEN Only)

Our consultation and examination may indicate that x-rays are necessary to accurately diagnose and analyze your spinal condition. Should x-rays be necessary, we would like to confirm that you are NOT pregnant at this time.

Name: _____

- ☐ There is a possibility that I may be pregnant at this time.
- ☐ Yes, I am definitely pregnant.
- ☐ No, I am definitely NOT pregnant at this time.
- ☐ I request that x-ray films not be taken because _____

_____

Date of last menstrual period: _____

Patient Signature _____ Date _____

Patient Health Information Consent Form

We at Forever Young Chiropractic want you to know how your Patient Health Information (PHI) is going to be used in this office and your rights concerning those records. Before we will begin any health care operations, we must require you to read and sign this consent form stating that you understand and agree with how your records will be used. If you would like a more detailed account of our policies and procedures concerning the privacy of your PHI, we encourage you to read the HIPAA NOTICE that is available to you at the billing office before signing this consent.

1. The patient understands and agrees to allow this chiropractic office to use his / her Patient Health Information (PHI) for the purpose of treatment, payment, healthcare operations, and coordination of care. As an example, the patient agrees to allow this chiropractic office to submit requested PHI to the Health Insurance Company / ies provided to us by the patient for the purpose of payment. Be assured that this office will limit the release of all PHI to the minimum needed for what the insurance company / ies require for payment.
2. The patient has the right to examine and obtain a copy of his / her health records at any time and request corrections. The patient may request to know what disclosures have been made and submit in writing any further restrictions on the use of his / her PHI. Our office is obligated to agree to those restrictions only to the extent they coincide with state and federal law.
3. A patient's written consent need only be obtained one time for all subsequent care given the patient in this office.
4. The patient may provide a written request to revoke consent at any time during care. This would not affect the use of those records for the care given prior to the written request to revoke consent but would apply to any care given after the request has been presented.
5. Our office may contact the patient periodically regarding appointments, treatments, products, services, or charitable work performed by our office. The patient may choose to opt-out of any marketing or fundraising communications at any time.
6. For the patient's security and right to privacy, all staff has been trained in the area of patient record privacy, and a privacy official has been designated to enforce those procedures in our office. We have taken all precautions that are known by this office to assure that patient records are not readily available to those who do not need them.
7. Patients have the right to file a formal complaint with our privacy official and the Secretary of Health and Human Services about any possible violation of these policies and procedures without retaliation by this office.
8. Our office reserves the right to make changes to this notice and to make the new notice provisions effective for all protected health information that it maintains. You will be provided with a new notice at your next visit following any change.
9. This notice is effective on the date stated below.
10. If the patient refuses to sign this consent for the purpose of treatment, payment, and health care operations, the chiropractic physician has the right to refuse to give care.

I have read and understand how my Patient Health Information will be used, and I agree to these policies and procedures.

I _____ **give** _____ **do <u>not</u> give** permission for appointment reminders to be sent electronically to my email or cellular phone account. My cell phone carrier is _____.

I _____ **give** _____ **do <u>not</u> give** permission for mail to be sent to my home address.

Patient Signature: _____ Date: _____

For further information regarding this notice, please contact Dr. Wolford at (502)-538-0222.

Patient Acknowledgement and Receipt of Notice of Privacy Practices Pursuant to HIPAA and Consent for Use of Health Information

_____ _____

Patient's Printed Name Date

The undersigned does hereby acknowledge that he or she has received a copy of this office's Notice of Privacy Practices Pursuant to HIPAA and has been advised that a full copy of this office's HIPAA Compliance Manual is available upon request.

The undersigned does hereby consent to the use of his or her health information in a manner consistent with the Notice of Privacy Practices Pursuant to HIPAA, the HIPAA Compliance Manual, State Law, and Federal Law.

Dated this _____ day of _____, 20___

By_____

Patient's Legal Signature

If patient is a minor or under a guardianship order as defined by State law:

By_____

Legal Signature of Parent / Guardian (circle one)

Physical Activity Readiness Questionnaire (PAR-Q)

Please read the following questions carefully and circle YES or NO next to the question.

YES	NO	1. Has your doctor ever told you that you have a heart of lung problem?
YES	NO	2. Have you ever had any heart-related problem?
YES	NO	3. Do you frequently feel chest discomfort or pain?
YES	NO	4. Do you often feel faint or have spells of severe dizziness?
YES	NO	5. Has your doctor ever told you that you have high blood pressure; have you ever had high blood pressure in the past; and / or are you currently taking any medication for blood pressure?
YES	NO	6. Are you aware of any bone, joint, or muscle problems that may be aggravated by exercise?
YES	NO	7. Have you ever had an episode of asthma induced by exercise – that is, severe wheezing, coughing, or severe shortness of breath – or do you have customary shortness of breath at rest or with mild exertion?
YES	NO	8. Do you ever have episodes of labored or difficult breathing during the night where you have to sit up to breathe?
YES	NO	9. Have you ever been told by a doctor that you have diabetes?
YES	NO	10. Are you over age 65 and not involved in a regular exercise program?
YES	NO	11. Is there a good reason no mentioned here why you should not engage in exercise?
YES	NO	12. Are you pregnant?
YES	NO	13. Have you had any surgeries in the last six months?

COMMENTS: _____

_____

I hereby certify that the above information is correct. Date: _____

Print Name _____ Signature _____

*Any "YES" response concerning cardiovascular, pulmonary, or metabolic problems may not engage in any fitness test or exercise program until a medical clearance form is completed or signed by an appropriate physician.

I hereby certify that, to the best of my knowledge, this person examined has no contraindications to participation in an exercise profile, musculoskeletal rehabilitation, and / or fitness program.

List any limitations or precautions:

_____

_____

Signature of Physician: _____ Date: _____

Revised OSWESTRY Index – Neck Pain

Name: _____ Date: _____ File #: _____

This questionnaire helps us to understand how much your **neck pain** has affected your ability to perform every day activities. Please mark with an X the one box in each section that most clearly describes your problem now.

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 (e.g., 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 only lift very light weights at the most.

Section 4 – Reading

[ ] I can read as much as I want with no pain in my neck.
[ ] I can read as much as I want with slight pain in my neck.
[ ] I can read as much as I want with moderate pain in my neck.
[ ] 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 due to pain.

Section 5 – Headaches

[ ] I have no headaches at all.
[ ] I have slight headaches that come infrequently.
[ ] I have moderate headaches that come infrequently.
[ ] I have moderate headaches that come frequently.
[ ] I have severe headaches that come frequently.
[ ] I have headaches almost all the time.

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 cannot do any work at all.

Section 8 – Driving

[ ] I can 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 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 mildly disturbed (1-2 hrs. sleepless).
[ ] My sleep is moderately disturbed (2-3 hrs. sleepless).
[ ] My sleep is greatly disturbed (3-5 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 neck pain.
[ ] 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.

Revised OSWESTRY Index – Low Back

Name: _____ Date: _____ File #: _____

This questionnaire helps us to understand how much your **low back** has affected your ability to perform every day activities. Please mark with an X the one box in each section that most clearly describes your problem now.

Section 1 – Pain Intensity

[ ] The pain comes and goes and is very mild.
[ ] The pain is mild and does not vary much.
[ ] The pain comes and goes and is moderately increasing.
[ ] The pain is moderate and does not vary much.
[ ] The pain comes and goes and is severe.
[ ] The pain is severe and does not vary much.

Section 2 – Personal Care (washing, dressing, etc.)

[ ] I do not have to change my way or washing or dressing in order to avoid pain.
[ ] I do not normally change my way of washing or dressing even though it causes some pain.
[ ] Washing and dressing increase the pain, but I manage not to change my way of doing it.
[ ] Washing and dressing increase the pain, and I find it necessary to change my way of doing it.
[ ] Because of the pain, I am unable to do some washing and dressing without help.
[ ] Because of the pain, I am unable to do any washing and dressing without help.

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 (e.g., 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 only lift very light weights at the most.

Section 4 – Walking

[ ] I have no pain when walking.
[ ] I have some pain when walking, but it does not increase with distance.
[ ] I cannot walk more than 1 mile without increasing pain.
[ ] I cannot walk more than ½ mile without increasing pain.
[ ] I cannot walk more than ¼ mile without increasing pain.
[ ] I cannot walk at all without increasing pain.

Section 5 – Sitting

[ ] I can sit in any chair as long as I like without pain.
[ ] I can sit only in my favorite chair as long as I like.
[ ] Pain prevents me from sitting more than 1 hour.
[ ] Pain prevents me from sitting more than ½ hour.
[ ] Pain prevents me from sitting more than 10 minutes.
[ ] I avoid sitting because it increases pain immediately.

Section 6 – Standing

[ ] I can stand as long as I want without pain
[ ] I have some pain standing, but it does not increase with time.
[ ] I cannot stand for longer than 1 hour without increasing pain.
[ ] I cannot stand for longer than ½ hour without increasing pain.
[ ] I cannot stand for longer than 10 minutes without increasing pain.
[ ] I avoid standing because it increases the pain immediately.

Section 7 – Sleeping

[ ] I get no pain in bed.
[ ] I get pain in bed, but it does not prevent me from sleeping well.
[ ] Because of pain, my normal night's sleep is reduced by less than ¼.
[ ] Because of pain, my normal night's sleep is reduced by less than ½.
[ ] Because of pain, my normal night's sleep is reduced by less than ¾.
[ ] Pain prevents me from sleeping at all.

Section 8 – Social Life

[ ] My social life is normal and gives me no 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, etc.).
[ ] Pain has restricted my social life, and I do not go much.
[ ] Pain has restricted my social life to my home.
[ ] I have hardly any social life because of my pain.

Section 9 – Traveling

[ ] I get no pain while traveling.
[ ] I get some pain while traveling, but none of my usual forms of travel make it worse.
[ ] I get extra pain while traveling, but it does not compel me to seek alternative forms of travel.
[ ] I get extra pain while traveling which compels me to seek alternative forms of travel.
[ ] Pain prevents all forms of travel except when done lying down.
[ ] Pain restricts all forms of travel.

Section 10 – Changing Degrees of Pain

[ ] My pain is rapidly getting better.
[ ] My pain fluctuates, but overall, it is definitely getting better.
[ ] My pain seems to be getting better, but slowly improves.
[ ] My pain is neither getting better nor worse.
[ ] My pain is gradually worsening.
[ ] My pain is rapidly worsening.

Patient Specific Functional and Pain Scales (PSFS)

Patient Last Name	Patient First Name	Patient ID	Date of Birth (MM/DD/YYYY)
Provider Name: Dr. Jason R. Wolford, D.C.		**Provider Phone:** 502-538-0222	

Clinician Instructions: Complete after the patient's history and before his/her exam.

Initial Assessment: Please list and score below **at least three** primary activities in your life that you are unable to perform or are having the most difficulty performing as a result of your chief problem. These may be general daily activities such as lifting, walking or showering, or they may be activities more specific to your work or play such as sitting at the computer, playing golf, or gardening. We will use these activities to measure your progress during your care.

Follow-Up Assessment: When you were assessed on _____, you told us that you were unable to perform or had difficulty performing the following activities because of your chief problem. Please score these same activities according to how you feel most recently.

Patient Specific Activity Scoring Scheme – Score ONE number for EACH activity for each new date.

0 = **UNABLE** to perform activity	0 1 2 3 4 5 6 7 8 9 10	10 = **ABLE** to perform activity at same level as before injury or problem

Activity	Date:	Date:	Date:	Date	Date:
1.	Score (0-10)	Score (0-10)	Score (0-10)	Score (0-10)	Score (0-10)
2.	Score (0-10)	Score (0-10)	Score (0-10)	Score (0-10)	Score (0-10)
3.	Score (0-10)	Score (0-10)	Score (0-10)	Score (0-10)	Score (0-10)
4.	Score (0-10)	Score (0-10)	Score (0-10)	Score (0-10)	Score (0-10)
5.	Score (0-10)	Score (0-10)	Score (0-10)	Score (0-10)	Score (0-10)
Totals:					

I understand that the information I have provided above is current, complete, and accurate to the best of my knowledge.

Patient Signature: _____ Date: _____

Patient Specific Functional Scale reprinted with permission from Straford P., Gill C., Westaway M., and Binkley J. Assessing disability and change on individual patients: A report of patient specific measure. Physiother Can 1995; 47:258-283.