



**CONFIDENTIAL HEALTH  
INFORMATION  
NEW PATIENT - AUTO CLAIM**

**Charles M. Anderson, D.C.**

**1550 Biddle Rd., Ste D,  
Medford, OR 97504  
P:(541) 779-9650  
F:(541) 779-5315**

Please allow our staff to photocopy your insurance details.  
All information you supply is confidential; we comply with all federal  
privacy standards.

**Personal Information**

\_\_\_\_\_  
Name Birth Date Date

\_\_\_\_\_  
Address Age

Female  Male

*May we contact you at work?*

No  Yes

\_\_\_\_\_  
City State Zip SSN

*Preferred Method of Contact:*

Home Phone

Cell phone

Work phone

\_\_\_\_\_  
Home Phone Cell Phone Work phone

\_\_\_\_\_  
Email Driver's License

Marital Status: S M D W

\_\_\_\_\_  
Spouse's Name (if applicable)

*Have you consulted a chiro-  
practor before?*

No  Yes

*If so, whom? When?*

\_\_\_\_\_  
Occupation Employer

\_\_\_\_\_  
Primary Care Provider

**Emergency Contact**

\_\_\_\_\_  
Name Relationship Phone

**Acknowledgement of Receipt: Anderson Chiropractic's Notice of Privacy Practices**

I have received a copy of this office's Notice of Privacy Practices. I understand that I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

Conduct, plan and direct my treatment and follow-up among the health care providers who may be directly and indirectly involved in providing my treatment.

Obtain payment from third-party payers.

Conduct normal health care operations such as quality assessments and accreditation.

Please list below the names and your relationship of people to whom you authorize Anderson Chiropractic to release your private health information:

Name	Relationship
_____	_____
_____	_____
_____	_____
_____	_____

\_\_\_\_\_  
**Signature** of Patient, Parent, Legal Guardian or Patient's Legal Representative Date

**Activities of Daily Living** What kind of negative effect does your condition have on your ability to function in the following situations? **0 = No effect, 1 = Mild, 2 = Moderate, 3 = Severe**

Sitting	0	1	2	3	Climbing Stairs	0	1	2	3	Using a computer	0	1	2	3
Standing	0	1	2	3	Concentrating	0	1	2	3	Rising out of a chair	0	1	2	3
Walking	0	1	2	3	Showering/bathing	0	1	2	3	Getting into/out of a car	0	1	2	3
Lying down	0	1	2	3	Getting dressed	0	1	2	3	Driving	0	1	2	3
Bending over	0	1	2	3	Exercising	0	1	2	3	Grocery shopping	0	1	2	3
Lifting objects	0	1	2	3	Getting to sleep	0	1	2	3	Household chores	0	1	2	3
Reaching overhead	0	1	2	3	Staying asleep	0	1	2	3	Yard work	0	1	2	3
Looking over shoulder	0	1	2	3	Love life	0	1	2	3	Caring for family	0	1	2	3

**Medications and Supplements** Please list all prescriptions, over the counter drugs, natural supplements, enzymes, vitamins and minerals that you are currently taking.

---



---



---

**Review of systems** Chiropractic care focuses on the integrity of your nervous system, which controls and regulates your entire body. Please check the circle beside any condition that you've **had** in the past or currently **have** and initial to the right.

	<i>Had</i>	<i>Have</i>		<i>Had</i>	<i>Have</i>		<i>Had</i>	<i>Have</i>	
<b>Musculoskeletal</b>	<input type="radio"/>	<input type="radio"/>	Osteoporosis	<input type="radio"/>	<input type="radio"/>	Neck pain	<input type="radio"/>	<input type="radio"/>	Knee injuries
	<input type="radio"/>	<input type="radio"/>	Arthritis	<input type="radio"/>	<input type="radio"/>	Back problems	<input type="radio"/>	<input type="radio"/>	Foot/ankle pain
	<input type="radio"/>	<input type="radio"/>	Scoliosis	<input type="radio"/>	<input type="radio"/>	Hip disorders	<input type="radio"/>	<input type="radio"/>	Shoulder problems
	<input type="radio"/>	<input type="radio"/>	TMJ issues	<input type="radio"/>	<input type="radio"/>	Poor posture	<input type="radio"/>	<input type="radio"/>	Elbow/wrist pain
<b>Neurological</b>	<input type="radio"/>	<input type="radio"/>	Anxiety	<input type="radio"/>	<input type="radio"/>	Headache	<input type="radio"/>	<input type="radio"/>	Pins and needles
	<input type="radio"/>	<input type="radio"/>	Depression	<input type="radio"/>	<input type="radio"/>	Dizziness	<input type="radio"/>	<input type="radio"/>	Numbness
<b>Cardiovascular</b>	<input type="radio"/>	<input type="radio"/>	High blood pressure	<input type="radio"/>	<input type="radio"/>	Angina	<input type="radio"/>	<input type="radio"/>	High cholesterol
	<input type="radio"/>	<input type="radio"/>	Low blood pressure	<input type="radio"/>	<input type="radio"/>	Excessive Bruising	<input type="radio"/>	<input type="radio"/>	Poor circulation
<b>Respiratory</b>	<input type="radio"/>	<input type="radio"/>	Asthma	<input type="radio"/>	<input type="radio"/>	Emphysema	<input type="radio"/>	<input type="radio"/>	Shortness of breath
	<input type="radio"/>	<input type="radio"/>	Apnea	<input type="radio"/>	<input type="radio"/>	Hay fever	<input type="radio"/>	<input type="radio"/>	Pneumonia
<b>Digestive</b>	<input type="radio"/>	<input type="radio"/>	Anorexia/bulimia	<input type="radio"/>	<input type="radio"/>	Food sensitivities	<input type="radio"/>	<input type="radio"/>	Constipation
	<input type="radio"/>	<input type="radio"/>	Ulcer	<input type="radio"/>	<input type="radio"/>	Heartburn	<input type="radio"/>	<input type="radio"/>	Diarrhea
<b>Sensory</b>	<input type="radio"/>	<input type="radio"/>	Blurred vision	<input type="radio"/>	<input type="radio"/>	Hearing loss	<input type="radio"/>	<input type="radio"/>	Loss of smell
	<input type="radio"/>	<input type="radio"/>	Ringing in ears	<input type="radio"/>	<input type="radio"/>	Ear infection	<input type="radio"/>	<input type="radio"/>	Loss of taste
<b>Skin</b>	<input type="radio"/>	<input type="radio"/>	Skin cancer	<input type="radio"/>	<input type="radio"/>	Eczema	<input type="radio"/>	<input type="radio"/>	Hair loss
	<input type="radio"/>	<input type="radio"/>	Psoriasis	<input type="radio"/>	<input type="radio"/>	Acne	<input type="radio"/>	<input type="radio"/>	Rash
<b>Endocrine</b>	<input type="radio"/>	<input type="radio"/>	Thyroid issues	<input type="radio"/>	<input type="radio"/>	Hypoglycemia	<input type="radio"/>	<input type="radio"/>	Swollen glands
	<input type="radio"/>	<input type="radio"/>	Immune disorders	<input type="radio"/>	<input type="radio"/>	Frequent infection	<input type="radio"/>	<input type="radio"/>	Low energy
<b>Genitourinary</b>	<input type="radio"/>	<input type="radio"/>	Kidney stones	<input type="radio"/>	<input type="radio"/>	Bedwetting	<input type="radio"/>	<input type="radio"/>	Erectile dysfunction
	<input type="radio"/>	<input type="radio"/>	Infertility	<input type="radio"/>	<input type="radio"/>	Prostate issues	<input type="radio"/>	<input type="radio"/>	PMS symptoms
<b>Constitutional</b>	<input type="radio"/>	<input type="radio"/>	Fainting	<input type="radio"/>	<input type="radio"/>	Poor appetite	<input type="radio"/>	<input type="radio"/>	Weakness
	<input type="radio"/>	<input type="radio"/>	Low libido	<input type="radio"/>	<input type="radio"/>	Sudden weight gain or loss (circle one)	<input type="radio"/>	<input type="radio"/>	Fatigue

Patient's Name \_\_\_\_\_

Signature \_\_\_\_\_

Date \_\_\_\_\_



**Health History** Identify your past health history, including accidents, injuries, illnesses and treatments. Please complete each section fully.

**Illnesses** Check the illnesses you've **had** in the past or **have** now.

<i>Had</i>	<i>Have</i>		<i>Had</i>	<i>Have</i>		<i>Had</i>	<i>Have</i>	
<input type="radio"/>	<input type="radio"/>	AIDS	<input type="radio"/>	<input type="radio"/>	Goiter	<input type="radio"/>	<input type="radio"/>	Polio
<input type="radio"/>	<input type="radio"/>	Alcoholism	<input type="radio"/>	<input type="radio"/>	Gout	<input type="radio"/>	<input type="radio"/>	Rheumatic fever
<input type="radio"/>	<input type="radio"/>	Allergies	<input type="radio"/>	<input type="radio"/>	Heart disease	<input type="radio"/>	<input type="radio"/>	Scarlet fever
<input type="radio"/>	<input type="radio"/>	Arteriosclerosis	<input type="radio"/>	<input type="radio"/>	Hepatitis	<input type="radio"/>	<input type="radio"/>	Sexually transmitted disease
<input type="radio"/>	<input type="radio"/>	Cancer	<input type="radio"/>	<input type="radio"/>	HIV positive	<input type="radio"/>	<input type="radio"/>	Stroke
<input type="radio"/>	<input type="radio"/>	Chicken pox	<input type="radio"/>	<input type="radio"/>	Malaria	<input type="radio"/>	<input type="radio"/>	Tuberculosis
<input type="radio"/>	<input type="radio"/>	Diabetes	<input type="radio"/>	<input type="radio"/>	Measles	<input type="radio"/>	<input type="radio"/>	Typhoid fever
<input type="radio"/>	<input type="radio"/>	Epilepsy	<input type="radio"/>	<input type="radio"/>	Multiple sclerosis	<input type="radio"/>	<input type="radio"/>	Ulcer
<input type="radio"/>	<input type="radio"/>	Glaucoma	<input type="radio"/>	<input type="radio"/>	Mumps	<input type="radio"/>	<input type="radio"/>	Other _____

**Operations** Surgical interventions, which may or may not have included hospitalization.

<input type="radio"/>	<input type="radio"/>	Appendix removal	<input type="radio"/>	<input type="radio"/>	Eye surgery	<input type="radio"/>	<input type="radio"/>	Tonsillectomy
<input type="radio"/>	<input type="radio"/>	Bypass surgery	<input type="radio"/>	<input type="radio"/>	Hysterectomy	<input type="radio"/>	<input type="radio"/>	Vasectomy
<input type="radio"/>	<input type="radio"/>	Cancer	<input type="radio"/>	<input type="radio"/>	Pacemaker	<input type="radio"/>	<input type="radio"/>	Cosmetic surgery
<input type="radio"/>	<input type="radio"/>	Spine _____	<input type="radio"/>	<input type="radio"/>	Elective surgery _____	<input type="radio"/>	<input type="radio"/>	Other _____

**Injuries** Have you ever...?

<input type="radio"/>	Had a fractured bone	<i>When?</i> _____	<input type="radio"/>	Been injured in an accident	<i>When?</i> _____
<input type="radio"/>	Had a spine or nerve disorder	_____	<input type="radio"/>	Used a crutch or other support	_____
<input type="radio"/>	Been knocked unconscious	_____	<input type="radio"/>	Used neck or back bracing	_____

**Social History**

	<i>Daily</i>	<i>Weekly</i>	<i>How much?</i>		<i>Daily</i>	<i>Weekly</i>	<i>How much?</i>
Alcohol use	<input type="radio"/>	<input type="radio"/>	_____	Soft drinks	<input type="radio"/>	<input type="radio"/>	_____
Coffee use	<input type="radio"/>	<input type="radio"/>	_____	Water intake	<input type="radio"/>	<input type="radio"/>	_____
Tobacco use	<input type="radio"/>	<input type="radio"/>	_____	Job pressure/stress	<input type="radio"/>	<input type="radio"/>	_____
Exercise	<input type="radio"/>	<input type="radio"/>	_____	Recreational drugs	<input type="radio"/>	<input type="radio"/>	_____
Pain relievers	<input type="radio"/>	<input type="radio"/>	_____	Hobbies: _____			

**Family History**

	Family member	Notes (for Dr. Anderson's use)
<input type="radio"/>	Cancer _____	_____
<input type="radio"/>	Heart disease _____	_____
<input type="radio"/>	Diabetes _____	_____
<input type="radio"/>	Other: _____	_____

For office use only: Height \_\_\_\_\_ Weight \_\_\_\_\_ Blood pressure \_\_\_\_\_ / \_\_\_\_\_

\_\_\_\_\_  
Patient's Name

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date



**Financial Policy**

In order to help you determine your responsibility toward payment for services, please read the following and initial your preference for the method of payment for your account. Please notify this office if the status of your insurance changes.

*Initial an option and write the corresponding letter in the blank below.*

**Private pay, no insurance:**

**A** \_\_\_\_\_ As I have no insurance, I agree to assume all responsibility and to keep my account current by paying for services when they are rendered. As allowed by Oregon state law, I am requesting a "Time of Service Discount" when I pay for my services on the same day that services are performed.

**Private pay, patient filing own claims:**

**B** \_\_\_\_\_ I have insurance, but I wish to file my claims personally, and I agree to assume all responsibility and to keep my account current by paying for each visit at the time services are rendered. As allowed by Oregon state law, I am requesting a "Time of Service Discount" when I pay for my services on the same day that services are performed. I am requesting a "Super Bill" be provided to me which includes the diagnosis so that I can submit a claim to my insurance company.

**Health or auto insurance:**

**C** \_\_\_\_\_ I would like Anderson Chiropractic to bill my auto insurance claim or health insurance. I understand that I am responsible for the costs of treatment, should my insurance company deny coverage for the claim submitted on my behalf. I acknowledge that it is my responsibility to find out whether my insurance covers all services rendered. I understand that if I let the office know which services are not covered by my health insurance, I will be eligible to pay the "Time of Service" discount for those services. I understand that I will be required to pay all co-pays or co-insurance percentages as stated in my insurance plan contract.

By my signature, I request option \_\_\_\_\_ as the method by which I will pay for my services performed in this clinic.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

**Acknowledgements** To set clear expectations, improve communications and help you get the best results in the shortest amount of time, please read each statement and initial your agreement.

**Initials**

\_\_\_\_\_ I instruct Dr. Anderson to deliver the care that, in his professional judgment, can best help me in the restoration of my health. I also understand that the chiropractic care offered in this practice is based on the best available evidence and designed to reduce or correct vertebral subluxation. Chiropractic is a separate and distinct healing art from medicine and does not proclaim to cure any named disease or entity.

\_\_\_\_\_ I grant permission to be called to confirm or reschedule appointments and to be sent occasional cards, letters, emails or health information as an extension of my care in this office.

\_\_\_\_\_ To the best of my ability, the information I have supplied is complete and truthful. I have not misrepresented the presence, severity or cause of my health concern.

\_\_\_\_\_  
Patient's Name

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date





# MOTOR VEHICLE ACCIDENT QUESTIONNAIRE

Charles M. Anderson, D.C.

1550 Biddle Rd., Ste D  
Medford, OR 97504  
P:(541) 779-9650  
F:(541) 779-5315

Name	Date
------	------

Date and time of injury: \_\_\_\_\_ City and Street where injury occurred: \_\_\_\_\_  
 Estimated damage to vehicle: \_\_\_\_\_

Do you have auto insurance coverage?  Yes  No  
 Insurance Company: \_\_\_\_\_

Have you reported this injury to your insurance company?  Yes  No

*Please notify our office if you retain an attorney.* Claim Number: \_\_\_\_\_  
 Adjustor's Name: \_\_\_\_\_

Did the police come to the accident scene and make a report?  Yes  No

Your vehicle's make, model and year: \_\_\_\_\_ Estimated speed at impact: \_\_\_\_\_ mph

The other vehicle's make, model and year: \_\_\_\_\_ Estimated speed at impact: \_\_\_\_\_ mph

Describe the collision in your own words: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

### Collision Description (check all that apply to you)

- Driver  Front passenger  Rear passenger  Pedestrian
- Rear-end impact  Head-on impact  Right side impact  Left side impact
- Roll-over  Hit guardrail/tree  Ran off road  Hit and run

### At the time of impact, your vehicle was:

- Slowing down  At a complete stop
- Gaining speed  Moving at a steady speed

### At the time of impact, the other vehicle was:

- Slowing down  At a complete stop
- Gaining speed  Moving at a steady speed

### During and after impact, your vehicle...

- Kept going straight, not hitting anything  Kept going straight, hitting the car in front  Was hit by another vehicle
- Spun around, not hitting anything  Spun around, hitting another car  Spun around, hitting an object other than a car

### Describe yourself during the collision (check only those that apply to you)

- You were unaware of the impending collision  You were aware of the impending collision and braced yourself
- Your body, torso and head were facing straight ahead  You had your head and/or torso turned at the time of impact (circle: to the left or right)
- You were wearing a seat belt (with shoulder harness? Y N)  You were holding onto the steering wheel at the time of impact
- You lost consciousness. For how long? \_\_\_\_\_

\_\_\_\_\_  
 Signature

**Did anything hit your body from inside or outside the vehicle? Or did your body hit something?**

---

---

**When did you first notice any pain after the injury?**     Immediately     \_\_\_\_ hrs later     \_\_\_\_ days later

**Type of head restraint:**     movable     fixed     no head restraint

**Position of head restraint:**     At the top of the back of your head     Midway at the back of your head  
 At the lower part of the back of your head     At the level of your neck

**Emergency Treatment**

Did you go to the emergency room after the collision?     Yes     No  
If yes, name of ER: \_\_\_\_\_

Did you go to the emergency room by ambulance?     Yes     No

Did you or another person drive you to the emergency room?     Yes     No

Were you hospitalized overnight?     Yes     No

Did the ER doctor take x-rays?     Yes     No

    If yes:     skull     neck     chest     low back     arm/leg

Did the ER doctor give you pain medication and/or muscle relaxants?     Yes     No

Did you have any cuts, lacerations or bruises?     Yes     No

Were you given a neck collar or brace to wear?     Yes     No

**Check the symptoms you have noticed since the collision:**

- Headache                       Irritability                       Tension                       Cold hands/feet
- Neck pain                       Chest pain                       Shortness of breath                       Bussing in ears
- Neck stiffness                       Dizziness                       Fatigue                       Loss of balance
- Sleeping problems                       Head seems too heavy                       Depression                       Upset stomach
- Back pain                       Tingling in arms/legs                       Eyes sensitive to light                       Bowel changes
- Nervousness                       Numbness in arms/legs                       Memory loss                       Loss of smell/taste

**Are you having difficulty completing your normal activities as a result of the accident?**     Yes     No

If yes, describe in detail: \_\_\_\_\_

---

**If you did not see a doctor within the first week after the collision, indicate why:** \_\_\_\_\_

---

**Describe any physical complaints you had before the collision:** \_\_\_\_\_

---

**Have you ever been in a collision before?**     Yes     No

If yes, describe (including date, type of collision, injuries and treatment): \_\_\_\_\_

---

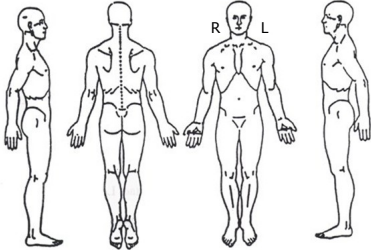
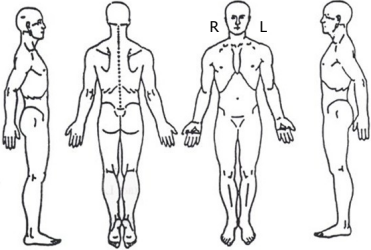
---

**Have you been able to work since the injury?**     Yes     No

If no, you were off work:     partially     completely    Dates: \_\_\_\_\_ to \_\_\_\_\_

\_\_\_\_\_  
Patient's Name                      Signature                      Date



<p><b>Primary Complaint</b> The primary symptom that prompted me to seek care today is:</p> <p>_____</p> <p>_____</p> <p>_____</p>	<p><b>Secondary Complaint</b> The secondary symptom that prompted me to seek care today is:</p> <p>_____</p> <p>_____</p> <p>_____</p>
<p><b>Intensity</b> How extreme are your symptoms? 0 1 2 3 4 5 6 7 8 9 10 Mild Mod Severe</p>	<p><b>Intensity</b> How extreme are your symptoms? 0 1 2 3 4 5 6 7 8 9 10 Mild Mod Severe</p>
<p><b>Duration</b> How often do you experience this? <input type="radio"/> Constant <input type="radio"/> Frequent <input type="radio"/> Occasional <input type="radio"/> Intermittent</p>	<p><b>Duration</b> How often do you experience this? <input type="radio"/> Constant <input type="radio"/> Frequent <input type="radio"/> Occasional <input type="radio"/> Intermittent</p>
<p><b>Quality of Symptoms</b></p> <p><input type="radio"/> Numbness <input type="radio"/> Tingling <input type="radio"/> Stiffness <input type="radio"/> Dull ache  <input type="radio"/> Cramping <input type="radio"/> Nagging <input type="radio"/> Sharp <input type="radio"/> Throbbing  <input type="radio"/> Stabbing <input type="radio"/> Burning <input type="radio"/> Shooting <input type="radio"/> Other</p>	<p><b>Quality of Symptoms</b></p> <p><input type="radio"/> Numbness <input type="radio"/> Tingling <input type="radio"/> Stiffness <input type="radio"/> Dull ache  <input type="radio"/> Cramping <input type="radio"/> Nagging <input type="radio"/> Sharp <input type="radio"/> Throbbing  <input type="radio"/> Stabbing <input type="radio"/> Burning <input type="radio"/> Shooting <input type="radio"/> Other</p>
<p><b>Location</b> Where does it hurt? Circle the area(s) on the illustration. "O" for current condition, "X" for conditions experienced in the past.</p>	<p><b>Location</b> Where does it hurt? Circle the area(s) on the illustration. "O" for current condition, "X" for conditions experienced in the past.</p>
	
<p><b>Radiation</b> Where does your pain radiate or shoot to? _____</p>	<p><b>Radiation</b> Where does your pain radiate or shoot to? _____</p>
<p><b>Aggravating or Relieving Factors</b> Makes it worse: _____ Makes it better: _____</p>	<p><b>Aggravating or Relieving Factors</b> Makes it worse: _____ Makes it better: _____</p>
<p><b>Prior Interventions</b> What have you done for relief?  <input type="radio"/> Ice <input type="radio"/> Heat  <input type="radio"/> Homeopathic Remedies <input type="radio"/> Over-the-counter drugs  <input type="radio"/> Prescription medication <input type="radio"/> Acupuncture  <input type="radio"/> Massage <input type="radio"/> Chiropractic  <input type="radio"/> Physical therapy <input type="radio"/> Surgery  <input type="radio"/> Other _____</p>	<p><b>Prior Interventions</b> What have you done for relief?  <input type="radio"/> Ice <input type="radio"/> Heat  <input type="radio"/> Homeopathic Remedies <input type="radio"/> Over-the-counter drugs  <input type="radio"/> Prescription medication <input type="radio"/> Acupuncture  <input type="radio"/> Massage <input type="radio"/> Chiropractic  <input type="radio"/> Physical therapy <input type="radio"/> Surgery  <input type="radio"/> Other _____</p>

# Neck Disability Index Questionnaire

This questionnaire is designed to help us better understand how your neck pain affects your ability to life activities. Please mark the one that most closely describes your situation **right now**.

Name: \_\_\_\_\_ Date: \_\_\_\_\_

## 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.

## Reading

- I can read as much as I want with no neck pain.
- I can read as much as I want with slight neck pain.
- I can read as much as I want with moderate neck pain.
- I can't read as much as I want because of moderate neck pain.
- I can't read as much as I want because of severe neck pain.
- I can't read at all because of the pain.

## Concentration

- I can concentrate fully without difficulty.
- I can concentrate fully with slight difficulty.
- I have a fair degree of difficulty concentrating.
- I have a lot of difficulty concentrating.
- I have a great deal of difficulty concentrating.
- I can't concentrate at all.

## Work

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

## Personal Care

- 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.

## Sleeping

- I have no trouble sleeping.
- My sleep is slightly disturbed for less than 1 hour.
- My sleep is mildly disturbed for up to 1-2 hours.
- My sleep is moderately disturbed for up to 2-3 hours.
- My sleep is greatly disturbed for up to 3-5 hours.
- My sleep is completely disturbed for up to 5-7 hours.

## Lifting

- I can lift heavy objects without causing extra pain.
- I can lift heavy weights, but it gives me extra pain.
- Pain prevents me from lifting heavy weights off the floor but I can manage if items are conveniently positioned (e.g. on a table).
- Pain prevents me from lifting heavy weights, but I can manage light weights if they are conveniently positioned.
- I can lift only very light weights.
- I cannot lift or carry anything at all.

## Recreation

- I have no neck pain during all recreational activities.
- I have some neck pain with all recreational activities.
- I have some neck pain with a few recreational activities.
- I have neck pain with most recreational activities.
- I can hardly do recreational activities due to neck pain.
- I can't do any recreational activities due to neck pain.

## Driving

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

## 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.

Signature \_\_\_\_\_

Charles M. Anderson, D.C. - 1550 Biddle Rd., Ste D, Medford, OR 97504 - P:(541) 779-9650 F:(541) 779-5315





# Back Pain Index Questionnaire



This form is designed to help us better understand how your back pain affects your ability to manage everyday life activities. Please mark the one that most closely describes your situation **today**.

Name: \_\_\_\_\_

Date: \_\_\_\_\_

## 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 moderate.
- 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.

## Sitting

- I can sit in any chair as long as I like.
- I can only sit in my favorite chair as long as I like.
- Pain prevents me from sitting more than 1 hour.
- Pain prevents me from sitting more than 30 min.
- Pain prevents me from sitting more than 10 min.
- I avoid sitting because it increases pain immediately.

## Standing

- I can stand as long as I want without pain.
- I have some pain while standing but it does not increase with time.
- I cannot stand longer than 1 hour without increasing pain.
- I cannot stand longer than 30 min without increasing pain.
- I cannot stand longer than 10 min without increasing pain.
- I avoid standing because it increases pain immediately.

## Walking

- I have no pain while walking.
- I have some pain while walking but it doesn't increase with distance.
- I cannot walk more than 1 mile without increasing pain.
- I cannot walk more than 1/2 mile without increasing pain.
- I cannot walk more than 1/4 mile without increasing pain.
- I cannot walk at all without increasing pain.

## Personal Care

- I do not have to change my way of 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 increases the pain but I manage not to change my way of doing it.
- Washing and dressing increases 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.

## Changing Degree of Pain

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

## 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 sleep is reduced by less than 25%.
- Because of pain my normal sleep is reduced by less than 50%.
- Because of pain my normal sleep is reduced by less than 75%.
- Pain prevents me from sleeping at all.

## Lifting

- I can lift heavy objects without extra pain.
- I can lift heavy objects but it causes extra pain.
- Pain prevents me from lifting heavy objects off the floor.
- Pain prevents me from lifting heavy objects off the floor, but I can manage if they are conveniently positioned (e.g. on a table).
- Pain prevents me from lifting heavy objects off the floor, but I can manage light to medium weights if they are conveniently positioned.
- I can only lift very light weights.

## Social Life

- My social life is normal and gives me no extra pain.
- My social life is normal but increases the degree of pain.
- Pain has restricted my social life and I do not go out very often.
- Pain has restricted my social life to my home.
- Pain has no significant affect on my social life apart from limiting my more energetic interests (e.g. dancing, etc).
- I have hardly any social life because of the pain.

## 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 cause me to seek alternate forms of travel.
- I get extra pain while traveling which causes me to seek alternate forms of travel.
- Pain restricts all forms of travel except that done while lying down.
- Pain restricts all forms of travel.

Signature \_\_\_\_\_

Charles M. Anderson, D.C. - 1550 Biddle Rd., Ste D, Medford, OR 97504 - P:(541) 779-9650 F:(541) 779-5315

