

INSURANCE FORMS/PAYMENT

If you receive any correspondence from your insurance carrier pertaining to the care you have received at this office or a request of more information regarding your care, please bring it in as soon as possible. It is very important that we keep your file as up to date as possible. Occasionally, either by mistake, or due to provisions in your policy, the check issued by the insurance company for payment of services rendered in our office, may come to you instead of our office. If you should receive any unexpected check in the mail, please contact us to see if it does represent payment of your bill here.

I have read and understand the payment policy of Bay State Chiropractic. I understand that my insurance is an arrangement between myself and my insurance company, NOT between Bay State Chiropractic and my insurance company. I request that Bay State Chiropractic prepare the customary forms at no charge so that I may obtain insurance benefits. I also understand that if my insurance does not respond within 60 days, or if I suspend or terminate my schedule of care as prescribed by the doctors at Bay State Chiropractic that fees will be due and payable immediately.

Patient's signature (or guardian if patient is a minor) Date

Witness

SPECIAL PAYMENT INSTRUCTIONS

Patient's Name: _____

1. We have verified your benefits and while your insurance company did not guarantee payment, they stated that you have a \$_____ deductible, \$_____ of which has been met. Additionally, your insurance will pay _____% of covered charges, leaving _____% of each visit due by you.
2. We have verified your benefits and while your insurance company did not guarantee payment, they stated that you have a \$_____ deductible, \$_____ of which has been met. Additionally, your insurance will pay _____% of covered charges, leaving \$_____ co-pay of each visit due by you.

Bay State Chiropractic Center **FINANCIAL POLICY**

Our recommendations are based on a desire to see you get well and stay well. Chiropractic care is covered under many insurance plans. Most of our patients that have health or accident insurance will fall under one of the plans discussed in this policy. Regardless of your coverage, we'll suggest the chiropractic care we think you need. We ask that you read and understand our policy as it applies to your particular situation.

Health Insurance

PATIENTS WITHOUT INSURANCE

We request that 100% of the first visit be paid at the time of the visit. On other visits, payment may be made at the end of the week if you sign a credit guarantee form. We are happy to accept your check, Master Card or Visa.

GROUP OR INDIVIDUAL INSURANCE

Your insurance is an agreement between you and your insurance company, not between your insurance company and our office. We cannot be certain if your insurance covers Chiropractic, although most policies do provide coverage. The amount they pay varies from one policy to another. When possible, we will call to verify benefits on your insurance; however, the benefits quoted to us by your insurance company are not a guarantee of payment. As a courtesy to you, our office will complete any necessary insurance forms at no additional charge, and file them with your insurance company to help you collect. It is to be understood and agreed that any services rendered are charged to you directly and you are personally responsible for payment of any non-covered services, deductibles or co-pays. You may also pay the full amount due each day thereby qualifying for our Time of Service Reduction in fees. You may then submit the bill to your insurance carrier for reimbursement.

“ON THE JOB” INJURY (Worker’s Compensation)

If you are injured on the job, your care should be paid for under your employer’s Worker’s Compensation insurance. You will need to inform your employer of the accident and obtain the name and address of the carrier of their insurance. If your employer does not provide us with this information, if a settlement has not been made within 3 months, or if you suspend or terminate care, any fees and services are due immediately.

PERSONAL INJURY OR AUTOMOBILE ACCIDENTS

Please present your auto insurance card, your health insurance card, and tell us if you have retained an attorney. There are four options available to the PI patient:

1. Pay cash for your care and we will submit reports whenever necessary.
2. We will bill (accept assignment) from the Med Pay portion of your auto insurance.
3. We will accept a Letter of Protection or Doctor’s Lien from an attorney and await payment at the time of settlement as long as you remain an active patient.
4. We will bill your standard health insurance plan and you will be responsible for all co-pays and deductibles as they are incurred.

Although you are ultimately responsible for your bill, we will wait for settlement of your claim for up to **(six)** months after your care is completed.

Once the claim is settled or if you suspend or terminate care, any fees for services are due immediately.

MEDICARE

We do accept assignment from Medicare. The check is usually sent directly to our office in payment of the services that Medicare will cover which for Chiropractors is **ONLY** manual manipulation of the spine. Medicare pays 80% of the allowable fee once the deductible has been met. You are required to pay the deductible and the remaining 20%. All other services we provide are **NON-COVERED**. These services include, but are not limited to, x-rays, examinations, therapies, orthotics, supports, and/or nutritional supplements. Medicare patients are fully responsible for charges of non-covered services. Secondary insurance may or may not pay for these non-covered services. Our office completes and files the forms for Medicare at no charge.

SECONDARY INSURANCE

Please inform us of any secondary insurance you may have. We will assist you if you need help in filing.

MANAGED CARE PLANS

We are preferred providers for the following companies (List Name of any HMO’s or PPO’s).

- You are required to pay a \$ _____ co-pay at the time of service.
- A referral from your primary care physician will be necessary. Out of network benefits are available if a referral is not obtained.

- Benefits are available for up to _____ visits per year. A \$ _____ co-pay is due at the time of service.

FLEX PLANS/MEDICAL SAVINGS ACCOUNTS

Please inform us if you have a medical savings account, sometimes known as a ‘flex plan’. We will be happy to provide you with a statement of your charges for reimbursement.

Bay State Chiropractic Center
405 Frederick Road, Suite 15, Catonsville, MD 21228
410-744-8800 (O)/ 410-744-8856 (FAX)

ACKNOWLEDGMENT OF RECEIPT OF HIPAA PRIVACY NOTICE

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.

Patient

Signature

Date

For Office Use Only

We attempted to obtain written Acknowledgment of receipt of our Notice of Privacy Practices, but Acknowledgment could not be obtained because:

- Individual refused to sign
- Communications barriers prohibited obtaining the Acknowledgment
- An emergency situation prevented us from obtaining Acknowledgment
- Other (Please Specify) _____

Staff signature

Date

Bay State Chiropractic Center
405 Frederick Road Suite 15 Catonsville, MD 21228
(410) 744-8800 FAX (410) 744-8856
www.baystatechiro.com

Financial Policy Summary

Notice:

In an effort to maintain compliance with various State and Federal regulations, managed care and preferred provider agreements, as well as billing and coding guidelines, we have adopted the following financial policies:

Our clinic has established a single fee schedule that applies to all patients for each service provided.

You may be entitled to a network or contractual discount under the following circumstances:

- If we are a participating provider in your health plan.
- If you are covered by a State or Federal program with a mandated fee schedule.
- If you are a member of a DMPO we may join (ie. Chirohealth USA) Patients who are uninsured, or under-insured (limited benefits for chiropractic care), will be entitled to network discounts similar to our insured patients. Membership is \$49.00 a year and covers you and your dependents. Ask our team for more information.
- If you are eligible and choose an auto-debit plan or a “prompt payment” option.
- Patients who meet State and or Federal poverty guidelines or other special circumstances outlined in our “Hardship Policy” may be offered a discount for a period of time as determined by the clinic. Verification will be required.

As part of our compliance plan, as of September 1, 2016, our office will be unable to extend any type of discounts other than those offered above.

Acknowledged By: _____ **Date:** _____

**Bay State Chiropractic Center
405 Frederick Road
Suite 15
Catonsville, Maryland 21228
410-744-8800 (phone) 410-744-8856 (fax)
www.baystatechiro.com**

MISSED APPOINTMENT POLICY

We want to thank you for choosing us as your chiropractic health provider. In order to provide you and our other patients with the best optimal spinal care, we request that you follow our guidelines regarding broken and/or canceled appointments. Please remember that we have reserved appointment times especially for you. Therefore, we request at least 24 hours notice in order to reschedule your appointment. This will enable us to offer your canceled time to other patients that desire to get their treatment completed. When you cancel your appointment at the last minute, everyone loses – you, the doctor and other patients that would like to have utilized your appointment time.

Please be advised that there will be a \$50.00 fee assessed for broken and/or canceled appointments that do not fall within these guidelines.

Thank you for your consideration of our policies and for the opportunity to be your chiropractic office of choice.

Signature

Date

Office Use Only

- 1
- 4-5
- >5

Patient #: _____

Bay State Chiropractic Center Pain Drawing

Name: _____

Date: _____

Date of Birth: _____

Examiner: _____

TELL US WHERE YOU HURT.

Please read carefully:

Mark the areas on your body where you feel your pain. Include all affected areas. Mark areas of radiation. If your pain radiates, draw an arrow from where it starts to where it stops. Please extend the arrow as far as the pain travels. Use the appropriate symbol(s) listed below.

Ache >>>>>

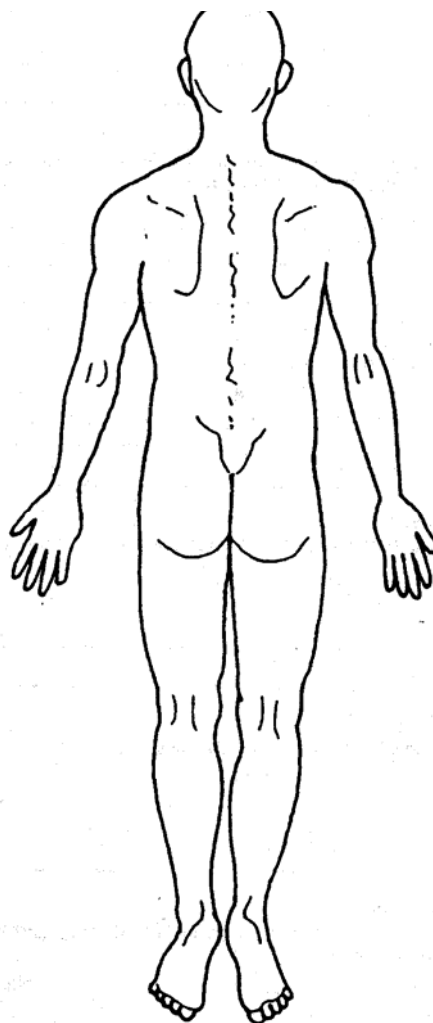
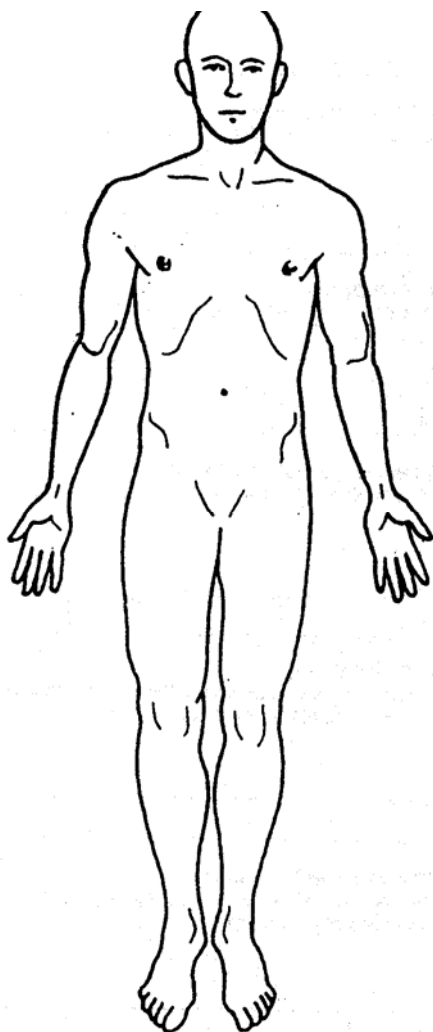
Burning x x x x

Numbness =====

Stabbing // // // //

Pins & Needles o o o o

Throbbing ~ ~ ~ ~ ~



Oswestry Disability Index

Section 1 – Pain Intensity

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

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

- I can look after myself normally but it is very painful.
- I can look after myself normally but it is very painful.
- 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 my personal care.
- I need help every day in most aspects of self-care.
- I do not get dressed, wash with difficulty, and stay in bed.

Section 3 - Lifting

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

Section 4 – Walking

- Pain does not prevent me walking any distance.
- Pain prevents me walking more than 1 mile.
- Pain prevents me walking more than ¼ of a mile.
- Pain prevents me walking more than 100 yards.
- I can only walk using a stick or crutches.
- I am in bed most of the time and have to crawl to the toilet.

Section 5 – Sitting

- I can sit in any chair as long as I like.
- I can sit in my favorite chair as long as I like.
- Pain prevents me from sitting for more than 1 hour.
- Pain prevents me from sitting for more than ½ hour.
- Pain prevents me from sitting for more than 10 minutes.
- Pain prevents me from sitting at all.

Section 6 – Standing

- I can stand as long as I want without extra pain.
- I can stand as long as I want but it gives me extra pain.
- Pain prevents me from standing more than 1 hour.
- Pain prevents me from standing for more than ½ an hour.
- Pain prevents me from standing for more than 10 minutes.
- Pain prevents me from standing at all.

Section 7 – Sleeping

- My sleep is never disturbed by pain.
- My sleep is occasionally disturbed by pain.
- Because of pain, I have less than 6 hours sleep.
- Because of pain, I have less than 4 hours sleep.
- Because of pain, I have less than 2 hours sleep.
- Pain prevents me from sleeping at all.

Section 8 – Sex life (if applicable)

- My sex life is normal and causes no extra pain.
- My sex life is normal but causes some extra pain.
- My sex life is nearly normal but is very painful.
- My sex life is severely restricted by pain.
- My sex life is nearly absent because of pain.
- Pain prevents any sex life at all.

Section 9 – Social Life

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

Section 10 – Traveling

- I can travel anywhere without pain.
- I can travel anywhere but it gives extra pain.
- Pain is bad but I manage journeys of over two hours.
- Pain restricts me to short necessary journeys under 30 minutes.
- Pain prevents me from traveling except to receive treatment.

Section 11 - Previous Treatment

Over the past three months have you received treatment, tablets or medicines of any kind for your back or leg pain? Please check the appropriate box.

- No
- Yes (if yes, please state the type of treatment you have received)

Neck Disability Index

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

Section 1 – Pain Intensity

- I have no pain at the moment. (0)
- The pain is very mild at the moment. (1)
- The pain is moderate at the moment. (2)
- The pain is fairly severe at the moment. (3)
- The pain is very severe at the moment. (4)
- The pain is the worst imaginable at the moment. (5)

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

- I can look after myself normally without causing extra pain. (0)
- I can look after myself normally but it causes extra pain. (1)
- It is painful to look after myself and I am slow and careful. (2)
- I need some help but manage most of my personal care. (3)
- I need help every day in most aspects of self care. (4)
- I do not get dressed, I wash with difficulty and stay in bed. (5)

Section 3 – Lifting

- I can lift heavy weights without extra pain. (0)
- I can lift heavy weights but it gives extra pain. (1)
- Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned, for example on a table. (2)
- Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned. (3)
- I can lift very light weights. (4)
- I cannot lift or carry anything at all. (5)

Section 4 – Reading

- I can read as much as I want to with no pain in my neck. (0)
- I can read as much as I want to with slight pain in my neck. (1)
- I can read as much as I want with moderate pain in my neck. (2)
- I cannot read as much as I want because of moderate pain in my neck. (3)
- I can hardly read at all because of severe pain in my neck. (4)
- I cannot read at all. (5)

Section 5 – Headaches

- I have no headaches at all. (0)
- I have slight headaches that come infrequently. (1)
- I have moderate headaches which come infrequently. (2)
- I have moderate headaches which come frequently. (3)
- I have severe headaches which come frequently. (4)
- I have headaches almost all the time. (5)

Section 6 – Concentration

- I can concentrate fully when I want to with no difficulty. (0)
- I can concentrate fully when I want to with slight difficulty. (1)
- I have a fair degree of difficulty in concentrating when I want to. (2)
- I have a lot of difficulty in concentrating when I want to. (3)
- I have a great deal of difficulty in concentrating when I want to. (4)
- I cannot concentrate at all. (5)

Section 7 – Work

- I can do as much work as I want to. (0)
- I can do my usual work, but no more. (1)
- I can do most of my usual work, but no more. (2)
- I cannot do my usual work. (3)
- I can hardly do any work at all. (4)
- I cannot do any work at all. (5)

Section 8 – Driving

- I can drive my car without any neck pain. (0)
- I can drive my car as long as I want with slight pain in my neck. (1)
- I can drive my car as long as I want with moderate pain in my neck. (2)
- I cannot drive my car as long as I want because of moderate pain in my neck. (3)
- I can hardly drive at all because of severe pain in my neck. (4)
- I cannot drive my car at all. (5)

Section 9 – Sleeping

- I have no trouble sleeping. (0)
- My sleep is slightly disturbed (less than 1 hour sleepless). (1)
- My sleep is mildly disturbed (1-2 hours sleepless). (2)
- My sleep is moderately disturbed (2-3 hours sleepless). (3)
- My sleep is greatly disturbed (3-5 hours sleepless). (4)
- My sleep is completely disturbed (5-7 hours sleepless). (5)

Section 10 – Recreation

- I am able to engage in all my recreation activities with no neck pain at all. (0)
- I am able to engage in all my recreation activities, with some pain in my neck. (1)
- I am able to engage in most, but not all, of my usual recreation activities because of pain in my neck. (2)
- I am able to engage in a few of my usual recreation activities because of pain in my neck. (3)
- I can hardly do any recreation activities because of pain in my neck. (4)
- I cannot do any recreation activities at all. (5)

0-4	No disability
5-14	Mild disability
15-24	Moderate disability
25-34	Severe disability
> 35	Complete disability

Bay State Chiropractic Center

Chiropractic Case History/Patient Information

Date: _____ Patient # _____ Doctor: _____

Name: _____ Social Security # _____ Home Phone: _____

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

E-mail address: _____ Fax # _____ Cell Phone: _____

Age: _____ Birth Date: _____ Race: _____ Marital: M S W D

Occupation: _____ Employer: _____

Employer's Address: _____ Office Phone: _____

Spouse: _____ Occupation: _____ Employer: _____

How many children? _____ Names and Ages of Children: _____

Name of Nearest Relative: _____ Address: _____ Phone: _____

How were you referred to our office? _____

Family Medical Doctor _____ Address: _____ Phone: _____

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

HISTORY OF PRESENT ILLNESS:

Chief Complaint: Purpose of this appointment: _____

_____ Date

symptoms first appeared or accident happened: _____ Is this due to: Auto ___ Work ___ Other _____

Have you **ever** had the same or a similar condition? Yes No If yes, when and describe: _____

Days lost from work: _____ Date of last physical examination: _____

PAST MEDICAL HISTORY

Childhood Diseases: Measles _____ Mumps _____ Chicken Pox _____ Others _____

Adult Diseases, Illnesses or Conditions _____

Have you ever been diagnosed as having or have you ever suffered from any of the following. Please mark the letter **N** by conditions you have now or the letter **P** if you have previously had any of these conditions:

- | | | | |
|---|--|---|---|
| <input type="checkbox"/> Broken or Fractured Bones | <input type="checkbox"/> Osteoarthritis | <input type="checkbox"/> Eating Disorder | |
| <input type="checkbox"/> Circulatory Problems | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Alcoholism | |
| <input type="checkbox"/> Rheumatoid Arthritis | <input type="checkbox"/> Pace Maker | <input type="checkbox"/> Drug Addiction | |
| <input type="checkbox"/> Seizures/Convulsions | <input type="checkbox"/> Strokes | <input type="checkbox"/> HIV Positive | |
| <input type="checkbox"/> A Congenital Disease | <input type="checkbox"/> Cancer | <input type="checkbox"/> Gall Bladder | |
| <input type="checkbox"/> Excessive Bleeding | <input type="checkbox"/> Ruptures | <input type="checkbox"/> Depression | |
| <input type="checkbox"/> High/Low Blood Pressure | <input type="checkbox"/> Coughing Blood | <input type="checkbox"/> Ulcers | |
| <input type="checkbox"/> Headaches; Frequency _____ | <input type="checkbox"/> Shoulder/Neck/Arm Pain | <input type="checkbox"/> Loss of Balance | <input type="checkbox"/> Fever |
| <input type="checkbox"/> Neck Pain | <input type="checkbox"/> Numbness in Fingers | <input type="checkbox"/> Fainting | <input type="checkbox"/> Sinus Problems |
| <input type="checkbox"/> Stiff Neck | <input type="checkbox"/> Numbness in Toes | <input type="checkbox"/> Loss of Smell | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Sleeping Problems | <input type="checkbox"/> Difficulty Urinating | <input type="checkbox"/> Loss of Taste | <input type="checkbox"/> Indigestion |
| <input type="checkbox"/> Back Pain | <input type="checkbox"/> Weakness in Extremities | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Joint Pain/Swell |
| <input type="checkbox"/> Nervousness | <input type="checkbox"/> Breathing Problems | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Menstrual Difficulty |
| <input type="checkbox"/> Tension | <input type="checkbox"/> Fatigue | <input type="checkbox"/> Hands Cold | <input type="checkbox"/> Weight Loss/Gain |
| <input type="checkbox"/> Irritability | <input type="checkbox"/> Lights Bother Eyes | <input type="checkbox"/> Feet Cold | <input type="checkbox"/> Loss of Memory |
| <input type="checkbox"/> Chest Pain/Tightness | <input type="checkbox"/> Ears Ring | <input type="checkbox"/> Muscle Spasms | <input type="checkbox"/> Buzzing in Ears |
| <input type="checkbox"/> Unusual Bowel Patterns | <input type="checkbox"/> Frequent Colds/Sickness | <input type="checkbox"/> Women: Are you Pregnant? | |

Do you have a history of stroke or hypertension? _____
Have you had any major illnesses, injuries, falls, auto accidents or surgeries? Women, please include information about childbirth (include dates): _____

Have you been treated for any health condition by a physician in the last year? Yes No
If yes, describe: _____

What medications or drugs are you taking? _____

Do you have any allergies to any medications? Yes No
If yes, describe: _____

Do you have any allergies of any kind? Yes No
If yes, describe: _____

Please list any other health problems you have, no matter how insignificant they may be: _____

SOCIAL HISTORY:

Do you drink alcoholic beverages? ___ If so, how much per week? _____
Do you use any tobacco products? ___ Do you smoke? ___ If so, packs per day: _____
Do you take vitamin supplements? ___ If so, please list: _____
Do you consume caffeine? ___ If so, how much per day: _____
Do you exercise? ___ If yes, what is the frequency and type of exercise? _____
What are your hobbies? _____
What percentage of time during the day (at home or at your job away from home) do you spend:
lifting ___ sitting ___ bending ___ working at a computer _____

FAMILY HISTORY:

Parents:
Father: living ___ deceased ___ Current age if still living: ___ Cause of death and age at death if deceased: _____ (check one)
Mother: living ___ deceased ___ Current age if still living: ___ Cause of death and age at death if deceased: _____ (check one)

Check if applicable to you: _____ As an adopted child, little is known of birth parents or family.

Do you have any family members who suffer from the same condition you do? If so, please list: _____

FAMILY DISEASES (check if applicable and indicate whether family member is **F**ather, **M**other, **S**ister, **B**rother):

- | | | |
|------------------|-------------------------|--------------------|
| Tuberculosis ___ | Cancer ___ | Mental Illness ___ |
| Diabetes ___ | Asthma ___ | Heart Disease ___ |
| Stroke ___ | Kidney Disease ___ | Lung Disease ___ |
| Arthritis ___ | Liver Disease ___ | Back Trouble ___ |
| Constipation ___ | High Blood Pressure ___ | Migraine ___ |
| Scoliosis ___ | Headaches ___ | |
| Other _____ | | |

Patient: _____

Please circle any and all insurance coverage that may be applicable in this case:

- Major Medical
- Worker's Compensation
- Medicaid
- Medicare
- Auto Accident
- Medical Savings Account & Flex Plans
- Other _____

Name of Primary Insurance Company: _____

Name of Secondary Insurance Company (if any): _____

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

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

Patient's Signature: _____

Date: _____

Guardian's Signature Authorizing Care: _____

Date: _____

BAY STATE CHIROPRACTIC CENTER

PATIENT: _____ NP REX

DATE: _____

SUMMARY

1. What are your top 4 major complaints, rate on a scale of 1-10 (0 being no pain; 10 is the worst possible.)

Worst	1.	_____
	2.	_____
Least	3.	_____
	4.	_____

2. What does this prevent you from doing or enjoying? _____

3. If this is a recurrence, when was the first time you noticed the problem? _____

How did it originally occur? _____

Has it become worse recently? Yes No Same Better Gradually Worse

If yes, when and how? _____

4. How frequent is the condition? Constant Daily Intermittent Night Only

How long does it last? All Day Few Hours Minutes

5. Are there any other conditions or symptoms that may be related to your major symptom?

Yes No If yes describe: _____

Are there other unrelated health problems? Yes No If yes describe: _____

6. Describe the pain: Sharp Dull Numbness Tingling Aching Burning Stabbing

Other _____

7. Is there anything you can do to relieve the problem? Yes No If yes, please describe:

If no, what have you tried that hasn't helped. _____

8. What makes the problem worse? Standing Sitting Lying Bending Lifting Twisting

Other _____

9. List any major accidents you have had other than those that might be mentioned above: _____

10. WOMEN ONLY: Are you pregnant or is it possible that you may be pregnant? Yes No Uncertain

11. Remarks: _____

Please place an "X" on the line below to indicate the level of your problem.
No Symptoms-----Extreme Symptoms

Doctors Signature: _____ Date: _____