

# Healing Touch Chiropractic

## ◆ General Information

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ Middle Initial: \_\_\_\_\_

What do you prefer to be called? \_\_\_\_\_ Employer/Occupation: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone ( ) \_\_\_\_\_ - \_\_\_\_\_ Work Phone ( ) \_\_\_\_\_ - \_\_\_\_\_ Ext: \_\_\_\_\_

Cell phone ( ) \_\_\_\_\_ - \_\_\_\_\_ Email Address: \_\_\_\_\_

Sex: M F Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Age: \_\_\_\_\_

Marital status: M S W D Spouse's name \_\_\_\_\_ # of children: \_\_\_\_\_

Nearest relative (Not living with you): \_\_\_\_\_ Phone number ( ) \_\_\_\_\_ - \_\_\_\_\_

Name of your primary physician: \_\_\_\_\_ Phone number ( ) \_\_\_\_\_ - \_\_\_\_\_

Have you ever seen a chiropractor before? Y N If yes, who and when: \_\_\_\_\_

When did you last have x-rays? \_\_\_\_\_ How were you referred to our office? \_\_\_\_\_

◆ **For Women Only:** Are you pregnant? Y N If yes, how far along? \_\_\_\_\_

## ◆ Health Information

Where specifically is the majority of your pain? \_\_\_\_\_

What recent activity/event caused your pain? \_\_\_\_\_ Date of event: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Please list any other areas of complaint: \_\_\_\_\_

Please rate your pain by circling the number below that best describes your pain **today and at its worst.**

**Today:** (mild pain) 1 2 3 4 5 6 7 8 9 10 (severe)

**Worst:** (mild pain) 1 2 3 4 5 6 7 8 9 10 (severe)

How often have your symptoms been present?

(Occasional)  0-25%  26-50%  51-75%  76-100% (Constant)

What activities or positions seem to make your pain **worse** (I.E. walking, sitting, standing, etc.)?

What makes your pain **better** (I.E. sitting, walking, lying, etc.)?

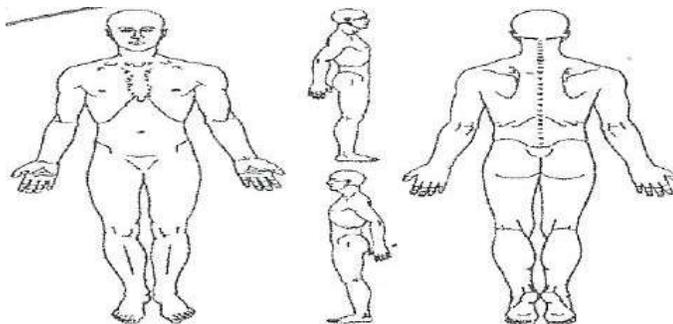
Which of the treatments listed below have decreased your level of pain:

Physical Therapy  Chiropractic Treatments  Muscle Relaxants  Pain Medications (specify) \_\_\_\_\_

Epidural Steroid Injections  Anti-Inflammatory Medications  Massage Therapy  Other: \_\_\_\_\_

Please mark the areas you are currently experiencing pain by using the letters that are appropriate.

**A** = ACHE **P** = PAIN **B** = BURNING **S** = STABBING **N** = NUMBNESS **O** = OTHER



## Social Health History (EHR)

1. **Demographics**  Unknown / Prefer not to answer  
 Ethnicity:  Non-Hispanic  Hispanic  Other: \_\_\_\_\_  
 Preferred Language:  English  Spanish  Other: \_\_\_\_\_  
 Race:  White/Caucasian  African American  Native American  Hawaiian/Pacific Islander  
 Other: \_\_\_\_\_
2. **Would you like access to your health records electronically?**  YES  NO  
 \* \_\_\_\_\_ (please initial) *I hereby give my consent to have my health records available to me via a secure, web-based portal.* Email address: \_\_\_\_\_
3. **Are you taking medications?**  YES  NO  
*If yes, please list medications (BE SPECIFIC) you are currently taking along with dosage. \*If you have a med list, we can copy it for you instead.*  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_
4. **Are you allergic to medication(s)?**  YES  NO  
*If yes, please list medications you are allergic to and the problem experienced:*  
 \_\_\_\_\_  
 \_\_\_\_\_
5. **Do you smoke now?**  YES  NO  
**Have you ever been a smoker?**  YES  NO  
**Do you use any other form of tobacco?**  YES  NO *If yes, please complete the following:*  
 What type: \_\_\_\_\_ How much: \_\_\_\_\_  
 Have you tried to quit? \_\_\_\_\_ What methods did you use? \_\_\_\_\_
6. **Do you exercise?**  YES  NO  
 How often?  Daily  Weekly  Monthly  Rarely  Never  
 What type? \_\_\_\_\_
7. **Do you drink alcohol?**  YES  NO  
 Alcohol quantity  1-2 per week  1-2 per day  2 or more per day  Other: \_\_\_\_\_

## Past Medical History

List all operations/hospitalizations and dates: \_\_\_\_\_  
 \_\_\_\_\_

List all major accidents and traumas and dates: \_\_\_\_\_  
 \_\_\_\_\_

◆ I have read all the information on this sheet and have completed the above answers. I certify this information to be true and correct to the best of my knowledge. I will notify Dr. Poindexter of any changes in my health status, insurance and any above information.

Patient's Signature: \_\_\_\_\_ Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Parent/Guardian's Signature: \_\_\_\_\_

Doctor's Signature: \_\_\_\_\_

**Financial Responsibility**

I agree to be financially responsible of all charges incurred at this clinic including my insurance deductible, co-payment and any services rejected by my insurance company. A no-show fee will be assessed to any massage patient who does not give the office a minimum of a 24 hour notification for cancellation. This charge is set at \$40.00 per occurrence. A fee of \$25.00 will be charged to your account for all returned checks to this office. This will be in addition to the amount of the original payment. We will not send the check to the bank more than once. If additional checks are returned for insufficient funds we will no longer accept a check as payment from you. A collection fee of \$40.00 will be charged to your account if it is forwarded to a collection agency.

\_\_\_\_\_  
Signature/Parent of minor/Guardian

\_\_\_\_\_  
Date

**Assignment**

I hereby instruct and direct my insurance company to pay by check made out and mailed directly to this clinic the professional or medical expense benefits allowable, and otherwise payable to me under my current insurance policy as payment toward the total charges for professional services rendered by this clinic.

\_\_\_\_\_  
Signature/Parent of minor/Guardian

\_\_\_\_\_  
Date

**Release of Information**

I authorize this clinic to release any information pertinent to my case to my insurance company, adjustor and attorney involved in this case; and hereby release this clinic of any consequences thereof.

\_\_\_\_\_  
Signature/Parent of minor/Guardian

\_\_\_\_\_  
Date

**Acknowledgement of Receipt of HIPAA Privacy Notice**

I hereby give my consent for Healing Touch Chiropractic to use and disclose protected health information (PHI) about me to carry out treatment, payment and health care operations (TPO).

I have the right and had the opportunity to review the Notice of Privacy Practices prior to signing this consent. I understand Healing Touch Chiropractic reserves the right to revise its Notice of Privacy Practice at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Dr. Poindexter at 4744 Beckley Road Battle Creek, MI 49015.

With this consent, Healing Touch Chiropractic may call my home or other alternative location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any calls pertaining to my clinical care, including laboratory test results, among others.

With this consent, Healing Touch Chiropractic may mail to my home or other alternative location any items that assist the practice in carrying out TPO.

With this consent, Healing Touch Chiropractic may e-mail or text message to me any items that assist the practice in carrying out TPO, such as appointment reminders, patient statements, practice newsletter, and educational information. I have the right to request that Healing Touch Chiropractic restrict how it uses or discloses my PHI to carry out TPO. The practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to allow Healing Touch Chiropractic to use and disclose my PHI to carry out TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, Healing Touch Chiropractic may decline to provide treatment to me.

\_\_\_\_\_  
Signature/Parent of minor/Guardian

\_\_\_\_\_  
Date

### Informed Consent for Treatment

I hereby give my consent to the performance of diagnostic tests, procedures, and Chiropractic treatment and/or massage therapy for my condition(s). I understand that the treatment I receive at this clinic is from a licensed and credentialed Doctor of Chiropractic and/or Licensed Massage Therapist. Chiropractic scope of practice includes a wide range of services, if upon completion of a differential diagnosis and assessment of patient condition, it is determined the services required are not provided by this office, we will direct you to the appropriate health care provider.

Chiropractic treatment or management of conditions almost always includes the chiropractic adjustment, a specific type of joint manipulation. Spinal manipulation is done to ease the pain and help the body function better. Like most health care procedures, the chiropractic adjustment carries with it some risks. Unlike many such procedures, the serious risks associated with the chiropractic adjustment are extremely rare.

**Following are the known risks of Chiropractic adjustments: Temporary soreness or increased symptoms or pain-** It is not uncommon for patients to experience temporary soreness or increased symptoms or pain after the first few treatments. **Dizziness, nausea, flushing-** These symptoms are relatively rare. It is important to notify the chiropractor if you experience these symptoms during or after your care. **Fractures-** When patients have underlying conditions that weaken bones, like osteoporosis, they may be susceptible to fracture. It is important to notify your chiropractor if you have been diagnosed with a bone weakening disease or condition. If your chiropractor detects any such condition while you are under care, you will be informed and your treatment plan will be modified to minimize risk of fracture. **Disc herniation or prolapse-** Spinal disc conditions like buldges or herniations may worsen even with chiropractic care. It is important to notify your chiropractor if symptoms change or worsen. **Stroke-** A certain extremely rare type of stroke has been associated with chiropractic care. Although there is an association between this type of stroke and chiropractic visits, there is also an association between this type of stroke and primary care medical visits. According to most of the recent research, there is no evidence of excess risk of stroke associated with chiropractic care. The increased occurrence of this type of stroke associated with both chiropractic and medical visits is likely explained by patients with neck pain and headache consulting both doctors of chiropractic and primary care medical doctors before or during their stroke. **Other risks** associated with chiropractic treatments include rare burns from physiotherapy devices that produce heat. **Bruising** – Instrument assisted soft tissue manipulation may result in temporary soreness or bruising. **Alternatives** to manipulation discussed through a shared decision-making process include: Medicines, Physical therapy, Massage, Mobilization, Acupuncture, and/or Cognitive-behavioral therapy. You can do these whether or not you are doing spinal manipulations.

I understand that the practice of chiropractic and/or massage therapy, like the practice of all healing arts, is not an exact science, and I acknowledge that no guarantee can be given as to the results or outcome of my care.

**Following are the known risks of Massage Therapy: Pain:** After a massage therapy session, the person is likely to have some muscle soreness due to constant rubbing and manipulation. Massage therapy helps relieve muscle tightness and there will be a feeling of muscle soreness in the form of mild pain. **Swelling:** Very rare, but possibility depends on the type of massage given and any pre-existing condition of the patient. **Temporary Discomfort:** Patient undergoing massage therapy session may have some temporary discomfort in the form of mild pain during the session due to constant rubbing and manipulation which the body is not used to. **Bruising:** There can be some slight bruising depending on the type of massage, but it will be temporary and will subside soon. **Allergy or sensitivity to massage oils:** A massage therapist is likely to use a wide variety of oils during massage and if the patient is allergic to any of those oils or its key ingredient(s) then some allergic reaction like skin rashes may happen. It is important to inform the therapist in advance of such allergies so that therapist avoids using those oils. **Feeling of Exhaustion:** Massage therapy session can last anywhere from 30 mins to 90 mins, so with constant pulling of the finger joints or rubbing of the body muscles, a patient is likely to feel a bit exhausted. **Urge to Urinate:** Massage therapy session helps to eliminate body toxins. There can be an increased need to urinate which should not be concerning.

***\*I have read this informed consent document. I have discussed or been given the opportunity to discuss any questions or concerns with my chiropractor and have had these answered to my satisfaction. I have made my decision voluntarily and freely.***

PATEINT'S NAME (PRINT) \_\_\_\_\_ DATE OF BIRTH \_\_\_\_/\_\_\_\_/\_\_\_\_

\_\_\_\_\_  
Signature/Parent of minor/Guardian

\_\_\_\_\_  
Date

**ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES**  
**HIPAA DISCLOSURE AUTHORIZATIONS**

Practice Name: Healing Touch Chiropractic

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_

**Receipt of Notice of Privacy Practices**

Initial \_\_\_\_ I acknowledge I have received or I have been provided the opportunity to receive a copy of Practice Name Notice of Privacy Practices that explains when, where and why my protected health information may be used or shared by Practice Name. I may obtain a current copy by contacting Practice Name Privacy/Security Official, or by visiting the Practice Name's web site at [myhtchiro.com](http://myhtchiro.com).

**HIPAA Disclosure Authorization(s)**

I authorize Practice Name to:

Initial \_\_\_\_ Contact me at the following number(s): \_\_\_\_\_

Initial \_\_\_\_ Leave a voice message with me at the following number(s): \_\_\_\_\_

Initial \_\_\_\_ Provide the following person(s) with my protected health information (i.e. emergency purposes, etc.):

Print Name: \_\_\_\_\_ Relationship to Patient/Phone number: \_\_\_\_\_

Print Name: \_\_\_\_\_ Relationship to Patient/Phone number: \_\_\_\_\_

I do not authorize Practice Name to:

Initial \_\_\_\_ Disclose my protected health information to anyone other than myself, except as permitted by HIPAA and as described in Practice Name Notice of Privacy Practices.

**HIPAA Unencrypted Communication Authorizations**

Electronic mail (email) and text messaging are common forms of communication and can be utilized to communicate with your physician and your care team. It is important for you to understand that unencrypted email and text messaging are not secure communications. This means there is a potential risk that messages containing your protected health information may be intercepted by a third party. Encryption is the process of making information unreadable, unless you have the password or key to decrypt the information. Practice Name does not encrypt text messages and we cannot guarantee that all email messages will be encrypted.

By initialing below and signing this authorization, I understand and accept the conditions outlined above. I authorize Practice Name to send unencrypted communications to the email address and/or phone number listed below.

I authorize Practice Name to:

Initial \_\_\_\_ Send email to the following address: \_\_\_\_\_

Initial \_\_\_\_ Send text messages to the following phone number: \_\_\_\_\_

I understand the HIPAA Disclosure Authorization(s) above may be revoked in writing at any time; however, the revocation will not affect disclosures of information previously authorized. I understand this authorization is valid while I continue to receive services from any Practice Name provider.

**My signature below acknowledges that I have been provided with a copy of the *Notice of Privacy Practices*:**

\_\_\_\_\_  
Signature of Patient or Personal Representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
Print Name

\_\_\_\_\_  
Relationship to Patient

**For Practice Use Only: Complete this section if you are unable to obtain a signature.**

If the Patient or personal representative is unable or unwilling to sign this *Acknowledgement*, or the *Acknowledgement* is not signed for any other reason, state the reason:

\_\_\_\_\_  
Completed by:

\_\_\_\_\_  
Signature of Practice Representative

\_\_\_\_\_  
Date

**PATIENT REVIEW OF SYSTEMS**

Please check the "PRESENT" box for all conditions that you are now experiencing and mark the "PAST" box for any conditions or symptoms experienced at any time in your life.

\*IF YOUR PARENTAL HISTORY IS UNKNOWN PLEASE CHECK HERE:

<b><u>Allergic/</u></b>									
<b><u>Immunological</u></b>									
Sinus issues	<input type="checkbox"/>	<input type="checkbox"/>							
Allergies	<input type="checkbox"/>	<input type="checkbox"/>							
Asthma	<input type="checkbox"/>	<input type="checkbox"/>							
<b><u>Cardiovascular</u></b>									
Heart problems	<input type="checkbox"/>	<input type="checkbox"/>							
Shortness of breath	<input type="checkbox"/>	<input type="checkbox"/>							
Blood clots	<input type="checkbox"/>	<input type="checkbox"/>							
Varicose veins	<input type="checkbox"/>	<input type="checkbox"/>							
High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>							
Low blood pressure	<input type="checkbox"/>	<input type="checkbox"/>							
Chest pain	<input type="checkbox"/>	<input type="checkbox"/>							
Palpitations	<input type="checkbox"/>	<input type="checkbox"/>							
<b><u>Ears, Nose &amp; Throat</u></b>									
Hearing loss	<input type="checkbox"/>	<input type="checkbox"/>							
Ringing in the ears	<input type="checkbox"/>	<input type="checkbox"/>							
Nose bleeds	<input type="checkbox"/>	<input type="checkbox"/>							
Pain w/ swallowing	<input type="checkbox"/>	<input type="checkbox"/>							
Ear infections	<input type="checkbox"/>	<input type="checkbox"/>							
<b><u>Endocrine</u></b>									
Hypothyroid	<input type="checkbox"/>	<input type="checkbox"/>							
Hyperthyroid	<input type="checkbox"/>	<input type="checkbox"/>							
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>							
Reproductive issues	<input type="checkbox"/>	<input type="checkbox"/>							
Heat intolerance	<input type="checkbox"/>	<input type="checkbox"/>							
Cold intolerance	<input type="checkbox"/>	<input type="checkbox"/>							
Excessive hunger	<input type="checkbox"/>	<input type="checkbox"/>							
Excessive thirst	<input type="checkbox"/>	<input type="checkbox"/>							
<b><u>Eyes</u></b>									
Glasses/contacts	<input type="checkbox"/>	<input type="checkbox"/>							
Blurry vision	<input type="checkbox"/>	<input type="checkbox"/>							
Cataracts	<input type="checkbox"/>	<input type="checkbox"/>							
Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>							
<b><u>Gastrointestinal</u></b>									
Digestion issues	<input type="checkbox"/>	<input type="checkbox"/>							
Acid reflux	<input type="checkbox"/>	<input type="checkbox"/>							
Hernia	<input type="checkbox"/>	<input type="checkbox"/>							
Nausea/vomiting	<input type="checkbox"/>	<input type="checkbox"/>							
Diarrhea	<input type="checkbox"/>	<input type="checkbox"/>							
Constipation	<input type="checkbox"/>	<input type="checkbox"/>							
Gallbladder disease	<input type="checkbox"/>	<input type="checkbox"/>							
Hemorrhoids	<input type="checkbox"/>	<input type="checkbox"/>							
Ulcer	<input type="checkbox"/>	<input type="checkbox"/>							
<b><u>Genitourinary</u></b>									
Difficulty urinating	<input type="checkbox"/>	<input type="checkbox"/>							
Painful urination	<input type="checkbox"/>	<input type="checkbox"/>							
Blood in urine	<input type="checkbox"/>	<input type="checkbox"/>							
Incontinence	<input type="checkbox"/>	<input type="checkbox"/>							
Urinary infections	<input type="checkbox"/>	<input type="checkbox"/>							
Increased urination	<input type="checkbox"/>	<input type="checkbox"/>							
Decreased urination	<input type="checkbox"/>	<input type="checkbox"/>							
Menstrual issues	<input type="checkbox"/>	<input type="checkbox"/>							
Bed wetting	<input type="checkbox"/>	<input type="checkbox"/>							
Kidney stones	<input type="checkbox"/>	<input type="checkbox"/>							
<b><u>Hematological/</u></b>									
<b><u>Lymphatic</u></b>									
Anemia	<input type="checkbox"/>	<input type="checkbox"/>							
Prolonged bleeding	<input type="checkbox"/>	<input type="checkbox"/>							
<b><u>Integumentary</u></b>									
Rash	<input type="checkbox"/>	<input type="checkbox"/>							
Bruising	<input type="checkbox"/>	<input type="checkbox"/>							
Hair loss	<input type="checkbox"/>	<input type="checkbox"/>							
Sores	<input type="checkbox"/>	<input type="checkbox"/>							
<b><u>Constitutional</u></b>									
Fatigue	<input type="checkbox"/>	<input type="checkbox"/>							
Stress	<input type="checkbox"/>	<input type="checkbox"/>							
Difficulty sleeping	<input type="checkbox"/>	<input type="checkbox"/>							
<b><u>Musculoskeletal</u></b>									
Neck pain	<input type="checkbox"/>	<input type="checkbox"/>							
Back pain	<input type="checkbox"/>	<input type="checkbox"/>							
Jaw pain	<input type="checkbox"/>	<input type="checkbox"/>							
Pain in arms/hands	<input type="checkbox"/>	<input type="checkbox"/>							
Pain in legs/feet	<input type="checkbox"/>	<input type="checkbox"/>							
Stiffness	<input type="checkbox"/>	<input type="checkbox"/>							
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>							
Joint swelling	<input type="checkbox"/>	<input type="checkbox"/>							
Muscle tenderness	<input type="checkbox"/>	<input type="checkbox"/>							
Muscle cramp	<input type="checkbox"/>	<input type="checkbox"/>							
Fractures	<input type="checkbox"/>	<input type="checkbox"/>							
Dislocations	<input type="checkbox"/>	<input type="checkbox"/>							
<b><u>Neurological</u></b>									
Headaches	<input type="checkbox"/>	<input type="checkbox"/>							
Numbness/tingling	<input type="checkbox"/>	<input type="checkbox"/>							
Twitches/tics	<input type="checkbox"/>	<input type="checkbox"/>							
Tremors	<input type="checkbox"/>	<input type="checkbox"/>							
Stroke	<input type="checkbox"/>	<input type="checkbox"/>							
Seizures	<input type="checkbox"/>	<input type="checkbox"/>							
Dizziness/vertigo	<input type="checkbox"/>	<input type="checkbox"/>							
Neuropathy	<input type="checkbox"/>	<input type="checkbox"/>							
Poor balance	<input type="checkbox"/>	<input type="checkbox"/>							
Weakness in limbs	<input type="checkbox"/>	<input type="checkbox"/>							
<b><u>Psychological</u></b>									
Depression	<input type="checkbox"/>	<input type="checkbox"/>							
Anxiety	<input type="checkbox"/>	<input type="checkbox"/>							
Emotional stress	<input type="checkbox"/>	<input type="checkbox"/>							
Sleep walking	<input type="checkbox"/>	<input type="checkbox"/>							
<b><u>Respiratory</u></b>									
Difficulty breathing	<input type="checkbox"/>	<input type="checkbox"/>							
Chronic cough	<input type="checkbox"/>	<input type="checkbox"/>							
Sleep apnea	<input type="checkbox"/>	<input type="checkbox"/>							
Wheezing	<input type="checkbox"/>	<input type="checkbox"/>							

<b><u>Conditions</u></b>					
Osteoporosis	<input type="checkbox"/>	<input type="checkbox"/>			
Osteopenia	<input type="checkbox"/>	<input type="checkbox"/>			
Multiple sclerosis	<input type="checkbox"/>	<input type="checkbox"/>			
Parkinson's	<input type="checkbox"/>	<input type="checkbox"/>			
Cancer/tumor	<input type="checkbox"/>	<input type="checkbox"/>	type/location: _____		
Polio	<input type="checkbox"/>	<input type="checkbox"/>			
Alcoholism	<input type="checkbox"/>	<input type="checkbox"/>	*Other: _____		
Gout	<input type="checkbox"/>	<input type="checkbox"/>	_____		

**FAMILY MEDICAL HISTORY**

Mother Deceased **Y / N**      Mother medical history \_\_\_\_\_

Father Deceased **Y / N**      Father medical history \_\_\_\_\_

Family medical history \_\_\_\_\_

## The Revised OWESTRY Questionnaire

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

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

### Low Back Pain Index

**Please read:** This questionnaire is designed to enable us to understand how much your low back pain has affected your ability to manage your everyday activities. Please answer each section by circling the **one choice that most applies to you**. If you are not experiencing low back pain, you may skip this side of the form.

<p>Section 1 – Pain Intensity</p> <p>A – The pain comes and goes and is very mild            B – The pain is mild and does not vary much            C – The pain comes and goes and is moderate            D – The pain is moderate and does not vary much            E – The pain comes and goes and is severe            F – The pain is severe and does not vary much</p>	<p>Section 6 – Standing</p> <p>A – I can stand as long as I like without pain            B – I have some pain when standing but it does not increase with time            C – I cannot stand for longer than one hour without increasing pain            D – I cannot stand for longer than 1/2 hour without increasing pain            E – I cannot stand for longer than 10 minutes without increasing pain            F – I avoid standing because it increases the pain immediately</p>
<p>Section 2 – Personal Care</p> <p>A – I do not have to change my way of washing or dressing in order to avoid pain            B – I do not normally change my way of washing or dressing even though it causes some pain            C – Washing and dressing increases the pain but I manage not to change my way of doing it            D – Washing and dressing increases the pain and I find it necessary to change my way of doing it            E – Because of the pain I am unable to do some washing and dressing without help            F – Because of the pain I am unable to do any washing and dressing without help</p>	<p>Section 7 – Travel</p> <p>A – I get no pain when traveling            B – I get some pain when traveling, but none of my usual forms of travel make it any worse            C – I get extra pain when traveling, but it does not compel me to take alternative forms of travel            D – I get extra pain when traveling, which compels me to seek alternative forms of travel            E – Pain restricts all forms of travel            F – Pain prevents all forms of travel except that done lying down</p>
<p>Section 3 – Lifting</p> <p>A – I can lift heavy weights without extra pain            B – I can lift heavy weights but it causes some extra pain            C – Pain prevents me from lifting heavy weights off the floor            D – Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned, e.g., on a table            E – Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned            F – I can only lift very light weights at the most</p>	<p>Section 8 – Sleeping</p> <p>A – I get no pain in bed            B – I get pain in bed but it does not prevent me from sleeping well            C – Because of pain my normal night's sleep is reduced by less than 1/4            D – Because of pain my normal night's sleep is reduced by less than 1/2            E – Because of pain my normal night's sleep is reduced by less than 3/4            F – Pain prevents me from sleeping at all</p>
<p>Section 4 – Walking</p> <p>A – I have no pain when walking            B – I have some pain when walking but it does not increase with distance            C – I cannot walk more than one mile without increased pain            D – I cannot walk more than 1/2 mile without increased pain            E – I cannot walk more than 1/4 mile without increased pain            F – I cannot walk at all without increasing pain</p>	<p>Section 9 – Social Life</p> <p>A – My social life is normal and gives me no pain            B – My social life is normal but increases the degree of my pain            C – Pain has no significant effect on my social life apart from limiting my more energetic interests, e.g., dancing, etc.            D – Pain has restricted my social life, and I do not go out very often            E – Pain has restricted my social life to my home            F – I have hardly any social like because of pain</p>
<p>Section 5 – Sitting</p> <p>A – I can sit in any chair as long as I like            B – I can sit only in my favorite chair as long as I like            C – Pain prevents me from sitting more than one hour            D – Pain prevents me from sitting more than 1/2 hour            E – Pain prevents me from sitting for more than 10 minutes            F – I avoid sitting because it increases pain straight away</p>	<p>Section 10 – Changing degree of pain</p> <p>A – My pain is rapidly getting better            B – My pain fluctuates but overall is definitely getting better            C – My pain seems to be getting better but improvement is slow at present            D – My pain is neither getting better nor worse            E – My pain is gradually getting worse            F – My pain is rapidly getting worse</p>

Neck Pain Index

**Please read:** This questionnaire is designed to enable us to understand how much your low back pain has affected your ability to manage your everyday activities. Please answer each section by circling the **one choice that most applies to you**. If you are not experiencing neck pain, you may skip this side of the form.

<p>Section 1 – Pain Intensity</p> <p>A – I have no pain at the moment            B – The pain I have is very mild at the moment            C – The pain is moderate at the moment            D – The pain is fairly severe at the moment            E – The pain is very severe at the moment            F – The pain is the worst imaginable at the moment</p>	<p>Section 6 – Concentration</p> <p>A – I can concentrate fully when I want with no difficulty            B – I can concentrate fully when I want with slight difficulty            C – I have a fair degree of difficulty in concentrating when I want to            D – I have a lot of difficulty in concentrating when I want to            E – I have a great deal of difficulty in concentrating when I want to            F – I cannot concentrate at all</p>
<p>Section 2 – Personal Care</p> <p>A – I can look after myself normally without causing extra pain            B – I can look after myself normally, but it causes extra pain            C – It is painful to look after myself and I am slow and careful            D – I need some help, but manage most of my personal care            E – I need help every day in most aspects of self care            F – I do not get dressed, I was with difficulty and stay in bed</p>	<p>Section 7 – Work</p> <p>A – I can do as much work as I want to            B – I can only do my usual work, but no more            C – I can do most of my usual work, but no more            D – I cannot do my usual work            E – I can hardly do any work at all            F – I cannot do any work at all</p>
<p>Section 3 – Lifting</p> <p>A – I can lift heavy weights without extra pain            B – I can lift heavy weights, but it gives extra pain            C – Pain prevents me from lifting heavy weights, but I can manage if they are conveniently positioned, e.g., on a table            D – Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned            E – I can lift very light weights            F – I cannot lift or carry anything at all</p>	<p>Section 8 – Driving</p> <p>A – I can drive my care without any neck pain            B – I can drive my car as long as I want with slight pain in my neck            C – I can drive my car as long as I want with moderate pain in my neck            D – I cannot drive my car as long as I want because of moderate pain in my neck            E – I can hardly drive at all because of severe pain in my neck            F – I cannot drive my car at all</p>
<p>Section 4 – Reading</p> <p>A – I can read as much as I want to with no pain in my neck            B – I can read as much as I want to with slight pain in my neck            C – I can read as much as I want with moderate pain in my neck            D – I cannot read as much as I want because of moderate pain in my neck            E – I cannot read as much as I want because of moderate pain in my neck            F – I cannot read at all</p>	<p>Section 9 – Sleeping</p> <p>A – I have no trouble sleeping            B – My sleep is slightly disturbed (less than 1 hour sleepless)            C – My sleep is mildly disturbed (1-2 hours sleepless)            D – My sleep is moderately disturbed (2-3 hours sleepless)            E – My sleep is greatly disturbed (3-5 hours sleepless)            F – My sleep is completely disturbed (5-7 hours sleepless)</p>
<p>Section 5 – Headaches</p> <p>A – I have not headaches at all            B – I have slight headaches which come infrequently            C – I have moderate headaches which come infrequently            D – I have moderate headaches which come frequently            E – I have severe headaches which come frequently            F – I have headaches almost all the time</p>	<p>Section 10 – Recreation</p> <p>A – I am able to engage in all of my recreational activities with no neck pain            B – I am able to engage in all of my recreational activities with some pain in my neck            C – I am able to engage in most, but not all of my recreational activities because of pain in my neck            D – I am able to engage in a few of my recreational activities because of pain in my neck            E – I can hardly do any recreational activities because of pain in my neck            F – I cannot do any recreational activities at all</p>

Comments:

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Signature: \_\_\_\_\_ Date: \_\_\_\_\_ Score (Clinician Only): \_\_\_\_\_

## You have the right to receive a “Good Faith Estimate” explaining how much your medical care will cost

Under the law, health care providers need to give **patients who don’t have insurance or who are not using insurance** an estimate of the bill for medical items and services.

- You have the right to receive a Good Faith Estimate for the total expected cost of any non-emergency items or services. This includes related costs like medical tests, prescription drugs, equipment, and hospital fees.
- Make sure your health care provider gives you a Good Faith Estimate in writing at least 1 business day before your medical service or item. You can also ask your health care provider, and any other provider you choose, for a Good Faith Estimate before you schedule an item or service,
- If you receive a bill that is at least \$400 more than your Good Faith Estimate, you can dispute the bill.
- Make sure to save a copy or picture of your Good Faith Estimate.

For questions or more information about your right to a Good Faith Estimate, visit [www.cms.gov/nosurprises](http://www.cms.gov/nosurprises) or call 269-979-7814