Patient Name: _____

Address: _____

Apt/Suite: _____ City: _____

State: _____ Zip Code: _____

Email: _____ @ _____ .com

Social Security #: _____ Home Ph: _____

Date of Birth: _____ Cell Ph: _____

Age: _____ Work Ph: _____

May we contact you by phone and leave a message? Yes or No

Employer: _____

Occupation: _____

Spouse's Name: _____

Spouse's Employer: _____ Work Ph: _____

Emergency Contact: _____

Emergency Contact #:

Who may we thank for referring you to our office?

Marital Status: Single Married Divorced Widow(er)

Race: White Black/African American American/Alaskan Indian
Patient Declined to Answer

Ethnicity: Hispanic/Latino Not Hispanic/Latino

Preferred Language: English French Spanish Italian
Chinese Japanese Russian Portuguese

Present Complaint: What is the reason for your visit today? (Be Brief)

Area of major complaint: _____

Pain/Problem began on: _____

Pain(s) are: Dull Achy Sharp Stabbing Shooting Deep Throbbing

Pain(s) frequency is: Intermittent Occassional Frequent Constant

What activites lessen your condition? _____

What activites aggravate your condition? _____

Is your condition worse during certain times of day? _____

Is this condition interfering with Work? _____ Sleep? _____ Routine? _____

Is this condition getting progressively worse? _____

Other Doctors seen for this condition? _____

Any home remedies? _____

As a result of my chiropractic care, I would like to:

Feel better quickly
Have a healthier body by keeping my nerve system healthy
Have a healthier spine
Live a healthier lifestyle

I am here today for an evaluation and possible treatment for my condition listed above.

_____ _____

Signature Date

Patient Name: _____ Date: _____

Medications

Medication	Dose	Qty	Frequency	Form						Route					Condition Treating
Name of Medications, Vitamins, OTC Medications			1x daily, Morning & Evenings, Bedtime	Tablet	Capsule	Solution	Suppository	Topical	Other	Orally	Injection	Topical	Rectal	Other	Medical condition being treated by medication listed below?
Ex. Lisinopril	*20mg*	*1*	*1x Morning and 1x Bedtime*	X						X					*High blood pressure*

Allergies

Medication	Reaction	Date of Onset
Ex. Codeine	*Hives*	*11/1/2011*

Vaccinations:

Influenza Shot	Yes		No		Date Received:	
Pneumonia Shot	Yes		No		Date Received:	

BACK TO HEALTH CHIROPRACTIC CENTER, LLC
617 North Jefferson Ave., Lebanon, MO 65536
(417)532-2986

Consent to use PHI

Acknowledgement for Consent to Use and Disclosure of Protected Health Information

Use and Disclosure of your Protected Health Information

Your Protected Health Information will be used by Back to Health Chiropractic Center, LLC or may be disclosed to others for the purposes of treatment, obtaining payment, or supporting the day-to-day health care operations of this office.

Please list those whom we may give your information to:

Name: _____ Phone#: _____
Name: _____ Phone#: _____
Name: _____ Phone#: _____

Notice of Privacy Practices

You should review the Notice of Privacy Practices for a more complete description of how your Protected Health Information may be used or disclosed. It describes your rights as they concern the limited use of health information, including your demographic information, collected from you and created or received by this office.

I have **received** a copy of the Notice of Patient Privacy Policy. _____Patient Initials

Requesting a Restriction on the Use or Disclosure of Your Information

You may request a restriction on the use or disclosure of your Protected Health Information.
This office may or may not agree to restrict the use or disclosure of your Protected Health Information.
If we agree to your request, the restriction will be binding with this office. Use or disclosure of protected information in violation of an agreed upon restriction will be a violation of the federal privacy standards.

Notice of Treatment in Open or Common Areas

Note that some of your treatment may be performed in an "open area". Private areas are available upon request to discuss your health information upon request. _____Patient Initials

Revocation of Consent

You may revoke this consent to the use and disclosure of your Protected Health Information. You must revoke this consent in writing. Any use or disclosure that has already occurred prior to the date on which your revocation of consent is received will not be affected.

By my signature below I give my permission to use and disclose my health information.

_____ _____
Patient or Legally Authorized Individual Signature — Date

_____ _____
Print Patient's Full Name — Time

_____ _____
Witness Signature — Date

CONSENT TO CHIROPRACTIC EXAMINATION AND CARE

I hereby authorize **Back to Health Chiropractic Center, LLC** and its licensed doctors and assistants, based on my complaints and the history I have provided, to undertake an examination and provide an evaluation and treatment plan which may include chiropractic adjustments and other tests and procedures considered therapeutically appropriate. I also with to rely on the practice doctors to make those decisions about my care, based on the facts then known, that they believe are in my best interest.

The nature and purpose of the chiropractic examination and evaluation, the chiropractic adjustments and the other procedures that may be recommended during the course of my care have been explained and described to my satisfaction.

By signing below I acknowledge my consent to be examined:

The specifics of the doctor's recommendation will be further explained during a Report of Findings following your examination and any subsequent examinations and significant changes in your diagnosis or treatment plan.

Based on current findings, practice doctors have discussed my diagnosis and treatment plan, the benefits and expected improvement with the proposed treatment and the reasonable alternatives to the proposed treatment. They have also explained the cost of my proposed care (or provided me with a current fee schedule) and to the extent practicable the costs of reasonable alternatives to the proposed treatment.

To aid the understanding of my condition and the reasons for the proposed course of care, the practice has provided me with the specific pamphlets and other literature and practice doctors have answered my questions regarding the planned treatments and course of care that I will receive. Practice doctors have also explained that my diagnosis and treatments may change during the course of care and that they will advise me of material changes in my diagnosis and treatment options and answer any additional questions that I may have at any time.

I have also been advised that although the incidence of complications associated with chiropractic services is very low, anyone undergoing adjusting or manipulative procedures should know of rare possible hazards and complications which may be encountered or result during the course of care. These include, but are not limited to, fractures, disk injuries, strokes, dislocations, sprains, and those which relate to physical aberrations unknown or reasonably undetectable by the doctor.

I understand and accept that:

1. I have the right to withdraw from or discontinue treatment at any time and that the Practice doctors will advise me of any material risks in this regard.
2. That neither the practice of chiropractic nor medicine is an exact science and that my care may involve the making of judgments based upon the facts known to the doctor during the course of my care.
3. That it is not reasonable to expect the doctor to be able to anticipate or explain all risks and complications or an undesirable result does not necessarily indicate an error in judgment or treatment.
4. The Practice does not guarantee as to results with respect any course of care or treatment.

5. My care and treatment will not be observed or recorded for any non-therapeutic purpose without my consent.

I have read this Consent (or have had it read to me) and have also had an opportunity to ask questions about the Consent and understand to my satisfaction the care and treatment I may receive. My signature below acknowledges my consent to the examination, evaluation and purposed course of care and treatments by the Practice.

_____

Patient's Printed Name

_____/_____

Patient's Signature Date

Doctor's Notes:

Patient counseled by:

_____

Signature of doctor

Consent to X-Ray

Patients Name: _____

I hereby authorize Dr. _____ and whomever he/she designates as his/her assistants to take x-rays of myself (or said minor).

Dated this _____ day of _____ 20____

Witness _____
Printed Name

_____
Signature

Patient _____
Printed Name

_____
Signature

_____
Signature of Parent or Guardian (if patient is a minor)

Pregnancy Warning

Patient Name_____ Date_____

◊ I understand that if I am pregnant and have x-rays taken which expose my lower torso to radiation, it is possible to injure the fetus.
◊ I have been advised that the 10 days following the onset of a menstrual period are generally considered to be safe for x-ray examination.

With those factors in mind, I am advising my doctor that:

I am pregnant:	Yes	No	Don't Know
I could be pregnant:	Yes	No	Don't Know
I have an IUD:	Yes	No	Don't Know
I have had a tubal ligation:	Yes	No	Don't Know
I am late with my menstrual period:	Yes	No	Don't Know
I am taking oral contraceptives:	Yes	No	Don't Know
I have had a hysterectomy:	Yes	No	Don't Know
I have irregular menstrual periods:	Yes	No	Don't Know

My last menstrual period began on: _____

With full understanding of the above, and believing that I am not currently at risk, I wish to have an x-ray examination performed now.

I hereby authorize the Doctor to examine and treat any condition as he/she deems appropriate through the use of Chiropractic Health Care, and I give authority for these procedures to be performed. It is understood and agreed the amount paid the Doctor for x-rays is for examination only and the x-rays negatives will remain the property of this office.

Patient Signature Date

Guardian or Parent Signature Authorizing Care Date

ASSIGNMENT OF BENEFITS/ERISA AUTHORIZED REPRESENTATIVE FORM

Back to Health Chiropractic Center LLC

Financial Responsibility

I have requested professional services from Back to Health Chiropractic Center LLC Dr. Melani Crocker D.C. on behalf of myself and/or my dependents, and understand that by making this request, I am responsible for all charges incurred during the course of said services. I understand that all fees for said services are due and payable on the date services are rendered and agree to pay all such charges incurred in full immediately upon presentation of the appropriate statement unless other arrangements have been made in advice.

Assignment of Insurance Benefits

I hereby assign all applicable health insurance benefits to which I and/or my dependents are entitled to the said Dr. Melani Crocker D.C. I certify that the health insurance information that I provided to Dr. Melani Crocker D.C. is accurate as of the date set forth below and that I am responsible for keeping it updated.

I hereby authorize Dr. Melani Crocker D.C. to submit claims, on my and/or my dependent's behalf, to the benefit plan (or its administrator) listed on the current insurance card I provided to Dr. Melani Crocker D.C., in good faith. I also hereby instruct my benefit plan (or its administrator) to pay Dr. Melani Crocker D.C. directly for services rendered to me or my dependents. To the extent that my current policy prohibits direct payment to Dr. Melani Crocker D.C., I hereby instruct and direct my benefit plan (or its administrator) to provide documentation stating such non-assignment to myself and Dr. Melani Crocker D.C. upon request. Upon proof of such non-assignment, I instruct my benefit plan (or its administrator) to make out the check to me and mail it directly to Dr. Melani Crocker D.C.

I am fully aware that having health insurance does not absolve me of my responsibility to ensure that my bills for professional services from Dr. Melani Crocker D.C. are paid in full. I also understand that I am responsible for all amounts not covered by my health insurance, including co-payments, co-insurance, and deductibles.

Authorization to Release Information

I hereby authorize Dr. Melani Crocker D.C. to: (1) release any information necessary to my health benefit plan (or its administrator) regarding my illness and treatment: (2) process insurance claims generated in the course of examination or treatment; and (3) allow a photocopy of my signature to be used to process insurance claims. This order will remain in effect until revoked by me in writing.

ERISA Authorization

I hereby designate, authorize, and convey to Dr. Melani Crocker D.C. to the full extent permissible under law and under any applicable insurance policy and/or employee health care benefit plain: (1) the right and ability to act as my Authorized Representative in connection with any claim, right or cause in action that I may have under such insurance policy and/or benefit plain; and (2) the right and ability to act as my Authorized Representative to pursue such claim, right or cause of action in connection with said insurance policy and/or benefit plain (including but not limited to, the right and ability to act as my Authorized Representative with respect to a benefit plan governed by the provisions of ERISA as provided in 29C.F.R. §2560.5031(b)(4) with respect to any healthcare expense incurred as a result of the services I receive from Dr. Melani Crocker D.C. and, to the extent permissible under the law, to claim on my behalf, such benefits, claims, or reimbursement, and any other applicable remedy, including fines.

A photocopy of this Assignment/Authorization shall be as effective and valid as the original.

_____ _____

Patient Print Date

_____ _____

ASSIGNMENT OF INSURANCE BENEFITS AND STATEMENT OF SERVICE
FOR CHIROPRACTIC CHARGES

I hereby assign and authorize payment made directly to **Back to Health Chiropractic Center LLC** of the covered insurance benefits including major medical benefits, whether payable to me by Medicare, commercial insurance companies and/or managed care plans. I understand that my health insurance provider may not cover part or all of the medical services rendered.

I fully understand that I am financially responsible for and agree to pay all charges not paid by my health care coverage, including deductibles, co-insurance, and payments from insurance companies sent to me directly. In consideration of the chiropractic services furnished to me, I hereby agree to pay Back to Health Chiropractic Center LLC any balance due within ninety days from presentation of my bill. In the event of default I promise to pay legal interest on Indebtedness together with 35% collection costs and attorney fees as may be required to effect collections.

I have disclosed the names of all my health insurance providers' including tie-in-coverage and I represent that such health care coverage is in full force and effect at this time.

If prior authorization or certification for chiropractic services is required under my health care coverage, I agree to obtain both and furnish such authorization for certification.

I authorize the release of medical information as may be required to process the claims for payment of the chiropractic services rendered and it is expressly understood that the right of such information to be privileged is hereby waived. I understand that I have an opportunity to discuss with the Doctor and staff to my satisfaction the nature of the services to be provided.

I acknowledge that no guarantees have been made to me as to the results.

This assignment shall apply to all chiropractic services now rendered and to be rendered in the future until it is revoked. I agree to promptly notify your office of any change of address or change of insurance. A copy of this assignment shall be considered as valid as the original.

I voluntarily consent to the participation of care, including treatment.

I certify that the information given by me in applying for payment under Title XVIII and Title XI of the Social Security Act, is correct. I authorize release of any medical records concerning me to the Social Security Administration or its intermediary carriers, any information needed for this or related Medicare or Medicaid claim. I request payment of authorized benefits be made on my behalf. I assign the benefits payable for physician(s) services. I understand that I am responsible for my health insurance deductibles and coinsurance. As a courtesy for you, we may call you on the telephone when an appointment is missed and/or you have not been in for a while. If you do not wish for us to call you or mail you reminder cards please let us know in writing for you file.

_____ _____

Signature of Patient (Guardian) Date

Motor Vehicle Accident Information

Last Name:	Social Security no.:
First Name:	Middle:

General Information

Date of Accident:			
Location (circle one)	**Driver**		
	Passenger	Location (circle one)	Front / Middle / Rear
		Position (circle one)	Left / Middle / Right

Work from Left to Right and Circle One

Patients Vehicle	**Type:**	Car / Van / Pickup / Truck / Bus / SUV / M. Cycle / Other:
	Size:	Mini / Sub Comp / Compact / Mid-Size / Full Size
	Action:	Stopped / Slowing / Acceleration / Cruising
	Speed: (MPH)	
	Time of Accident:	Day Light / Dawn / Dusk / Dark
	Road Condition:	Dry / Damp / Wet / Snow / Ice
	Visibility:	Good / Fair / Poor

Enter impact Information for up to three Vehicles or Objects

Impact Information: Vehicle or Object (I)

(Select one) ☐ **Vehicle** ☐ **Object**	**Name Object:**	
	Vehicle Type:	Car / Van / Pickup / Truck / Bus / SUV / M. Cycle / Other:
	Size:	Mini / Sub Comp / Compact / Mid-Size / Full Size
	Damage to Veh.:	Minimal / Moderate / Extensive / Totaled / Unsure
Impact Location		

Impact Information: Vehicle or Object (II)

(Select one) ☐ **Vehicle** ☐ **Object**	**Name Object:**	
	Vehicle Type:	Car / Van / Pickup / Truck / Bus / SUV / M. Cycle / Other:
	Size:	Mini / Sub Comp / Compact / Mid-Size / Full Size
	Damage to Veh.:	Minimal / Moderate / Extensive / Totaled / Unsure
Impact Location		

Impact Information: Vehicle or Object (III)

(Select one) ☐ **Vehicle** ☐ **Object**	**Name Object:**	
	Vehicle Type:	Car / Van / Pickup / Truck / Bus / SUV / M. Cycle / Other:
	Size:	Mini / Sub Comp / Compact / Mid-Size / Full Size
	Damage to Veh.:	Minimal / Moderate / Extensive / Totaled / Unsure
Impact Location		

During Impact Information:

Seat Belt?	☐ Yes	☐ No	Brakes Applied?	☐ Yes	☐ No
Air Bag Deployed?	☐ Yes	☐ No	Seat Broken?	☐ Yes	☐ No
Seat Back position Changed?	☐ Yes	☐ No			

Head Rest: (Circle one)	Low / Mid / High / None
Prepare for Accident: (Circle One)	Un-expected / Expected / Expected and Braced
Body Position: (Circle one)	Straight / Rotated Left / Rotated Right / Unsure / Other:
Body Thrown?	☐ Yes / ☐ No
Direction of Throw :(Circle One)	Backwards / Forward / Outside / Unsure / Other:

(Circle One)

Head Position:	Straight / Rotated Left / Rotated Right / Forward / Unsure / Other:
Head Motion:	Forward Backwards / Backwards Forward / Right Left / Left Right / Unsure / Other:

Body Impact (Indicate any parts of your body that were struck during the impact)

☐ Head	☐ Upper Back	☐ Right hand	☐ Lower Back
☐ Left Shoulder	☐ Left Leg	☐ Mid Torso	☐ Right Foot
☐ Left Arm	☐ Right Leg	☐ Mid Back	☐ Left Foot
☐ Left Elbow	☐ Right Shoulder	☐ Right Knee	☐ Other:
☐ Left hand	☐ Right Arm	☐ Left Knee	
☐ Upper Front Torso	☐ Right Elbow	☐ Lower Front Torso	

After Accident Information:

Immediately After Accident:	☐ Dizzy/dazed ☐ Upset ☐ Weak ☐ Nervous ☐ Headache ☐ Disoriented ☐ Unconscious ☐/Other:

Pain (Indicate if you experienced any pain immediately following the accident)

☐ Head	☐ Left foot	☐ Right foot	☐ Left Knee
☐ Left Hand	☐ Left Shoulder	☐ Right Shoulder	☐ Right knee
☐ Right Arm	☐ Left Elbow	☐ Left Arm	☐ Other:
☐ Upper Front Torso	☐ Mid Torso	☐ Right elbow	
☐ Upper Back	☐ Mid back	☐ Lower Front Torso	
☐ Left Leg	☐ Right Leg	☐ Lower Back	

Numbness:	☐Left Hand ☐ Right Hand ☐ Left Leg ☐ Right Leg ☐ Left Upper Arm ☐ Right Upper Arm ☐ Left Foot ☐ Right Foot ☐ Other:

Medical Information (Did you get medical care for this accident before coming to our office)

Medical Care?	☐ Yes	☐ No

Time of care	Next day / At time of Accident / Later that Day / Days Later: (Specify)
Transported	Drove Self / Ambulance / Other
Went To	Orthopedic / Chiropractor / Neurologist / Family Doc / ER / Other:(Specify)
Admitted to Hospital?	☐ Yes ☐ No Days Spent in Hospital:
Test:	☐ X-ray ☐ Lab Work ☐ MRI ☐ CT Scan ☐ Other:(Specify)
Treatment:	☐ Ice Pack ☐ Hot Pack ☐ None ☐ Cervical Collar ☐ Medication ☐ Other:(Specify)

Previous Injuries

Previous Injuries / Accidents	☐ No ☐ Yes, Specify:
Residual pain from Previous Injuries/Accidents	☐ No ☐ Yes, Specify:

Later Symptoms (Please note any symptoms that started after the accident occurred)

Head	☐ Headache ☐ Dizziness ☐ Blurred Vision ☐ Light Headedness ☐ Loss of Vision ☐ Fainting ☐ Loss of Memory ☐ Pain in ear ☐ Double Vision ☐ Other Specify:
Neck (with Movement)	☐ Pain in Neck ☐ Forward ☐ Backward ☐ Turn Left ☐ Popping in Neck ☐ Muscle Spasms ☐ Turn Right ☐ Bend Left ☐ bend Right ☐ Other Specify:
Shoulders	☐ Pain in Shoulder joint ☐ Tension in shoulders ☐ Muscle Spasms in Shoulder ☐ Pain across shoulder ☐ Can't raise arms above [] Above shoulder level [] Over head ☐ Other Specify:
Arms and Hands	☐ Pain in Fingers ☐ Numbness in Left Arm ☐ Hands Cold ☐ Pin & needles in hands ☐ Numbness in Right Arm ☐ Loss of Grip Strength ☐ Pin & needles in fingers ☐ Swollen joints in Fingers ☐ Other Specify:
Chest	☐ Chest pain ☐ Pain Around Ribs ☐ Shortness of Breath ☐ Breast Pain ☐ Other Specify:
Abdomen	☐ Nervous Stomach ☐ Nausea ☐ Diarrhea ☐ Gas ☐ Constipation ☐ Other Specify:
Mid back	☐ Sharp Stabbing ☐ Mid pain back ☐ Pain From front to back ☐ Dull Ache ☐ Pain in Kidney Area ☐ Muscle Spasms ☐ Pain between shoulders ☐ Other Specify:
Lower Back	☐ Low Back Pain Low back pain is worse when ☐ Working ☐ Lifting ☐ Stooping ☐ Standing ☐ Sitting ☐ Bending ☐ Coughing ☐ Lying Down ☐ Muscle Spasms ☐ Other Specify:
Hips, Legs & Feet	☐ Pain in Buttocks ☐ Pain and needles in Legs ☐ Pain down leg ☐ Pain in hip joint ☐ Feet feel Cold ☐ Swollen Feet ☐ Numbness in Toes ☐ Numbness of Leg ☐ Knee pain ☐ Leg cramps ☐ Cramps in Feet ☐ Other Specify:
General	☐ Nervousness ☐ Fatigue ☐ Irritable ☐ Depressed ☐ Generally, Feel Rundown ☐ Prostate Pain/Swelling ☐ Difficulty Urinating ☐ Night Urination ☐ Cramping ☐ Irregularity Loss of Sleep: [_____] hrs. per night Loss of weight: [_____] lbs. Gain weight: [_____] lbs. Other:

Signature: _____ Date: _____

All questions contained in this questionnaire are strictly confidential and will become part of your medical record.

Patient Basic Information

Personal Information:

Last Name:	First Name:
Address:	City, State, Zip Code
Home Phone#:	Work Phone#:
Date of Birth:	Date of Injury:
Dominant Hand: ☐ Right ☐ Left ☐ Both	

1. Description of Accident/Injury/Onset

Enter a full description of the accident, injury or onset in the space below.

2. Your condition during and immediately after injury/onset

Enter the details of your condition during and immediately after your injury/onset.

BACK TO HEALTH CHIROPRACTIC CENTER, LLC

AUTO ACCIDENT INSURANCE INFORMATION

MED PAY (YOUR CAR INSURANCE)

MOST CAR INSURANCE POLICY'S HAVE A MEDICAL PAY THAT YOU ARE ENTITLED TO FILE CLAIMS ON FOR AND AUTO ACCIDENT YOU ARE INVOLVED IN. MISSOUR IS A NO FAULT STATE. FILING WITH YOUR MED PAY WILL **NOT** CAUSE YOUR CAR INSURANCE RATES TO INCREASE. IT IS NOT LEGAL TO DO SO.

INSURANCE CO: _____ POLICY: _____

NAME OF INSURED:

_____

AGENTS NAME:

_____

ADDRESS:

_____

PHONE #: _____ ADJUSTER: _____

DATE OF ACCIDENT: _____ CLAIM#: _____

I _____ WANT TO FILE MY AUTOMOBILE ACCIDENT CHAREGES ON MY MED-PAY INSURANCE AND I GIVE BACK TO HEALTH CHIROPRACTICE CENTER, LLC PERMISSION TO OBTAIN ANY INFORMATION REGARDING THIS ACCIDENT THAT IS REQUIRED FOR BILLING PURPOSES.

SIGNATURE: _____ DATE: _____

INSURANCE OF PERSON WHO HIT YOU

NAME OF INSURED: _____

INSURANCE CO: _____ PHONE #: _____

ADDRESS: _____

YOUR ATTORNEY'S NAME AND PHONE #

NAME: _____ PHONE: _____

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
FORM 502

Patient name: _____ Signature: _____ Date: _____

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
☐ 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 to with slight pain in my neck.
☐ C I can read as much as I want with moderate pain in my neck.
☐ D I cannot read as much as I want because of moderate pain in my neck.
☐ E I cannot read as much as I want because of severe pain in my neck.
☐ F I cannot read at all.

Section 5 – Headaches
☐ A I have no headaches at all.
☐ B I have slight headaches which come infrequently.
☐ C I have moderate headaches which come infrequently.
☐ D I have moderate headaches which come frequently.
☐ E I have severe headaches which come frequently.
☐ F I have headaches almost all the time.

Section 6 – Concentration
☐ A I can concentrate fully when I want to with no difficulty.
☐ B I can concentrate fully when I want to with slight difficulty.
☐ C I have a fair degree of difficulty in concentrating when I want to.
☐ D I have a lot of difficulty in concentrating when I want to.
☐ E I have a great deal of difficulty in concentrating when I want to.
☐ F I cannot concentrate at all.

Section 7 – Work
☐ A I can do as much work as I want to.
☐ B I can only do my usual work, but no more.
☐ C I can do most of my usual work, but no more.
☐ D I cannot do my usual work.
☐ E I can hardly do any work at all.
☐ F I cannot do any work at all.

Section 8 – Driving
☐ A I can drive my car without 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 hr. 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 hrs. sleepless).
☐ F My sleep is completely disturbed (5-7 hrs. 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 recreation activities at all.

Back To Health Chiropractic Center LLC — Roland-Morris Questionnaire

Patient name:_____ Signature:_____ Date: _____

Previous Date & Score_____ ____%increase/decrease Score_____

Please read instructions: 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.

1[ ] I stay at home most of the time because of my pain.

2[ ] I change position frequently to try to get my comfortable.

3[ ] I walk more slowly than usual because of my pain.

4[ ] Because of my pain, I am not doing any jobs that I usually do around the house.

5[ ] Because of my pain, I use a handrail to get upstairs.

6[ ] Because of my pain, I lie down to rest more often.

7[ ] Because of my pain, I have to hold on to something to get out of an easy chair.

8[ ] Because of my pain, I try to get other people to do things for me.

9[ ] I get dressed more slowly than usual because of my pain.

10[ ] I only stand up for short periods of time because of my pain.

11[ ] Because of my pain, I try not to bend or kneel down.

12[ ] I find it difficult to get out of a chair because of my pain.

13[ ] I have pain almost all the time.

14[ ] I find it difficult to turn over in bed because of my pain.

15[ ] My appetite is not very good because of my pain.

16[ ] I have trouble putting on my sock (or stockings) because of the pain.

17[ ] I can only walk short distances because of my pain.

18[ ] I sleep less well because of my pain.

19[ ] Because of my pain, I get dressed with the help of someone else.

20[ ] I sit down for most of the day because of my pain.

21[ ] I avoid heavy jobs around the house because of my pain.

22[ ] Because of pain, I am more irritable and bad tempered with people than usual.

23[ ] Because of my pain, I go upstairs more slowly than usual.

24[ ] I stay in bed most of the time because of my pain.

Patient name: _____ Signature: _____ Date: _____

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

☐ A the pain comes and goes and is vary mild.
☐ B The pain is mild and does not vary much.
☐ C The pain comes and goes and is moderate.
☐ D The pain is moderate and does not vary much.
☐ E The pain comes and goes and is severe.
☐ F The pain is severe and does not vary much.

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

☐ A I would not have to change my way of washing or dressing in order to avoid pain.
☐ B I do not normally change my way of washing or dressing even though it causes some pain.
☐ C Washing and dressing increase the pain but I manage not to change my way of doing it.
☐ D Washing and dressing increase the pain and I find it necessary to change my way of doing it.
☐ E Because of the pain I am unable to do some washing and dressing without help.
☐ F Because of the pain I am unable to do any washing and dressing without help.

Section 3 – Lifting

☐ A I can lift heavy weights without extra pain.
☐ B I can lift heavy weights but it gives extra pain.
☐ C Pain prevents me from lifting heavy weights off the floor.
☐ D Pain prevents me from lifting heavy weights off the floor but I can manage if they are conveniently positioned, e.g. on a table.
☐ E Pain prevents me from lifting heavy weights but I can manage light to medium weights if they are conveniently positioned.
☐ F I can only lift very light weights at the most.

Section 4 – Walking

☐ A I have no pain on walking.
☐ B I have some pain with walking but it does not increase with distance.
☐ C I cannot walk more than One Mile without increasing pain.
☐ D I cannot walk more than 1/2 Mile without increasing pain.
☐ E I cannot walk more than 1/4 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 only sit in my favorite chair as long as I like.
☐ C Pain prevents me from sitting more than one hour.
☐ D Pain prevents me from sitting more than 30 minutes.
☐ E Pain prevents me from sitting more than 10 minutes.
☐ F I avoid sitting because it increases pain straight away.

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 increasing pain.
☐ D I cannot stand for longer than 1/2 hour without increasing pain.
☐ E I cannot stand for longer than 10 minutes without increasing pain.
☐ F I avoid standing because it increases pain straight away.

Section 7 – Sleeping

☐ A I get no pain in bed.
☐ B I get pain in bed but it does not prevent me from sleeping well.
☐ C Because of pain my normal nights sleep is reduced by less than 1/4.
☐ D Because of pain my normal nights sleep is reduced by less than 1/2.
☐ E Because of pain my normal nights sleep is reduced by less than 3/4.
☐ F Pain prevents me from sleeping at all.

Section 8 – Social Life

☐ A My social life is normal and gives me no pain.
☐ B My social life is normal but increases the degree of my pain.
☐ C Pain has no significant effect on my social life apart from limiting my more energetic interests, e.g. dancing, etc.
☐ D Pain has restricted my social life and I do not go out very often.
☐ E Pain has restricted social life to my home.
☐ F I have hardly any social life because of the pain.

Section 9 – Traveling

☐ A I get no pain while traveling.
☐ B I get some pain while traveling but none of my usual sorts of travel make it any worse.
☐ C I get extra pain while traveling but it does not compel me to seek alternative forms of travel.
☐ D I get extra pain while traveling which compels me to seek alternative forms of travel.
☐ E Pain restricts all forms of travel.
☐ F Pain prevents all forms of travel except that done lying down.

Section 10 – Changing Degree of Pain

☐ A My pain is rapidly getting better.
☐ B My pain fluctuates but overall is definitely getting better.
☐ C My pain seems to be getting better but improvement is slow at the present.
☐ D My pain is neither getting better or worse.
☐ E My pain is gradually worsening.
☐ F My pain is rapidly worsening.