BODY in BALANCE

Dr. Kimberly Guthrie
Dr. Jessica Hudson

Body in Balance Wellness Center

7360 SW Hunziker St., Suite 203
Tigard, OR 97223
ph. 503-675-8747 fax 503-360-0894

Name:	Date:	DOB:
Address:	City:	State/Zip:
Cell Phone #:	Add'l Phone #:	Gender:
Email:		Marital Status:
In case of emergency, notify:	Phone #:	Relationship:
Occupation:	Employer:	

Accident Information

Date of Accident:	Time of Accident:	Where were you located in the vehicle at the time of the accident? ❒ Driver ❒ Front Passenger ❒ Backseat ❒ Other
Did your vehicle strike anything? If yes, describe:		Did another vehicle strike your car? If yes, describe:
Your vehicle: ❒ Car ❒ SUV ❒ Truck ❒ Van ❒ Other		Other vehicle: ❒ Car ❒ SUV ❒ Truck ❒ Van ❒ Other
Were you wearing a seatbelt:	Did you hit your head? If yes, describe:	Knocked unconscious?

Describe in detail how the accident happened, include location, conditions, etc...:

Where did you go after the accident?	Did you go by ambulance? If yes, which hospital:
Since the accident, are your symptoms: ❒ improving ❒ staying the same ❒ getting worse	Have you been treated by any other doctors for this injury? If yes, list:
Number of people in the car:	Names of people in the car with you:
Were the police on the scene:	Were citations issued? If yes, describe: / Do you have the report:

Have you lost time from work? If yes, give dates or times and describe:

Have you been involved in an accident in the past? If yes, describe (with dates):

Do you have any activity restrictions as a result of this injury? If yes, describe:

Do you have an attorney? If yes, please provide contact info:

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Name:	Date:

Please list all serious illnesses and accidents, include year:

Please list any recent x-rays, labs, or other tests, include date and where done:

CHECK THE FOLLOWING SYMPTOMS NOTICED SINCE THE ACCIDENT:

❒ Middle Back Pain	❒ Tingling in Arms	❒ Ears Ringing / Buzzing	❒ Chest Pain	❒ Any Cuts
❒ Lower Back Pain	❒ Tingling in Legs	❒ Headache	❒ Bruised Chest	❒ Upset Stomach
❒ Lower Back Stiffness	❒ Upper Arm Pain (shoulder)	❒ Sleep Disturbance	❒ Bruising Anywhere	❒ Blurred Vision
❒ Neck Pain	❒ Lower Arm Pain (elb/wri)	❒ Muscle Spasms	❒ Loss of Balance	❒ Sensitivity to Light
❒ Neck Stiffness	❒ Upper Leg Pain (hip)	❒ Light Headedness	❒ Loss of Smell	❒ Anxiety / Depression
❒ Radiating Pain	❒ Lower Leg Pain (knee/ank)	❒ Fatigue	❒ Loss of Taste	❒ Irritability
❒ Numbness	❒ Jaw Pain (TMJ)	❒ Diarrhea / Constipation	❒ Loss of Memory	❒ Other:

Were there any symptoms which you had after the accident that have now resolved?

Have you done any of the following since the accident?

❒ Ice	❒ Heat (any kind)	❒ Rest	❒ Massage	❒ Other:
❒ Exercise (describe)		❒ Medication (list all)		

DO YOU HAVE A HISTORY OF ANY OF THE FOLLOWING:

❒ Heart Disease	❒ High Blood Pressure	❒ Cancer:	❒ Chest Pain	❒ Gout
❒ Thyroid Disease	❒ Stroke	❒ Headache / Migraine	❒ Seizures	❒ Transfusion
❒ Kidney Disease	❒ Anemia	❒ Polio / MS	❒ Sciatica	❒ Drug Dependence
❒ Lung Disease	❒ Diabetes	❒ Hepatitis	❒ Asthma	❒ Depression
❒ Colon Disease	❒ Stomach / Ulcers	❒ Arthritis	❒ Bleeding	❒ Anxiety

Please provide any other pertinent information you think we should know:

Your Automobile Insurance Carrier:	Policy #:
Billing Address:	Claim#:

Claim Adjuster:	Phone:	Insured Name:

HIPAA COMPLIANCE: Our office is required by law to maintain the HIPAA Notice of Privacy Practices. This notice explains our legal duties and privacy practices with respect to your protected health information. My signature below acknowledges that I have read this Notice of our Privacy Practices. A copy will be provided to me upon request.

Patient Signature: Date:

Provider Signature:	Date:

WERE YOU AWARE THAT...

DOCTORS OF CHIROPRACTIC WORK WITH THE NERVOUS SYSTEM?	☐ YES ☐ NO
THE NERVOUS SYSTEM CONTROLS ALL BODILY FUNCTIONS AND SYSTEMS?	☐ YES ☐ NO
CHIROPRACTIC IS THE LARGEST NATURAL HEALING PROFESSION IN THE WORLD?	☐ YES ☐ NO

GOALS FOR YOUR CARE

People see Chiropractors for a variety of reasons. Some go for relief of pain, some to correct the cause of pain and others for correction of whatever is malfunctioning in their body. Your Doctor will weigh your needs and desires when recommending your care program. Please check the type of care desired so that we may be guided by your wishes whenever possible.

- ☐ **Relief care:** Symptomatic relief of pain or discomfort.
- ☐ **Corrective care:** Correcting and relieving the cause of the problem as well as the symptom.
- ☐ **Comprehensive care:** Bring whatever is malfunctioning in the body to the highest state of health possible with Chiropractic care.
- ☐ ***I want the Doctor to select the type of care appropriate for my condition.***

MEDICATIONS YOU TAKE

☐ CHOLESTEROL MEDICATIONS	☐ BLOOD PRESSURE MEDICINE
☐ STIMULANTS	☐ BLOOD THINNERS
☐ TRANQUILIZERS	☐ PAIN KILLERS (INCLUDING ASPIRIN)
☐ MUSCLE RELAXERS	☐ OTHER:
☐ INSULIN	☐ OTHER:
☐ VITAMINS & SUPPLEMENTS:	

YOUR CONCERNS

INSTRUCTIONS: *Please circle the health concerns or conditions you may be experiencing now or have in the past. Each area of concern relates to an area of the spine and nerve function.*

Sore Throat
Stiff Neck
Radiating Arm Pain
Hand/Finger Numbness
Asthma
Allergies
High Blood Pressure
Heart Conditions

Headaches
Migraines
Dizziness
Sinus Problems
Allergies
Fatigue
Head Colds
Vision Problems
Difficulty Concentrating
Hearing Problems

Middle Back Pain
Congestion
Difficulty Breathing
Bronchitis
Pneumonia
Gallbladder Conditions
Stomach Problems
Ulcers
Gastritis
Kidney Problems

Constipation
Colitis
Diarrhea
Gas Pain
Irritable Bowel
Bladder Problems
Menstrual Problems
Low Back Pain
Pain or Numbness in legs
Reproductive Problems

OTHER:

_____
_____
_____
_____
_____
_____
_____
_____

HEALTH CONDITIONS

INSTRUCTIONS: *Please check each of the diseases or conditions that you now have or have had in the past. While they may seem unrelated to the purpose of the appointment, they can affect the overall diagnosis, care plan and the possibility of being accepted for care.*

☐ SEVERE OR FREQUENT HEADACHES	☐ THYROID PROBLEMS	☐ PAIN IN ARMS/ LEGS/HANDS	☐ NUMBNESS	FOR WOMEN ONLY:
☐ HEART SURGERY/ PACEMAKER	☐ SINUS PROBLEMS	☐ LOW BLOOD PRESSURE	☐ ALLERGIES	ARE YOU PREGNANT? ☐ YES ☐ NO
☐ LOWER BACK PROBLEMS	☐ HEPATITIS	☐ RHEUMATIC FEVER	☐ DIABETES	IF YES, WHEN IS YOUR DUE DATE?
☐ DIGESTIVE PROBLEMS	☐ DIFFICULTY BREATHING	☐ ULCERS/COLITIS	☐ SURGERIES:	ARE YOU NURSING? ☐ YES ☐ NO
☐ PAIN BETWEEN SHOULDERS	☐ KIDNEY PROBLEMS	☐ TUBERCULOSIS	☐ ASTHMA	ARE YOU TAKING BIRTH CONTROL? ☐ YES ☐ NO
☐ CONGENITAL HEART DEFECT	☐ HIGH BLOOD PRESSURE	☐ ARTHRITIS	☐ LOSS OF SLEEP	DO YOU: EXPERIENCE PAINFUL PERIODS? ☐ YES ☐ NO
☐ FREQUENT NECK PAIN	☐ CHEMOTHERAPY	☐ SHINGLES	☐ DIZZINESS	HAVE IRREGULAR CYCLES? ☐ YES ☐ NO HAVE BREAST IMPLANTS? ☐ YES ☐ NO

AUTHORIZATION FOR CARE

I hereby authorize the Doctor to work with my condition through the use of adjustments to my spine, as he or she deems appropriate. I clearly understand and agree that all services rendered me are charged directly to me and that I am responsible for all bills incurred at this office. The Doctor will not be held responsible for any pre-existing medically diagnosed conditions nor for any medical diagnosis. I also understand that if I suspend or terminate my care, any fees for professional services rendered me will become immediately due and payable.

I hereby authorize assignment of my insurance rights and benefits (if applicable) directly to the provider for services rendered. I understand and agree that health and accident insurance policies are on arrangement between an insurance carrier and myself. I understand that the Doctor's office will prepare any necessary reports and forms to assist me in collecting from the insurance company and that any amount authorized to be paid directly to the Doctor's office will be credited to my account on receipt.

Ownership of X-ray Films: It is understood and agreed that the payments to the Doctor for X-rays is for examination of X-rays only. The X-ray negative will remain the property of the office. They are kept on file where they may be seen at any time while I am a patient at this office.

SIGNATURE:	DATE:
SIGNATURE OF GUARDIAN OR SPOUSE AUTHORIZING CARE:	DATE:

WHO SHOULD RECEIVE BILLS FOR PAYMENT ON YOUR ACCOUNT?

☐PATIENT ☐SPOUSE ☐PARENT ☐WORKERS COMP ☐AUTO INSURANCE

TERMS OF ACCEPTANCE

When a patient seeks chiropractic care we accept such a patient for care, it is essential for both to be working towards the same objective. Chiropractic has only one goal. It is only when the patient understands both the objective and the method that they will be able to attain it. This will prevent any confusion or disappointment.

An **adjustment** is the specific adjustments to the spine.

Health is a state of optimal physical, mental and social wellbeing, not merely the absence of disease.

Vertebral Subluxation is a misalignment of one or more of the joints of the body. This can cause pain or alteration of nerve function and interference of the transmission of nerve impulses, lessening the body's innate ability to maintain maximum health.

We do not offer to diagnose or treat any disease or condition other then vertebral subluxation. However, if during the course of a chiropractic spinal evaluation, we encounter non-chiropractic or unusual findings, we will advise you. If you desire advice, diagnosis or treatment for those findings, we will recommend that you seek the services of a health care provider who specializes in that area. Regardless of what the disease is called, we do not offer to treat it. Nor do we offer advice regarding treatment prescribed by others. OUR ONLY PRACTICE OBJECTIVE is to eliminate a major interference to the expression of the body's innate wisdom. Our only method is specific adjusting to correct vertebral subluxation.

I have read and fully understand the above statement. Any questions regarding the doctor's objectives pertaining to my care in this office have been answered to my complete satisfactions. I therefore accept chiropractic care on this basis.

SIGNATURE:	DATE:
WITNESS SIGNATURE:	DATE:

Body in Balance Wellness Center

Dr. Kimberly Guthrie and Dr. Jessica Hudson
Chiropractic Physicians
7360 SW Hunziker Rd, Suite 203
Tigard, OR. 97223
Phone: 503-675-8747 Fax: 503-699-9136

OFFICE & FINANCIAL POLICIES

- Payment is expected at the time of service. We accept cash, check, Visa, Mastercard, Discover cards.
- You are responsible for timely payment on your account. Unpaid balances **over 60 days** may be charged 1.5% interest per month (18% annual) and/or subject to collection activity.
- Maximum allowable outstanding balance is $200.00 unless other arrangements have been made. You may be ineligible to receive further services until your balance is paid down.
- All supplements/vitamins, lab work, supports and other supplies must be paid for at the time they are received unless prior arrangements have been made.
- If you are late for your re-exam appointment, this may result in additional waiting time, and your scan may need to be rescheduled.
- If you have not had an adjustment in **three months**, you must have an exam prior to being adjusted.
- If you choose to discontinue care, you are required to have an exam before being released from care. If you choose to return, you must have an exam before your next adjustment.
- If you are late for your appointment, this may result in additional waiting time, an adjustment only, or your appointment may need to be rescheduled.
- Missed appointments may be subject to a $75.00 cancellation fee if we do not receive your **cancellation at least 24 hours prior to your scheduled appointment**. You are responsible for this fee and it must be paid in full prior to your next appointment.

Motor Vehicle Accident, Personal Injury and Worker's Compensation Claims:

- Cases will be billed directly to the insurance company, providing the appropriate paperwork has been filled out and a claim is filed. **If your claim is denied or reimbursement/compensation does not cover fees incurred, you are responsible for prompt payment of your account balance.**
- We do not do third party billings to other insurance companies for motor vehicle accident and personal injury cases.
- If you choose not to file a claim with your insurance company, or are uninsured, your account will be treated as a cash account and all fees will be due at the time of service.
- Lab work, supports and other supplies may not be covered by your insurance company. If your insurance company does not pay such items, then you are responsible for your bill.

By signing below, you acknowledge that you have read, understand and agree to the above office and financial policies.

_____ _____

Patient Signature or Guardian Signature Date

Late Cancellation/ No Show Policy

For us to best care for you and your family and friends we ask that when you need to cancel or reschedule an appointment that you give us a courtesy 24 hours' notice, so your place can be filled by someone else needing that appointment time.

However, we understand that life can get hectic, so our policy is as follows:

- 1st Missed Appt- We understand, anyone can forget once!
- 2nd Missed Appt- $50 will be charged to your card on file.
- 3rd Missed Appt- You will be required to pay the FULL AMOUNT for the missed appointment, payment is due before we can schedule you for anymore appointments.

Please note that we make every effort possible to remind you of your appointments with reminders texts/ calls.

We appreciate your effort to be on time or give us an appropriate notice to reschedule as it helps us to give the very best care to all our valued clients. We usually have a waiting list of patients in need of our services that could have really benefited from your appointment. Unfortunately for repeat incidences where our clinic wasn't called, we must charge this office administration fee for each patient appointment missed to chase you up. We understand that in rare circumstances emergencies do arise, however not repeatedly, and as a duty of care we must follow up on each and all missed appointment cases at unnecessary extra time and effort needed on our part. Please don't put us in this situation. We love you and appreciate you!

I HAVE READ THE AGREEMENT AND I ACCEPT THE TERMS OF THE AGREEMENT.

Patient's Signature: _____

Patient's Name (print):_____

Date Signed: ____/_____ /_____

Patient Name: _____
CC#: _____
Exp. : _____/_____
CVC# _____

BODY in BALANCE

7360 Sw Hunziker St. Ste. 203 • Tigard, OR 97223

BODY in BALANCE
7380 SW Hunziker St., Suite 203
Tigard, OR 97223

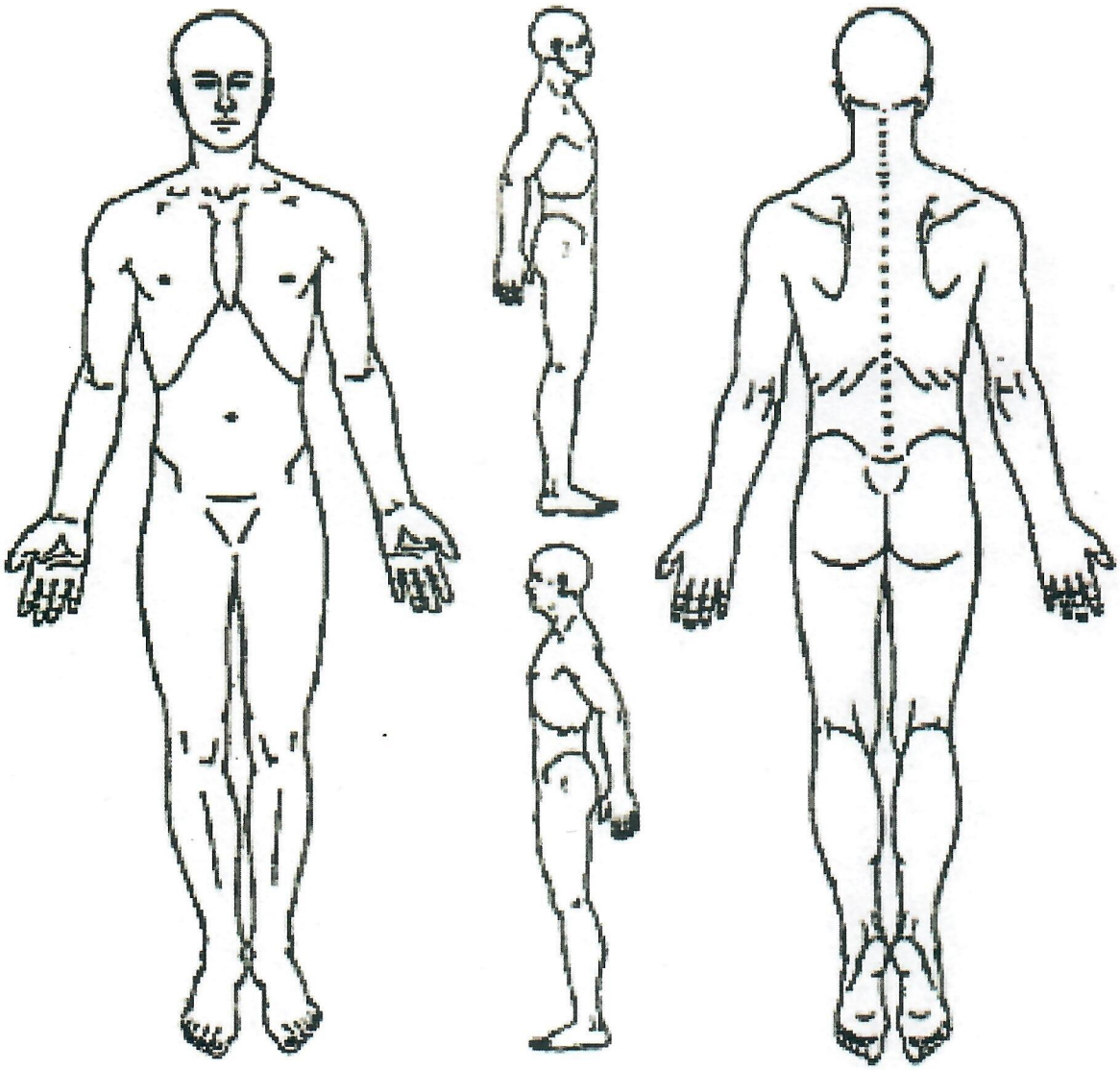
THE NECK DISABILITY INDEX QUESTIONNAIRE

Name: _____ Date: _____

Age: _____ Date of Birth: _____ Occupation: _____

How long have you had neck pain? _____ Years _____ Months _____ Weeks _____ Days

On the diagram below, please indicate where you are experiencing pain or other symptoms, right now.



A = ACHE
P = PINS & NEEDLES

B = BURNING
S = STABBING

N = NUMBNESS
O = OTHER

Patient's Name_____ Number_____ Date_____

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 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 the 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 and 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___ x 2) / (____Sections x 10) = _____ %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 when I want to.
- ☐ I have a lot of difficulty in concentrating when I want to.
- ☐ I have a great deal of difficulty in concentrating when I want to.
- ☐ 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 in my neck.
- ☐ I can drive my car as long as I want with moderate pain in my neck.
- ☐ I can't drive my car as long as I want because of moderate pain in my neck.
- ☐ I can hardly drive my car at all because of severe pain in my neck.
- ☐ I can't drive my car at all.

Section 9 – Sleeping

- ☐ I have no trouble sleeping.
- ☐ My sleep is 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 pain in my neck.
- ☐ I am able to engage in most, but not all of my usual recreation activities because of pain in my neck.
- ☐ I am able to engage in a few of my usual recreation activities because of pain in my neck.
- ☐ I can hardly do any recreation activities because of pain in my neck.
- ☐ I can't do any recreation activities at all.

Comments_____ %ADL

Reference: Vernon, Mior. JMPT 1991; 14(7): 409-1

BODY in BALANCE
7380 SW Hunziker St., Suite 203
Tigard, OR 97223

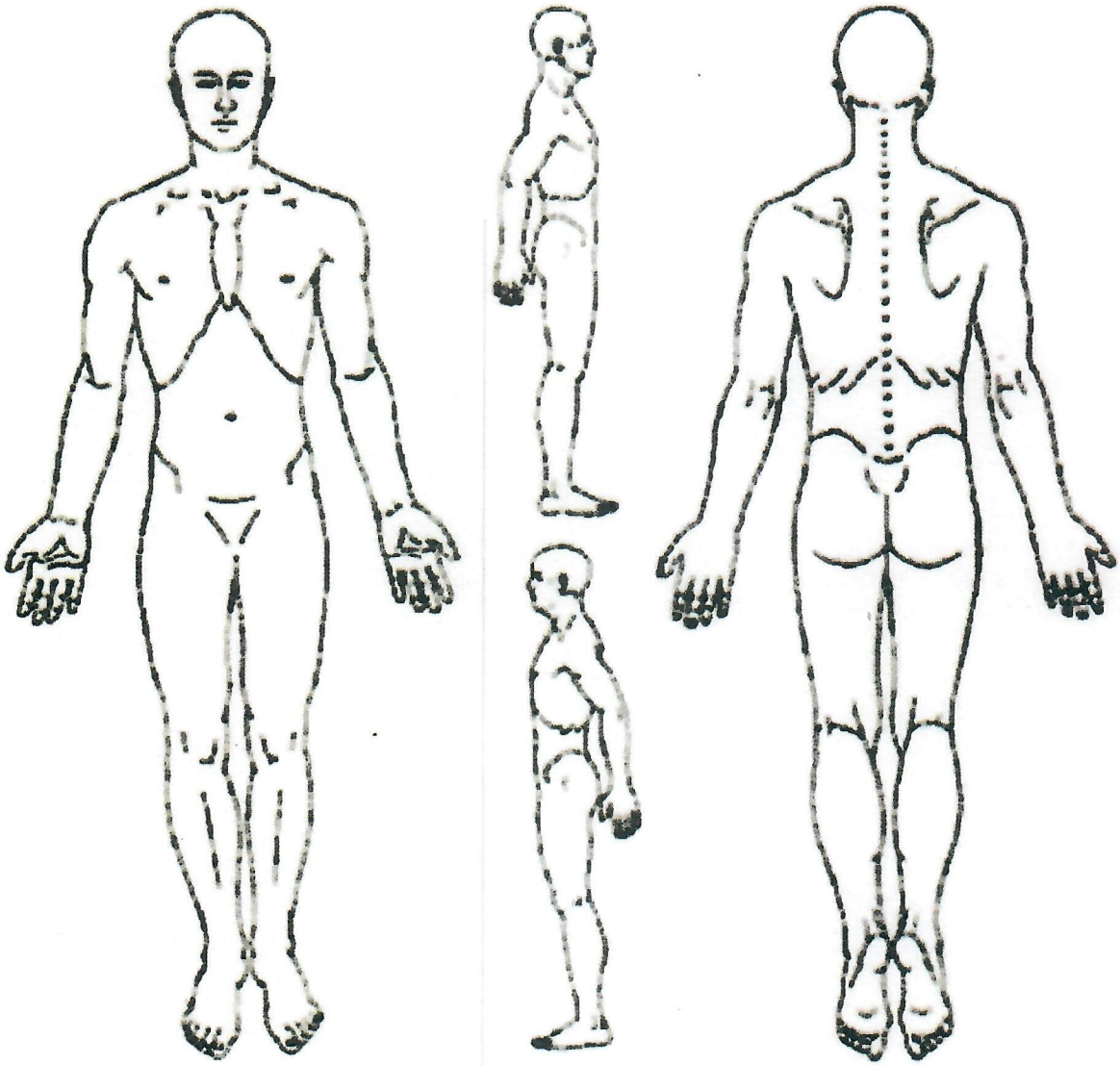
THE LOW BACK DISABILITY INDEX QUESTIONNAIRE

Name: _____ Date: _____

Age: _____ Date of Birth: _____ Occupation: _____

How long have you had back pain? _____ Years _____ Months _____ Weeks _____ Days

On the diagram below, please indicate where you are experiencing pain or other symptoms, right now.



A = ACHE
P = PINS & NEEDLES

B = BURNING
S = STABBING

N = NUMBNESS
O = OTHER

Patient's Name_____ Number_____ Date_____

LOW BACK DISABILITY QUESTIONNAIRE (REVISED OSWESTRY)

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 painkillers.
- ☐ The pain is bad but I can manage without taking painkillers.
- ☐ 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 distance.
- ☐ 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 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 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 and multiply by 2. Divide by number of sections answered multiplied by 10. A score of 22% or more is considered significant activities of daily living disability.
(Score___ x 2) / (____Sections x 10) = _____ %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 sleep.
- ☐ Even when I take tablets I have less than 4 hours sleep.
- ☐ Even when I take tablets I have less than 2 hours 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 the degree of pain.
- ☐ Pain has no significant effect on my social life apart from limiting my more energetic interests, e.g. 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 journeys 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_____

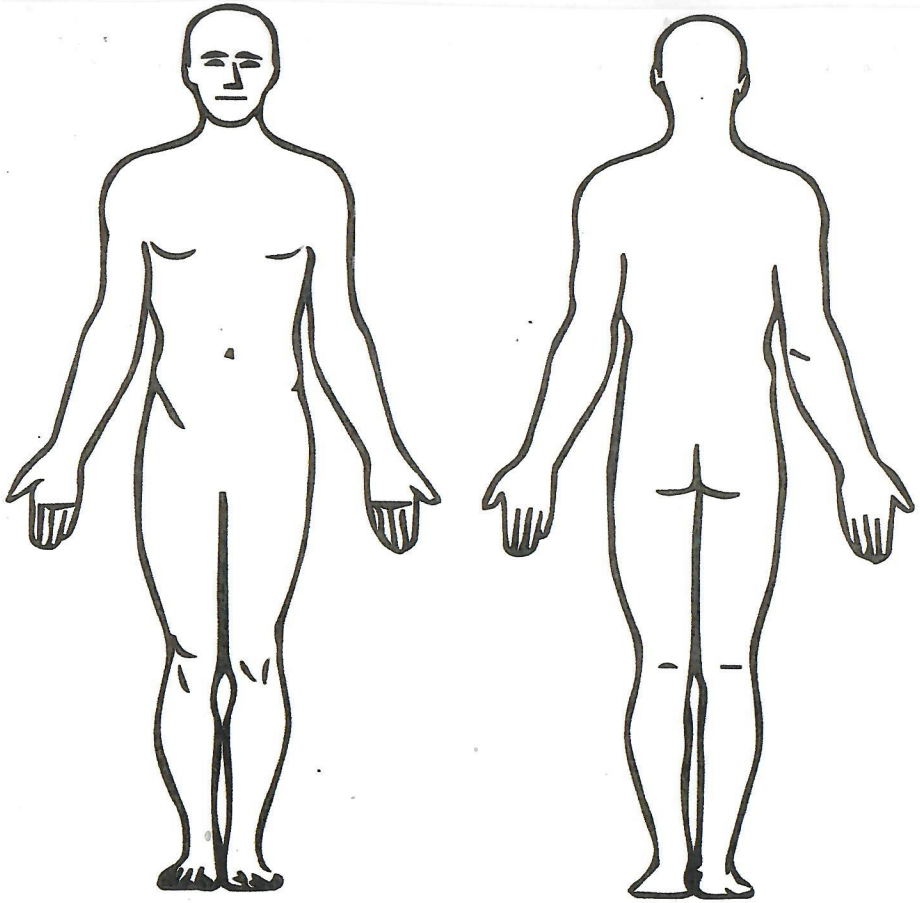
Reference: Fairbank, Physiotherapy 1981; 66(8): 271-3, Hudson-Cook. In Roland, Jenner (eds.), Back Pain New Approaches To Rehabilitation & Education. Manchester Univ Press, Manchester 1989: 187-204

Spinal Instability Pain Correlation Form

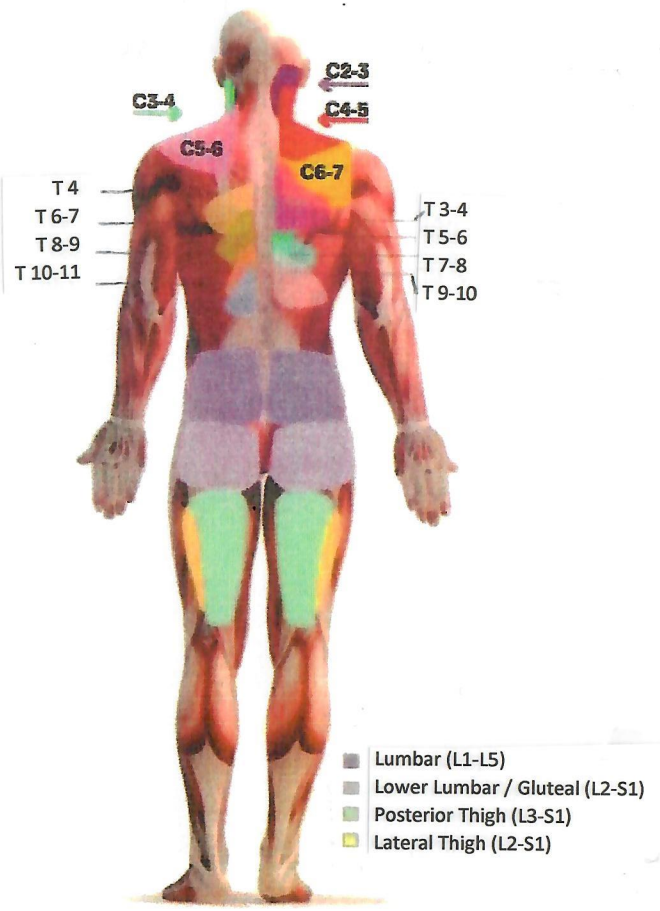
Patient Name: _____

Today's Date: _____ Date of Accident: _____

PLEASE, COMPLETE THE FOLLOWING "PAIN DIAGRAM" BY USING THE FOLLOWING LETTERS TO INDICATE ON THE DIAGRAM YOUR AREAS OF PAIN. P = PAIN, T= TINGLING, N = NUMBNESS, B = BURNING, S= STIFFNESS



Commonly Mapped Pain Patterns



Patient's Signature: _____