Deans Family Chiropractic
256 Great Road Suite 2,
Littleton, MA 01460
978-486-9531

Office Financial Agreement

1. Upon arrival, please sign in at the front desk.
2. It is your responsibility to understand your insurance benefits. According to your insurance plan, you are responsible for any and all co-payments, deductibles and co-insurance. We make no representation that we can guarantee insurance coverage, and will not take any responsibility for payment.
3. If our office does not participate in your insurance plan, payment in full is expected from you at the time of your visit unless other arrangements are made. For scheduled appointments, prior balances must be paid prior to the visit.
4. If you have no insurance, payment is expected at the time of the visit. We do not provide any services for free, as doing so is forbidden under Medicare guidelines and could result in penalties including loss of credentials. We offer a membership in Chiro Health USA (a discount medical plan organization) that will allow us to offer treatment at a discounted rate.
5. Co-pays are due at time of service.
6. Patient balances are billed after payment has been received from your insurance company.
7. If previous arrangements have not been made, any account balance over 90 days will be turned over to a collection agency.
8. A $35 fee will be assessed for appointments cancelled without 24 hours' notice. ***EXCEPTIONS WILL BE MADE DEPENDENT UPON CIRCUMSTANCES.***
9. A $50 fee will be assessed for not showing up for your scheduled appointment. ***EXCEPTIONS WILL BE MADE DEPENDENT UPON CIRCUMSTANCES.***
10. New Patient exams must be canceled 48 hours prior to appointment time. A $100 fee will be assessed for cancelations less than 48 hour prior and a $150 fee will be assessed for not showing up to your exam. ***EXCEPTIONS WILL BE MADE DEPENDENT UPON CIRCUMSTANCES.***

LEGAL ASSIGNMENT OF BENEFITS AND RELEASE OF MEDICAL AND PLAN DOCUMENTS

I request that payment of authorized Medicare, or any other insurance benefits be made on my behalf to Deans Family Chiropractic for any services provided to me by that group. I understand that any holder of medical information about me may release any information to the Health Care Finance Administration (HCFA) and its agents, in order to facilitate reimbursement for services rendered. I authorize Deans Family Chiropractic to release information to all parties and/or their representatives that may be required to provide or pay for services rendered. I understand that the above consent/authorizations do not guarantee payment/reimbursement, nor does it release me from any obligation and responsibility for all outstanding charges not covered as a result of, but not exclusive to: co-payments, co-insurance, deductibles, usual and customary schedules, maximum allowances/limits or non-covered services.

I have read and understand the above Office Financial Agreement and agree to comply and accept the responsibility for any payment that becomes due as outlined above.

Patient Name:(Print): _____Date: _____

Patient Signature: _____

INFORMED CONSENT TO CHIROPRACTIC CARE

Deans Family Chiropractic
Aaron S. Deans, DC
256 Great Road, Suite 2,
Littleton, MA 01460

Patient: Please discuss any questions or concerns with the Doctor before signing this document.

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of therapy and diagnostic x-rays, on me (or on the patient named below, for whom I am legally responsible) by a licensed chiropractor at Deans Family Chiropractic.

I have had the opportunity to discuss with the doctor and/or with other office or clinic personnel purpose and benefits of the chiropractic adjustments and other treatments outlined below. Alternatives to treatment have been reviewed.

Though chiropractic adjustments and treatments are usually beneficial and seldom cause any problem, I understand and am informed that there are some risks to treatment. Risks include, but are not limited to sprains, fractures, disc injuries, and vascular problems.

I understand that I will be receiving the following treatment:

Chiropractic spinal adjustments and supportive procedures.

_____

I understand that chiropractic is not an exact science and that, therefore, reputable practitioners cannot fully guarantee results. I acknowledge that no guarantee or assurance has been made by anyone regarding the chiropractic treatment that I have requested and authorized. I have had the opportunity to read this form and ask questions. My questions have been answered to my satisfaction. I consent to the proposed treatment.

Signature of Patient: _____ Date: _____

Signature of Parent/Guardian: _____ Date: _____
(If patient is a minor.)
Witness Signature: _____ Date: _____

Doctor's Signature: _____ Date: _____

HIPAA PATIENT AUTHORIZATION FORM

We are required by the Health Insurance Portability and Accountability Act of 1996 (HIPAA) to maintain the privacy of your protected health information (PHI) and to provide you with a Notice of Privacy Practices. Our Notice of Privacy Practices provides information about how we may use and disclose your PHI, and contains a section describing your rights as a patient under the law. You have the right to review our Notice before signing this Authorization and you are advised to do so. This authorization for release of information covers the period of healthcare from January, 20____ to December, 20____.

By signing this form, you authorize our use and disclosure to third parties, including but not limited to our billing and scheduling software provider, Chiro Touch, of your PHI for treatment, payment, and health care operations, and for certain marketing purposes, as described in our Notice of Privacy Practices. If you sign this Authorization but later change your mind, you have the right to revoke this Authorization by delivering to us a written, dated document signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior Authorization.

The patient understands and agrees that:

The Clinic has a Notice of Privacy Practices. The patient has received, and had the opportunity to review, this Notice before signing this Authorization. The Clinic encourages all patients to review the Notice of Privacy Practices.

The clinic reserves the right to modify the Notice of Privacy Practices to keep up with changes in the law or office practices. We will make all modifications available for review by patients.

All my medical records and protected health information may be disclosed or used for treatment, payment, or health care operations, and for certain marketing purposes. The Clinic will not receive any payment from a third party for marketing purposes in connection with the use or disclosure of your PHI.

The Clinic or its business affiliates may use your PHI to contact you with appointment reminders and educational and promotional items in the future via email, U.S. Mail, telephone, fax and/or pre-recorded messages. WE WILL NOT ever sell or "SPAM" your personal contact information.

The patient has the right to restrict the uses of his or her information, but the Clinic does not have to agree to all such restrictions.

The patient may revoke this Authorization in writing at any time and all future disclosures that require the patient's prior written authorization will then cease. See the Notice of Privacy Practices for additional details.

The Clinic may not condition your treatment or payment on whether you sign this Authorization.

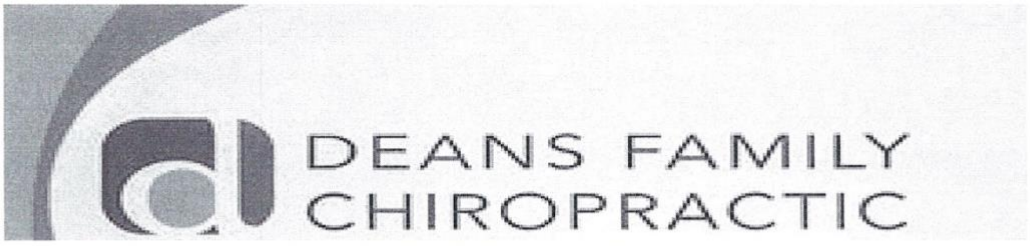
Information used or disclosed pursuant to this Authorization may be re-disclosed by the recipient and may no longer be protected by federal or state law.

The Authorization was signed by: _____ Date: _____
(Printed Name-Patient or Representative)

_____ Date: _____
(Signature)

Relationship to Patient (if other than Patient): _____

Witness: Printed Name: _____ Signature: _____ Date: _____



WELCOME!

First Name_____ Middle _____ Last_____

Gender: □ male □female Birthdate:_____ Age: _____

Home Phone: _____ Cell Phone:_____

Address:_____

City:_____ State: _____ Zip: _____

Email Address: _____

Marital Status: S M W D

Job Title: _____ Work Phone: _____

Name of their employer: _____ _____City:_____

Employer phone: _____

Person Responsible for account:_____

Health Insurance:_____

Name on Card:_____

Emergency Contact:

Name:_____ Phone:_____

Primary Care:_____ Phone:_____

Main Complaint?

_____

_____

Is this a Personal Injury? Y N

Patient Signature:_____ Date:_____

January 2018

Deans Family Chiropractic
HISTORY OF ILLNESS / INJURY / PAIN

Patient Name: _____ Date: _____/_____/_____ Account #: _____

Primary Complaint:

LOCATION: Chief complaint and its location:

_____

_____

TIMING & DURATION: How often? ____ Constant ____ Frequent ____ Intermittent ____ Occasional
What caused the onset?

_____

_____

Date of onset? ____/____/_____ (Please list your most recent incident (minor or major) that prompted this visit.)

SEVERITY: On a scale of 0 to 10 with 0 representing no pain and 10 being the most severe pain imaginable, use the key below to rate the severity of your pain.

0 = None 1 = Minimal 2 = Very Mild 3 = Mild 4 = Mild to Moderate 5 = Moderate 6 = Moderate to Severe
7 = Mildly Severe, Restricts Some Activity 8 = Severe, Limits Most Activity
9 = Very Severe 10 = Excruciating

Sitting here today, right now, what is the intensity of your pain on a scale of 0 to 10? (Circle One)
0 1 2 3 4 5 6 7 8 9 10
What is the least intense the symptom has been on a scale of 0 to 10? (Circle One)
0 1 2 3 4 5 6 7 8 9 10
What is the most intense the symptom has been on a scale of 0 to 10? (Circle One)
0 1 2 3 4 5 6 7 8 9 10

ASSOCIATED SIGNS & SYMPTOMS: Please check those that apply
____Inflexibility ____Stiffness ____Spasms ____Cramps
If this pain radiates or travels, please identify where to:

_____

_____

QUALITY: How would you best describe the sensation of the pain/symptom:
___Sharp ___Stabbing ___Aching ___Pins & Needles ___Burning ___Dull ___Tingling/Numb ___Throbbing
___Pounding ___Crawling ___Shooting ___Stinging

MODIFYING FACTORS:
*What aggravates the pain/symptom?
___Sneezing ___Coughing ___Stress ___Repetitive movement ____Lifting ___Sitting ___Driving ___Carrying
___Exercising ___Stooping ___Getting out of bed ___Straining at BM ___Looking up/down ___Looking side/side
___Pushing ___Climbing stairs ___Walking ___Standing ___Pulling ___Getting in/out of car
___Other:_____
*What relieves this pain/symptom?
___Resting ___Shower ___Sleeping ___Advil ___Lifting ___Stooping ___Exercising __Looking side/side
___Looking up/down ___Mineral Ice ___Other: _____
*Over the past weeks/months this complaint is: ____About the same ____Improving ____Getting worse
*Have you seen anyone for this condition? ____YES ____NO WHOM? _____

*How did you hear about us? _____

Doctor Signature: _____Date: _____

Patient Signature: _____Date: _____

Patient Name: _____ Date: _____/_____/_____ Account #: _____

Secondary Complaint:

LOCATION: _____

Sitting here today, right now, what is the intensity of your pain on a scale of 0 to 10? (Circle One)

0 1 2 3 4 5 6 7 8 9 10

What is the least intense the symptom has been on a scale of 0 to 10? (Circle One)

0 1 2 3 4 5 6 7 8 9 10

What is the most intense the symptom has been on a scale of 0 to 10? (Circle One)

0 1 2 3 4 5 6 7 8 9 10

ASSOCIATED SIGNS & SYMPTOMS: Please check those that apply

____Inflexibility ____Stiffness ____Spasms ____Cramps

If this pain radiates or travels, please identify where to:

_____

_____

QUALITY: How would you best describe the sensation of the pain/symptom:

___Sharp ___Stabbing ___Aching ___Pins & Needles ___Burning ___Dull ___Tingling/Numb ___Throbbing ___Pounding ___Crawling ___Shooting ___Stinging

Third Complaint:

LOCATION:_____

Sitting here today, right now, what is the intensity of your pain on a scale of 0 to 10? (Circle One)

0 1 2 3 4 5 6 7 8 9 10

What is the least intense the symptom has been on a scale of 0 to 10? (Circle One)

0 1 2 3 4 5 6 7 8 9 10

What is the most intense the symptom has been on a scale of 0 to 10? (Circle One)

0 1 2 3 4 5 6 7 8 9 10

ASSOCIATED SIGNS & SYMPTOMS: Please check those that apply

____Inflexibility ____Stiffness ____Spasms ____Cramps

If this pain radiates or travels, please identify where to:

_____

_____

QUALITY: How would you best describe the sensation of the pain/symptom:

___Sharp ___Stabbing ___Aching ___Pins & Needles ___Burning ___Dull ___Tingling/Numb ___Throbbing ___Pounding ___Crawling ___Shooting ___Stinging

KEY VALUE QUESTIONS

1. What is your pain keeping you from doing that is most important in your life?

_____

_____

2. What do you enjoy doing most in your life?

_____

_____

Notes/Comments:

_____

_____

_____

Doctor Signature: _____ Date: _____

Patient Signature: _____ Date: _____

Patient Name: _____ Date: _____/_____/_____ Account #: _____

Please place a checkmark by the condition that applies to you: P = Present . N = Not Present . PP = If it has ever been present in the past

P	N	PP		P	N	PP		P	N	PP		P	N	PP	
			Fatigue				Irritability				Joint Stiffness				Seizures
			Fever				Depression				Spinal Curvature				Dizziness
			Chills				Memory Loss				Back Pain				Tremors
			Night Sweats				Headache				Hot Joints				Loss of Sensation
			Fainting				Muscle Pain				Joint Swelling				Paralysis
			Nervousness				Muscle Weakness				Stiff Neck				Difficulty of speech
			Concentration Loss				Muscle Cramps				Lumps/Masses				Loss of Coordination

P=Present • **N**=Not Present • **PP**= If it has ever been present in the past • Do the same for your Family History
Family History Key: **F**= Father • **M**= Mother • **B**= Brother • **S**= Sister • **GF**=Grandfather • **GM**= Grandmother

P	N	PP	Past Problem	When and Explanation of Condition (Use back if needed)	F	M	B	S	GF	GM
			Cancer							
			Stroke							
			Thyroid Problems							
			Asthma							
			Heart Attack							
			HIV							
			Angina/Chest Pain							
			Diabetes							
			Arthritis							
			Other							

List any allergies:

_____

_____

Do you have a pacemaker? _____ YES _____ NO

Are you Pregnant? _____ YES _____ NO
Do you think you may be pregnant? _____ YES _____ NO

FOR DOCTOR'S USE ONLY - PATIENT PLEASE PROCEED TO PAGE 4

Review of Systems

System Reviewed

- ☐ Allergic/Immunologic
- ☐ Constitutional
- ☐ Endocrine
- ☐ Gastrointestinal
- ☐ Genitourinary
- ☐ Integumentary
- ☐ Neurological
- ☐ Respiratory
- ☐ Cardiovascular
- ☐ Ears/Nose/Mouth
- ☐ Eyes
- ☐ All other system reviews negative
- ☐ Hematological/Lymphatic
- ☐ Musculoskeletal
- ☐ Psychiatric

Notes/Comments:

_____

_____

_____

Doctor Signature: _____ Date: _____

Patient Signature: _____ Date: _____

Patient Name: _____ Date: _____/_____/_____ Account #: _____

PLEASE LIST PAST SURGERIES:

1. _____ Year ____
2. _____ Year ____
3. _____ Year ____
4. _____ Year ____
5. _____ Year ____
6. _____ Year ____

List any other key slips, falls or accidents you've had from childhood to present Date:		Have you ever taken?	Y	N	YEAR
1)		Insulin			
2)		Cortisone			
3)		Thyroid medication			
4)		Male/Female Hormones			
5)		Blood Pressure			
What medications are you currently taking (Include Date, use back if needed)		Tranquilizers/Sedatives			
1)	4)	Birth Control			
2)	5)				
3)	6)				
Known allergies to medications:					
Hospitalizations:					

Marital Status: ___ Married ___ Divorced ___ Single ___ Separated ___ Widowed

Number of Children: ___ Children's Name(s): _____

Frequency of Exercise: ___Never - Rarely __Occasionally __Moderately __Regularly

Intensity of Exercise: ____ Low Level ____ Medium Level ____ High Level ____ Competition Level

Sufficient Rest: ____ Never ____ Rarely ____ Occasionally ____ Moderately

Hours of Sleep: ____ 6 ____ 8 ____ 10 ____ More than 10

Well-balanced diet: ____ Never ____ Rarely ____ Occasionally ____ Moderately

Do you smoke? ____ No ____ Occasionally____ 1 to 2 ____ 2 to 3 ____ 4 to 5 ____ More than 5 packs/day

Do you drink caffeinated beverages? ____ No ____ Occasionally____ 1 to 2 ____ 2 to 3 ____ 4 to 5 ____ More than 5 drinks

Do you drink alcoholic beverages? ____ No ____ Occasionally____ 1 to 2 ____ 2 to 3 ____ 4 to 5 ____ More than 5 drinks

Have you ever used street drugs? ____Yes ____No

Hobbies:_____

_____

Patient history was obtained from: __Patient ____Father ____Mother ____Son ____Daughter

Notes / Comments:

_____

_____

Doctor Signature: _____ Date: _____

Patient Signature: _____ Date: _____

HEADACHE DISABILITY INDEX

Patient Name: _____ Date: _____/_____/_____ Account #: _____

INSTRUCTIONS: Please CIRCLE the correct response:
1.I have headaches: (1) 1 Per month (2) more than 1 but less than 4 per month (3) more than one per week
2.My headache is: (1) mild (2) moderate (3) severe

Please read carefully: The purpose of the scale is to identify difficulties that you may be experiencing because of your headaches. Please check off "YES" "SOMETIMES", or "NO" to each item. Answer each question as it pertains to your headache only.

YES	SOMETIMES	NO	
___	_____	___	Because of my headaches I feel handicapped
___	_____	___	Because of my headaches I feel restricted in performing my routine daily activities
___	_____	___	No one understands the effect my headaches have on my life
___	_____	___	I restrict my recreational activities (e.g. Sports, hobbies) because of my headaches
___	_____	___	My headaches make me angry
___	_____	___	Sometimes I feel that I am going to lose control because of my headaches
___	_____	___	Because of my headaches I am less likely to socialize
___	_____	___	My spouse or family and friends have no idea what I am going through because of my headaches
___	_____	___	My headaches are so bad that I feel that I am going to go insane
___	_____	___	My outlook on the world is affected by my headaches
___	_____	___	I am afraid to go outside when I feel that a headache is starting
___	_____	___	I feel desperate because of my headaches
___	_____	___	I am concerned that I am paying penalties at work or at home because of my headaches
___	_____	___	My headaches place stress on my relationships with family or friends
___	_____	___	I avoid being around people when I have a headache
___	_____	___	I believe my headaches are making it difficult for me to achieve my goals in life
___	_____	___	I am unable to think clearly because of my headaches
___	_____	___	I get tense (e.g. Muscle tension) because of my headaches
___	_____	___	I do not enjoy social gatherings because of my headaches
___	_____	___	I feel irritable because of my headaches
___	_____	___	I avoid traveling because of my headaches
___	_____	___	My headaches make me feel confused
___	_____	___	My headaches make me feel frustrated
___	_____	___	I find it difficult to read because of my headaches
___	_____	___	I find it difficult to focus my attention away from my headaches and on other things

Other Comments:

_____

_____

Doctor Signature: _____ Date: _____

Patient Signature: _____ Date: _____

DFC 2020

NECK DISABILITY INDEX

Patient Name: _____ Date: _____/_____/_____ Account #: _____

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
- 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 that moment
- The pain is the worst imaginable at the moment

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

Section 3- Lifting
- I can lift heavy weights without extra pain
- I can lift heavy weights but it gives extra pain
- Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned, for example 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 very light weights
- I cannot lift or carry anything at all

Section 4- Reading
- I can read as much as I want to with no pain in my neck
- I can read as much as I want to with slight pain in my neck
- I can read as much as I want with moderate pain
- I can't read as much as I want because of moderate pain in my neck
- I can hardly read at all because of severe pain in my neck
- I cannot read at all

Section 5- Headaches
- I have no headaches at all
- I have slight headaches which come infrequently
- I have slight headaches which come frequently
- I have moderate headaches which come infrequently
- I have severe headaches which come frequently
- I have headaches almost all the time

Scoring: Questions are scored on a vertical scale of 0-5. Total scores multiply by 2. Divide by number of sections answered multiplied by 10. A score of 22% or more is considered a significant activities of daily living disability (Score___x2)/(____Sections x10)=_____%ADL.

Section 6- Concentration
- I can concentrate fully when I want to with no difficulty
- I can concentrate fully when I want to with slight difficulty
- I have a fair degree of difficulty in concentrating
- I have a lot of difficulty in concentrating
- I have a great deal of difficulty in concentrating
- I cannot concentrate at all

Section 7- Work
- I can do as much work as I want to
- I can only do my usual work, but no more
- I can do most of my usual work, but no more
- I cannot do my usual work
- I can hardly do any work at all
- I can't do any work at all

Section 8- Driving
- I drive my car without any neck pain
- I can drive my car as long as I want with slight pain
- I can drive my car as long as I want with moderate pain
- I can't drive my car as long as I want because of moderate pain
- I can hardly drive my car at all because of severe pain
- I can't drive my car at all

Section 9- Sleeping
- I have no trouble sleeping
- My sleep in slightly disturbed (less than 1 hr. sleepless)
- My sleep is moderately disturbed (1-2 hrs. sleepless)
- My sleep is moderately disturbed (2-3 hrs. sleepless)
- My sleep is greatly disturbed (3-4 hrs. sleepless)
- My sleep is completely disturbed (5-7 hrs. sleepless)

Section 10- Recreation
- I am able to engage in all my recreation activities with no neck pain at all
- I am able to engage in all my recreation activities with some neck pain
- I am able to engage in most, but not all of my usual activities
- I can hardly do any recreation activities because of neck pain
- I can't do any recreation activities at all

Comments:_____
_____
_____

LOW BACK DISABILITY INDEX

Patient Name: _____ Date: _____/_____/_____ Account #: _____

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
- I can tolerate the pain without having to use pain killers
- The pain is bad but I can manage without taking pain killers
- Painkillers give complete relief from pain
- Painkillers give moderate relief from pain
- Painkillers give very little relief from pain
- Painkillers have no effect on the pain and I do not use them

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

Section 3- Lifting
- I can lift heavy weights without extra pain
- I can lift heavy weights but it gives extra pain
- Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned, for example 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 very light weights
- I cannot lift or carry anything at all

Section 4- Walking
- Pain does not prevent me from walking any distances
- Pain prevents me from walking more than one mile
- Pain prevents me from walking more than one-half mile
- Pain prevents me from walking more than one-quarter mile
- I can only walk using a stick/cane/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 only sit in my favorite chair as long as I like
- Pain prevents me from sitting more than one hour
- Pain prevents me from sitting more than 30 minutes
- Pain prevents me from sitting more than 10 minutes
- Pain prevents me from sitting almost all the time

Scoring: Questions are scored on a vertical scale of 0-5. Total scores multiply by 2. Divide by number of sections answered multiplied by 10. A score of 22% or more is considered a significant activities of daily living disability (Score___x2)/(____Sections x10)=_____%ADL.

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 extra pain
- Pain prevents me from standing more than 1 hour
- Pain prevents me from standing more than 30 minutes
- Pain prevents me from standing more than 10 minutes
- Pain prevents me from standing at all

Section 7- Sleeping
- Pain does not prevent me from sleeping well
- I can sleep well only by using tablets
- Even when I take tablets I have less than 6 hours of sleep
- Even when I take tablets I have less than 4 hours of sleep
- Even when I take tablets I have less than 2 hours of sleep
- Pain prevents me from sleeping at all

Section 8- Social Life
- My social life is normal and gives me no extra pain
- My social life is normal but increases my degree of pain
- Pain has no significant effect on my social life apart from limiting my more energetic interests, eg. dancing
- Pain has restricted my social life and I do not go out as often
- Pain has restricted my social life to my home
- I have no social life because of pain

Section 9- Traveling
- I can travel anywhere without extra pain
- I can travel anywhere but it gives me extra pain
- Pain is bad but I manage journey over 2 hours
- Pain is bad but I manage journeys less than 1 hour
- Pain restricts me to short necessary journeys under 30 minutes
- Pain prevents me from traveling except to the doctor or hospital

Section 10- Changing Degree of Pain
- My pain is rapidly getting better
- My pain fluctuates but overall is definitely getting better
- My pain seems to be getting better but improvement is slow at the present
- My pain is neither getting better nor worse
- My pain is gradually worsening
- My pain is rapidly worsening

Comments:_____
_____
_____