SCHERTZ CHIROPRACTIC

17323 IH 35 N #106
Schertz, TX 78154
ph: (210)646-6000

**CONFIDENTIAL PATIENT INFORMATION: AUTO COLLISION (please print clearly)**

Legal First Name:_____MI:_____Last Name:_____
Prefer to be called:_____
Address:_____City/ST:_____Zip:_____
Cell Phone: (___)_____Work Phone: (___)_____Home Phone: (___)_____
E-mail:_____
Age: _____ Date of Birth: ____/____/____ Social Security #: _____
Employer:_____ Occupation: _____
Marital Status: M S W D Name of Spouse (if applicable): _____
Spouse Employer: _____Work Phone: (___)_____
How did you hear about our office? _____
Date of Last Physical Examination:____/____/____ Dr. Name: _____
Have You Ever Suffered From:

| | Yes | No | | Yes | No |
|---|---|---|---|---|---|
| 1. Cancer | ☐ | ☐ | 5. Respiratory Problems | ☐ | ☐ |
| 2. Dizziness | ☐ | ☐ | 6. Insomnia | ☐ | ☐ |
| 3. Heart Trouble | ☐ | ☐ | 7. Digestive Disorders | ☐ | ☐ |
| 4. Diabetes | ☐ | ☐ | 8. Arthritis | ☐ | ☐ |

Purpose of this appointment: _____
Have you been evaluated for this or any other health conditions? ☐ Yes ☐ No
Treatment Provided: _____

Exercise: Never Occasional 3-5x/wk Daily
Alcohol: Never Occasional 2-5x/wk Daily
Dominant Hand: Right Left

Tobacco: Never/Former Occ. Light Med Heavy
Caffeine: Never Occ. Daily

**PAYMENT IS EXPECTED AT THE TIME OF VISIT**:
Are you being represented by an attorney? ☐ Yes ☐ No

**We do NOT file third-party claims.**
Law Firm: _____

For our non-attorney represented patients:

Would you like us to file claims with your medical insurance? ☐ Yes ☐ No
We are in-network providers for (circle one) BCBS AETNA MEDICARE

Would you like to use your Personal Injury Protections (PIP) through your auto insurance company? ☐ Yes ☐ No
(not everyone has PIP coverage. Check with your insurance company.)

If yes, please provide: Insurance company _____Phone Number (___)____-_____
Claim #_____
Adjustor's Name_____

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand Schertz Chiropractic will prepare any necessary reports and forms to assist me in making collection from the insurance company and the amount authorized to be paid directly to Schertz Chiropractic will be credited to my account on receipt and that all billing receipts will be provided only on request. However, I clearly understand and agree that all services rendered are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate care and treatment, any fees for professional services rendered to me will be immediately due and payable.

**Patient/Responsible Party Signature**: _____ **Date**:____/____/____

Office Use ONLY
_____/_____

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*This notice describes how your health information may be used and how you can gain access to this information. Please review it carefully.*

**Our Promise to You, Our Valued Patient.**

We want to assure you that we take the Federal HIPAA (Health Insurance Portability and Accountability Act) laws seriously. These laws were written to protect the confidentiality of your health information. We trust you will never delay treatment in our office because of fear that your personal health information might be unnecessarily disclosed to others outside our office.

**Why A Privacy Policy Now ?**

The most significant variable that has motivated the Federal government to legally enforce the privacy of health information is the rapid evolution of electronic technology in the health care business. The government has appropriately sought to standardize and protect the electronic exchange of your health information. This has challenged us to review how your information is used within our computers, internet, phones, fax machines, and any devices used to copy or transfer that data. We want to advise you that we have developed policies and procedures for our practice to assure that your personal health information will be shared only as required for the purpose of administering your care. Our office is subject to State and Federal laws regarding the confidentiality of your health information and we promise our adherence to those laws. We also want you to understand our procedures and your rights as a valued patient. Your health information will be communicated only for the purpose of conducting health care business and obtaining payment for services. Be assured that without your written permission, your health information will not be used for any other purpose.

**How Your Health Information May Be Used To Provide Treatment**

Within our office, your health information will be used to provide you the best care and services possible. This may include administrative and clinical procedures designed to optimize scheduling and coordination between you and all office personnel. In addition, we may share this information with referring physicians, clinical pathology laboratories, or other health professionals providing you treatment.

**To Obtain Payment**

Your health information may be included with an invoice in order to collect payment for the services provided to you in this office. We may do this with insurance forms filed for you electronically or by mail. We will make every effort to work with companies with a similar commitment to the security of your health information.

**To Conduct Health Care Operations**

Your health information may be used during performance evaluations to our staff. Some of the best teaching opportunities use clinical situations experienced by patients receiving care in our office. As a result, your health information may be included in the training programs for students, interns, and associates, as well as business and clinical employees. It is also possible that your health information will be disclosed during insurance company audits or by government appointed agencies as part of their quality assurance and compliance reviews. Your health information may be reviewed during the routine process of certification, licensing, or credentialing activities.

**In Patient Reminders**

Because we believe regular care is very important to your general health, we will remind you of a scheduled appointment or that it is time for you to contact us and make an appointment. Additionally, we may contact you to follow up on your care and inform you of treatment options or services that may be of interest to you and your family. These communications are an important part of our philosophy, which is to partner with our patients to see they receive the best chiropractic care we can provide. This may include postcards, newsletters, flyers, and telephone or electronic reminders such as e-mail (unless you tell us that you prefer not to receive reminders).

**Public Health and National Security**

We may be required to disclose necessary health information to Federal officials or military authorities in order to complete investigations related to public health and or national security.

**For Law Enforcement**

As permitted or required by State and Federal law, we may disclose your health information under certain circumstances to proper authorities for the purpose of law enforcement. This may take place if you are a victim of a crime, or in order to report a suspected crime.

**Family, Friends and Care Givers**

We may share your health information with those that assist you with your home hygiene, care, treatment, or payment. We will be certain to obtain your permission prior to sharing your information. In the event of an emergency, if you are unable communicate your wishes; we will use best judgment when sharing your health information with anyone participating in your care.

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**Medical Research**

Advancing health care knowledge often involves learning from the careful study of health histories of prior patients. Formal review and study of health histories will transpire only under the ethical guidance, requirements, and approval of an Institution Review Board.

**Authorization to Use or Disclose Heath Information**

Other than the information stated above, or information that Federal, State, and Local laws require, we will not disclose your health information without your written authorization. You may revoke that authorization in writing at any time.

**Patient Rights**

This law is careful to describe that you have rights related to you health Information. Be assured that our office will make every effort to honor reasonable restriction preferences from our patients.

**Confidential Communications**

You have the right to request that we communicate with you in a specific way. You may request that we only communicate your health information privately, with or without other family members present, or through sealed mail communications. We will make all reasonable efforts to honor your request.

**Inspect and Copy Your Health Information**

You have the right to read, review, and copy your health information. This includes your complete chart, x-rays, and billing records. If you would like a copy of your health information, please let us know. We may need to charge you a reasonable fee to duplicate and assemble your copy.

**Amend Your Health Information**

You have the right to ask us to update or modify your records if you believe your health information is incorrect or incomplete. We will be happy to accommodate you as long as our office maintains this information. In order to standardize our process, please provide us with your request in writing and describe as completely as possible your reason for the request. Your request may be denied if the health information record in question was not created by our office, is not part of our records, or if the records containing your health information have been requested, sealed, and or delivered to any authority for review.

**Documentation of Health Information**

You have the right to request a description of how our office used your health information for reasons other than treatment, payment, or health care operations. Our documentation procedure will enable us to provide information on your health information usage from April 14, 2003 and forward. Please let us know in writing the time period for which you are interested. We greatly appreciate your limited request for no more than six years at a time. We may need to charge you a reasonable fee for your request.

**Request a Paper Copy of This Notice**

You have the right to request and obtain a copy of the Notice of Privacy Practices directly from our office at any time. We are required by law to maintain privacy of our health information and provide to you or your representative this Notice of Privacy Practices. We are required to practice the policies and procedures described in this notice, but we do reserve the right to change the terms of our notice. Patients will be notified of any such changes. You have the right to express concerns or complaints to any staff member of Schertz Chiropractic, or to the Secretary of Health and Human Services if you believe your privacy rights have been compromised. We encourage you to express in writing any concerns you may have regarding the privacy of your health information.

**Testimonial**

I hereby testify that any testimonial I communicate, whether in writing or verbal, to Schertz Chiropractic, along with my image may be used in part, or in its entirety, for the purpose of in office patient education or any other type of advertising, including but not limited to direct mail, newspaper, newsletters etc.

**Patient Acknowledgment**

Patient's Name: (print) _____ Date: _____

Patient's Signature: _____

Privacy Officer: Patrick W. Martin, D.C.

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# INFORMED CONSENT

PRINT
PATIENT NAME:_____ DATE:_____/_____/_____

Please read this entire document prior to signing it. It is important that you understand the information contained in this document. Please ask questions before you sign if there is anything that is unclear.

**The nature of the chiropractic adjustment.**

The primary treatment I use as a Doctor of Chiropractic is spinal manipulative therapy. I will use that procedure to treat you. I may use my hands or a mechanical instrument upon your body in such a way as to move your joints. That may cause an audible "pop" or "click," much as you have experienced when you "crack" your knuckles. You may feel a sense of movement.

**Analysis / Examination / Treatment**

As a part of the analysis, examination, and treatment, you are consenting to the following procedures:

| | | |
|---|---|---|
| spinal manipulative therapy | Palpation | vital signs |
| range of motion testing | orthopedic testing | basic neurological |
| muscle strength testing | postural analysis | ultrasound |
| radiographic studies | hot/cold therapy | EMS |

**The material risks inherent in chiropractic adjustment.**

As with any healthcare procedure, there are certain complications which may arise during chiropractic manipulation and therapy. These complications include but are not limited to: fractures, disc injuries, dislocations, muscle strain, cervical myelopathy, costovertebral strains and separations, and burns. Some types of manipulation of the neck have been associated with injuries to the arteries in the neck leading to or contributing to serious complications including stroke. Some patients will feel some stiffness and soreness following the first few days of treatment. I will make every reasonable effort during the examination to screen for contraindications to care; however, if you have a condition that would otherwise not come to my attention, it is your responsibility to inform me.

**The probability of those risks occurring.**

Fractures are rare occurrences and generally result from some underlying weakness of the bone which I check for during the taking of your history and during examination and X-ray. Stroke has been the subject of tremendous disagreement. The incidences of stroke are exceedingly rare and are estimated to occur between one in one million and one in five million cervical adjustments. The other complications are also generally described as rare.

**The availability and nature of other treatment options.**

If you chose to use one of these "other treatment" options, you should be aware that there are risks and benefits of such options and you may wish to discuss these with your primary medical physician. Other treatment options for your condition may include:

- Self-administered, over-the-counter analgesics and rest
- Medical care and prescription drugs such as anti-inflammatory, muscle relaxants and pain-killers
- Hospitalization
- Surgery

**The risks and dangers attendant to remaining untreated.**

Remaining untreated may allow the formation of adhesions and reduce mobility which may set up a pain reaction further reducing mobility. Over time this process may complicate treatment making it more difficult and less effective the longer it is postponed.

**I have read the above explanation of the chiropractic adjustment and related treatment. I have had my questions answered to my satisfaction. By signing below I state that I have weighed the risks involved in undergoing treatment and have decided that it is in my best interest to undergo the treatment recommended. Having been informed of the risks, I hereby give my consent to that treatment.**

**Patient/Responsible Party Signature**_____

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Name: _____

Date: _____

I,_____, in signing this form, state to the best of my knowledge, there is no pregnancy, confirmed or suspected at this time.

Patient Signature: _____

Witness Signature: _____

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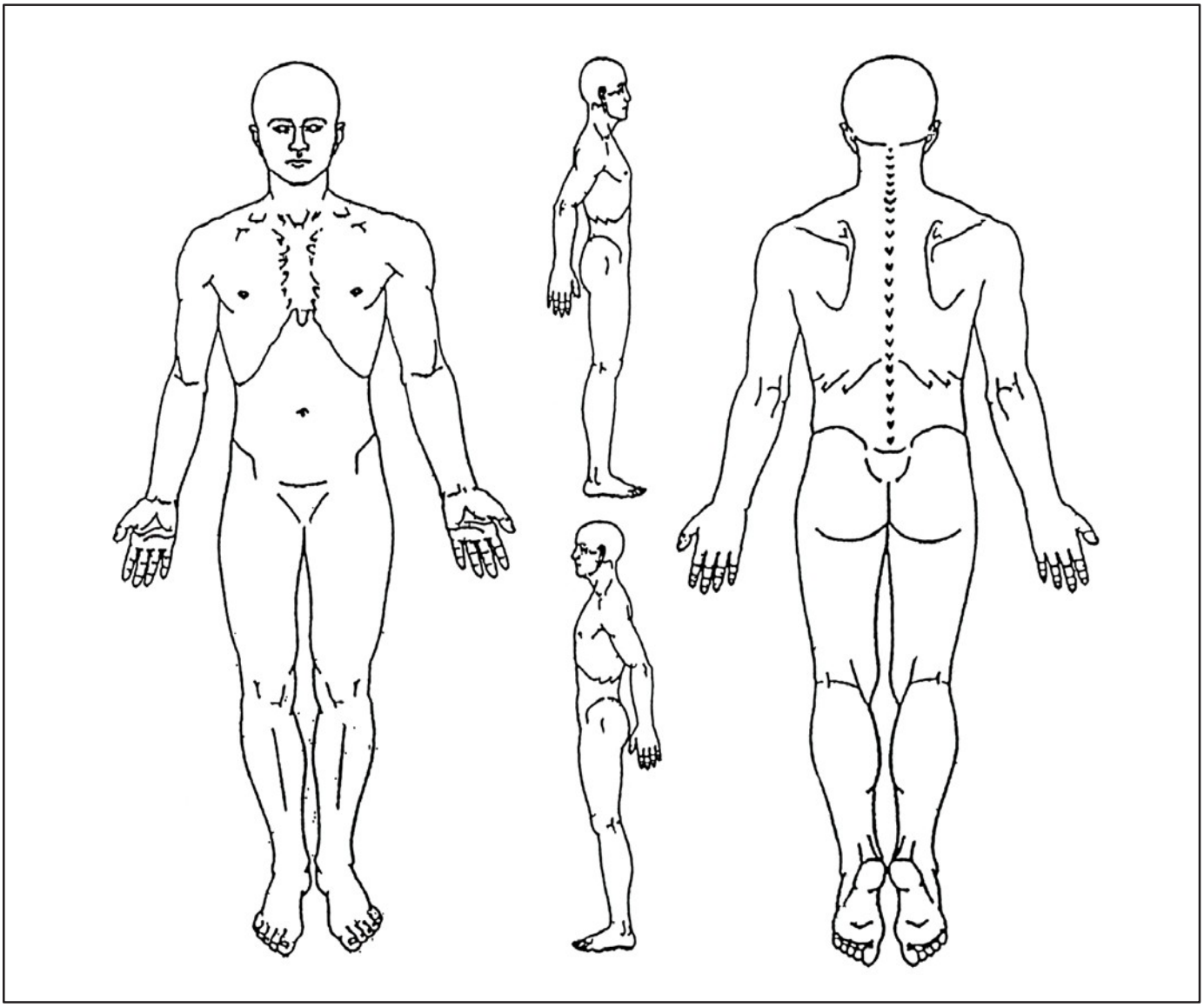
Name: _____

Date: _____

*Complete this pain diagram by putting a letter or letters on the figures below to indicate your symptoms*

| | | |
|---|---|---|
| **A** = ACHE | **B** = BURNING | **N** = NUMBNESS |
| **P** = PINS & NEEDLES | **S** = STABBING | **O** = OTHER |



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# PARTIAL ASSIGNMENT OF CAUSE OF ACTION, ASSIGNMENT OF PROCEEDS, CONTRACTUAL LIEN AND TREATMENT AGREEMENT

Definitions For the purposes of this Agreement, the following terms shall have the following meaning: "Office" shall refer to: Schertz Chiropractic located at 17323 IH 35 North Ste 106 Schertz Texas 78154. "Payer" shall refer to, without limit, any insurance carrier, health benefit plan administrator and fiduciary health maintenance organization, preferred and independent provider organization, attorney at fault party, tortfeasor, individual, and any other entity, which may elect or be obligated to payor disburse Proceeds to me, either now or in the future, for any reason; "Proceeds" shall include, without limit the proceeds from any settlement, judgment, or verdict, the proceeds from any promise to payor reimburse, and the proceeds relating to the following benefits, plans, or coverages: individual and group health benefits, Medicare, Medicaid, workers' compensation, disability, liability, uninsured and underinsured motorist, no-fault, medical payments benefits, personal injury protection, lost wages, lost services, property damage, and malpractice; "Charges" shall include, without limit, the full fees for the Office's services (including., without limit, treatment, medical equipment, supplies., supplements, narrative reports, depositions, and testimony), any Collection Costs incurred by the Office, 18% interest on outstanding Charges, and any other charges incurred by me at the Office; "Collection Costs" shall include, without limit, any pre- and post judgment court costs, filing fees, service of process charges, attorneys fees, and any other costs of collection incurred by the Office in any effort or action to collect my Charges either from me or any payer.

Consideration In order to facilitate the ability of the Office to collect its Charges directly from various Payers and thereby to enhance the patient-provider relationship, I, the undersigned, as consideration for the Office's services, agree to the following and direct all Payers as follows:

Partial Assignment of the Cause of Action, Assignment of Proceeds, and Contractual Lien I hereby assign, in-sofar as permitted by law, all of my rights, remedies, and benefits to the Office, as well as any and all causes of action that I might have now or in the future against any Payer to the extent of my Charges, the right to prosecute such causes of action either in my name or in the Office's name, and the right to settle or otherwise resolve such causes of action as the Office sees fit. I further assign my right to receive any Proceeds from any Payer to the office and further grant a contractual lien to the Office with respect to my Charges. I understand that these assignments of rights and contractual lien may effectuate, automatically or otherwise, a secured interest under the applicable Uniform Commercial Code. I intend for this Agreement to effectuate such a lien and hereby authorize the Office to file the form(s) normally filed with the secretary of state or other governmental agency in order to perfect such lien. Except as provided herein, nothing in this Agreement shall be construed as an election or waiver by the Office to a secured interest under any other statutory lien law. Consistent with these rights, I hereby direct any and all Payers, to pay the Proceeds directly and immediately to, and exclusively in the name of, the Office in the amount of my charges.

Other Terms I understand that I remain personally responsible for my Charges. Consistent with law or contract, I agree to pay the full amount of my Charges to the Office upon its demand. Unless mutually agreed to in writing, the receipt and processing of partial payments by the Office shall not constitute a waiver of the Office's right to receive payment-in-full upon demand and shall not constitute an accord and satisfaction of my Charges, irrespective of any restrictions indicated on any payments. I understand that at anytime, I can request a copy of my total Charges. I hereby waive any statute of limitations that may apply to the collection of my charges.

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In the event that I retain one or more attorneys to assist me in collecting any Proceeds, I direct each attorney to issue an irrevocable letter of protection to the Office regarding my Charges. I further direct (and the Office hereby requests) each attorney to provide immediate notice to the Office regarding any Proceeds received by the attorney, to promptly pay the Office in-full out of such Proceeds, and to provide a full accounting of such Proceeds to the Office.

I authorize and direct the Office to submit my Charges to any and all Payers including, without limit, my health benefit plan. I understand, however, that in the event that my Charges are submitted to more than one Payer, I hereby authorize and direct the Office to apply any Proceeds received from one Payer to any reductions, write- offs, or discounts, issued by another.

I authorize the Office to endorse or sign my name on any and all checks listing me as a payee that are received by the Office for payment of Charges incurred by me, my spouse or my dependents. I further authorize the Office to apply any credit balances on my Charges to any other outstanding Charges still owed by myself, my spouse, or my dependents, regardless of whether these other Charges are related to my condition.

This Agreement shall not be modified or revoked without the mutual written consent of the Office and myself. I hereby revoke the terms of any previously signed documents to the extent those terms conflict with the terms of this Agreement.

This Agreement shall be governed under the laws of the state where the Office is located and performable in the county where the Office is located. I hereby consent to personal jurisdiction and venue of any court in said county and waive all objections based on improper jurisdiction, venue, or forum non-conveniens.

I agree that each and every provision of this Agreement is reasonably necessary for the protection of the rights and interests of the Office and myself. However, should any provision of this Agreement be found to-be in- valid, illegal or unenforceable, or for any reason cease to be binding on any party hereto, all other portions and provisions of this Agreement shall, nevertheless; remain in full force and effect. “

Patient Name (please print)_____

Patient Signature:_____ Date_____

Name of Custodial Parent or Legal Guardian, on Behalf of the Patient (please print)

Parent/Guardian Signature_____ Date_____

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# CAD Injury History Form

**General Information:**

Patient's name:_____
Today's Date:_____/_____/_____
Date of Injury:_____/_____/_____
Marital Status: ☐ M ☐ S ☐ W ☐ D
Habits:
Smoke: ☐ None Pk/day_____ Years_____
Alcohol: ☐Never ☐Social ☐Light ☐Mod.
☐ Heavy
Employment:
At time of crash:_____
☐ Unemployed
Currently employed:_____
☐ Unemployed
Due to crash? ☐Yes ☐No
Type of work: ☐Office/clerical ☐Light labor
☐ Moderate labor ☐Heavy labor

**Past Medical History:**

Surgeries (dates and residuals): _____
_____
_____
_____
Fractures (dates and residuals): _____
_____
_____
_____
Serious Illness (dates and residuals): _____
_____
_____
_____
Workers' comp injuries (date, treatment, awards, residuals)__
_____
_____
_____
Personal injuries (dates, treatment, awards, residuals) _____
_____
_____
_____
Sports or other injuries to head, neck or back: _____
_____
_____
_____

Any prior History of current complaints?
1. _____
2. _____
3. _____

Past medical history (cont'd)

Prior treatment by Chiropractor:
1. _____
2. _____
3. _____

Current Medical history:

Current health problems: ☐None
_____
_____
_____
_____

Current Medications: ☐None
_____
_____
_____
_____

**Injury history; General:**

Was the crash on-the-job? ☐Yes ☐No
Were you: ☐Driver ☐Front seat passenger
☐ Rear seat passenger ☐Motorcycle operator
☐ Motorcycle passenger ☐Other _____
Vehicle driven by: _____
Your vehicle: Year _____Make _____Model_____
Your estimated speed at time of crash: _____mph
☐ Stopped ☐ Slowing ☐ Accelerating
Other vehicle: Year _____Make _____Model_____
Time of day: ☐ Daylight ☐Dawn ☐Dusk ☐Dark
Road Conditions: ☐ Dry ☐Damp ☐Wet ☐Snow
☐ Ice ☐Other _____
Headrest (restraint): ☐None ☐Integral type
☐ Adjustable type: ☐Up ☐Down
☐Don't know
If adjustable, was the position altered by the crash?
☐ Yes ☐ No ☐Don't know
Was the seat back adjustment altered by the crash?
☐ Yes ☐ No ☐Don't know
Was the seat broken? ☐Yes ☐No ☐Don't know
Lap belt: ☐Wearing ☐Not wearing ☐Don't know
Shoulder belt: ☐None ☐Wearing ☐Not wearing
☐ Don't know
Did air bag deploy? ☐Yes ☐No
If yes, were you struck by bag? ☐ Yes ☐No
Body position: ☐Good ☐Forward lean ☐Other
Head position: ☐Forward ☐ Left ☐ Right ☐ Up
☐ Down

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Injury history, General (cont'd):

Hands: ☐One on wheel ☐ Two on wheel ☐ N/A
Brakes applied? ☐Yes ☐ No

Crash description: _____

**Crash diagram:**

Were you aware of impending crash? ☐Yes ☐ No

**During the crash:**
Did you strike any parts of the vehicle? ☐Yes ☐ No
If yes, describe_____
Did vehicle strike any objects after the crash? ☐Yes ☐ No
If yes, describe_____
Wearing hat or glasses? ☐Yes ☐ No
If yes, still on after the crash? ☐Yes ☐ No
Did you lose consciousness? ☐Yes ☐ No
If yes, for how long?_____
Estimated property damage to your vehicle: $_____
Estimated damage to other vehicle(s): ☐ None
☐ Minimal ☐ Moderate ☐ Major
Were the police on scene? ☐Yes ☐ No
If yes, was a report made? ☐Yes ☐ No

**After the crash**

Symptoms: ☐ Headache ☐ Dizziness ☐ Nausea
☐Confusion/disorientation ☐ Neck pain
☐ Pins/Needles
If yes, where?_____
☐ Extremity pain
If yes, where?_____
☐ Back pain
When did symptoms first appear? ☐ Immediately
_____Hrs afterward
Where did you go after crash? ☐ Home ☐ Work
☐ Hospital
Mode of transportation_____

**Emergency department:**

X-Rays? ☐ Yes ☐ No
Body parts imaged: _____
Results:_____
Lab work? ☐ Yes ☐ No
Cervical collar ☐ ☐ Ice
Medications:_____
Other:_____
Follow-up instructions: ☐ Yes ☐ No

**Treatment History:**
1. Dr.:_____
Specialty:_____Date first seen:___/___/___
Treatment type:_____
Treatment frequency:_____ Duration_____
Currently treating? ☐ Yes ☐ No
If yes, describe:_____
Did treatment help? ☐ Yes ☐ No
Notes:_____
2. Dr.:_____
Specialty:_____Date first seen:___/___/___
Treatment type:_____
Treatment frequency:_____ Duration_____
Currently treating? ☐ Yes ☐ No
If yes, describe:_____
Did treatment help? ☐ Yes ☐ No
Notes:_____

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# REVISED OSWESTRY BACK PAIN DISABILITY QUESTIONNAIRE

Name _____ Date _____

**Please read carefully:**

*This questionnaire has been designed to enable us to understand how your back pain has affected your ability to manage everyday life. Please answer every section, and mark in each section only* ***ONE CHOICE*** *which applies to you. We realize that you may consider that two of the statements in any one section relate to you, but please just* ***mark the one box which most closely describes your problem right now.***

**SECTION 1 – Pain Intensity**

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

**SECTION 2 – Personal Care**

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 increases the pain, but I manage not to change my way of doing it.
D. Washing and dressing increases the pain and I find it necessary to change my way of doing it.
E. Because of the pain, I am unable to do some washing and dressing without help.
F. Because of the pain, I am unable to do any washing or dressing without help.

**SECTION 3 – Lifting**

A. I can lift heavy weights without extra pain.
B. I can lift heavy weights but it gives me extra pain.
C. Pain prevents me from lifting 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-eg, 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. Pain does not prevent me from walking any distance.
B. Pain prevents me from walking more than 1 mile.
C. Pain prevents me from walking more than ½ mile.
D. Pain prevents me from walking more than ¼ mile.
E. I can only walk using a stick or crutches.
F. I am in bed most of the time and have to crawl to the toilet.

**SECTION 5 – Sitting**

A. I can sit in any chair as long as I like without pain.
B. I can only sit in my favorite chair as long as I like.
C. Pain prevents me sitting more than 1 hour.
D. Pain prevents me sitting more than ½ hour.
E. Pain prevents me sitting more than 10 minutes.
F. Pain prevents me from sitting at all.

**OTHER COMMENTS:**

_____

_____

**SECTION 6 – Standing**

A. I can stand as long as I want without pain.
B. I have some pain while standing, but it does not increase with time.
C. I cannot stand for longer than 1 hour without increasing pain.
D. I cannot stand for longer than ½ hour without increasing pain.
E. I cannot stand for longer than 10 minutes without increasing pain.
F. Pain prevents me from standing at all.

**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 night's sleep is reduced by less than one-quarter.
D. Because of pain, my normal night's sleep is reduced by less than one-half.
E. Because of pain, my normal night's sleep is reduced by less than three-quarters.
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, eg, dancing, etc.
D. Pain has restricted my social life and I do not go out very often.
E. Pain has restricted my social life to my home.
F. I have hardly any social life because of the pain.

**SECTION 9 – Traveling**

A. I get no pain while traveling.
B. I get some pain while traveling but none of my usual forms of travel make it any worse.
C. I get extra pain 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 present.
D. My pain is neither getting better nor worse.
E. My pain is gradually worsening.
F. My pain is rapidly worsening.

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Examiner

With Permission from:Hudson-Cook N, Tomes-Nicholson K, Breen AC. A Revised Oswestry Back Disability Questionnaire. Manchester Univ Press, 1989.