VALRICO
Spine & Rehab Center

PATIENT INFORMATION & CONDITION FORM

Patient Name: _____ Today's Date: ____/____/_____

Social Security Number _____ Birth Date: ____/____/_____ Age: _____ Gender: F M

Height: _____ Weight: _____ Specify Right or Left Handed _____

Email _____

Address: _____

City _____ State _____ Zip _____

Phone (_____) _____ Marital Status: ☐ Married ☐ Separated ☐ Widowed ☐ Single

If you are under 18 years of age, who are your legal parents or guardian?

Father: _____ Date of Birth: ____/____/____ Phone: (_____) _____

Mother: _____ Date of Birth: ____/____/____ Phone: (_____) _____

Guardian: _____ Date of Birth: ____/____/____ Phone: (_____) _____

Who do you normally live with? ☐ Mother and Father ☐ Father ☐ Mother ☐ Legal Guardian ☐ None of these

Your Occupation _____ Employer _____

Work Address _____ Work Phone (_____) _____

Student at _____ ☐ FULL-TIME ☐ PART-TIME

Name of Spouse _____ Spouse's Date of Birth ____/____/____

Who should we contact in the event of an emergency? _____ Phone (_____) _____

Do you have health insurance? ☐ YES ☐ NO ☐ Not Sure Company: _____

Full Name of Policy Holder: _____ Policy Holder's Date of Birth ____/____/_____

Auto Insurance Carrier: _____ Claim Number: _____

Adjuster Name: _____ Adjuster Number: _____

Do you have an attorney representing you for this accident?: _____

Patient Questionnaire – Auto-Accident

Patient Name: _____ Today's Date: ____/____/_____

Date of Exam: ____/____/_____ Provider: _____ New Patient □ Yes □ No

Basic Information about the Accident:

Date Accident Occurred or Started: _____/_____/_____ Time of Day when Accident Occurred or Started: _____:_____ AM / PM

Describe how the Accident took place: _____

_____

_____

_____

Auto-Accident Specific Information:

Were you the: ☐ Driver ☐ Passenger ☐ Pedestrian

Automobile you were in: Year _____ Make _____ Model _____

Damage to your car: ☐ Front ☐ Rear ☐ Driver Side ☐ Passenger Side ☐ Bumper ☐ Fender

Damage Amount Estimate: $_____ ☐ Minor ☐ Major ☐ Totaled ☐ Moderate

Other Automobile: Year _____ Make _____ Model _____

Damage to other car: ☐ Front ☐ Rear ☐ Driver Side ☐ Passenger Side ☐ Bumper ☐ Fender

☐ Minor ☐ Major ☐ Totaled ☐ Moderate

Where did the accident happen? Street Names: _____ City/State _____

Was it? ☐ Controlled Intersection ☐ Uncontrolled ☐ Not Intersection

Was there a traffic light? ☐ None ☐ Green ☐ Red ☐ Turn Arrow ☐ Stop Sign

Were you: ☐ Slowly Moving ☐ Moving ☐ Stopped

Time of day: ☐ Day ☐ Twilight ☐ Night

Weather Conditions: ☐ Sunny ☐ Rainy ☐ Cloudy ☐ Clear

Street Surface: ☐ Dry ☐ Wet ☐ Slick ☐ Icy ☐ Pavement ☐ Other _____

Type of Impact: ☐ Rear end ☐ Front ☐ Side Impact ☐ Roll Over

Brakes on Impact: ☐ Locked Tight ☐ Loosely Applied ☐ Foot not on brake

How far did your car move? ☐ Did not move ☐ Moved 1-5 ft ☐ Moved 6-10 ft ☐ Moved over 10 ft

Where were you seated in the vehicle: _____ Wearing Seat belt? ☐ Yes ☐ No

Shoulder harness: ☐ Yes ☐ No Headrest: ☐ Yes ☐ No Headrest Position: ☐ Up ☐ Down

Is the car equipped with airbags? ☐ Yes ☐ No Did they deploy? ☐ Yes ☐ No

Did you see the impact coming? ☐ Yes ☐ No Did you brace yourself for impact? ☐ Yes ☐ No

On impact, your head was looking: ☐ Ahead ☐ Behind ☐ Up ☐ Down ☐ To the Right ☐ To the Left

On impact were you: ☐ Thrown forward ☐ Thrown backwards ☐ Thrown sideways ☐ Other _____

Did your body hit anything inside the car? ☐ Yes ☐ No Body Part: _____

What did it hit? _____

Head trauma? ☐ Yes ☐ No Loss of Consciousness? ☐ Yes ☐ No For how long? _____

Do you remember the accident happening? ☐ Yes ☐ No

Hospital? ☐ Yes ☐ No Name of hospital: _____ How long there? _____

Taken by ambulance? ☐ Yes ☐ No

X-rays taken? ☐ Yes ☐ No X-ray areas: ☐ Neck ☐ Mid-back ☐ Low-back ☐ Other X-rays _____

Medication Given? ☐ Yes ☐ No RX: _____

Other instruction: _____ Follow-up: _____

Additional Information Related to the Condition:

Describe the condition or symptoms caused by the Accident: _____

_____

_____

_____

Describe your pain: ☐ Burning ☐ Sharp ☐ Dull ☐ Ache ☐ Throbbing

What caused it? _____

What aggravates it? _____

What relieves it? _____

Has the Patient ever had the same or similar condition or symptoms previous to this most recent occurrence? ☐ Yes ☐ No

When? ____/____/_____

Describe: _____

_____

_____

_____

Please indicated any other healthcare providers you have seen for the condition or symptoms:

Name	Type of Licensure	Date of Last Visit
_____	_____	____/____/_____
_____	_____	____/____/_____

Have you missed work or school due to your injuries? ☐ Yes ☐ No

Do you smoke? ☐ Yes ☐ No Number of packs: _____

Do you drink alcohol? ☐ Yes ☐ No Number of Drinks _____

Do you now have or have you ever had? Please check all that apply.

ALLERGIC-IMMUNOLOGIC: ☐ Hives/Eczema ☐Hay fever ☐ Catch colds easily ☐ Frequent sinus trouble ☐ Frequent influenza ☐ HIV ☐ AIDS ☐ Allergies ☐ Fever

CARDIOVASCULAR: ☐ Murmur ☐ Chest pain ☐ Palpitations ☐ Dizziness ☐ Shortness of breath ☐ Swollen ankles ☐ Heart attack ☐ Irregular heartbeat ☐ Pressure over the chest ☐ Pain down the left arm ☐ High triglycerides ☐ High cholesterol levels ☐ Profuse sweating ☐ Nausea ☐ Vomiting ☐ Low blood pressure ☐ Fainting spells ☐ High blood pressure ☐ Difficulty lying flat

CONSTITUTIONAL: ☐ Weight loss ☐ Fatigue ☐ Fever

EAR/NOSE/THROAT: ☐ Difficulty hearing ☐ Buzzing in ears ☐ Ringing in ears ☐ Vertigo ☐ Sinus trouble ☐ Nasal stuffiness ☐ Hearing loss ☐ Ear pain ☐ Mouth sores ☐ Hoarseness ☐ Nose bleeds ☐ Dental problem ☐ Frequent sore throat ☐ Difficulty swallowing

ENDOCRINE: ☐ Loss of hair ☐ Heat/Cold Intolerance ☐ Hypothyroidism ☐ Hyperthyroidism ☐ Diabetes ☐ Goiter
EYES: ☐ Glasses/Contacts ☐ Eye pain ☐ Light bothers eyes ☐ Double vision ☐ Cataracts ☐ Vision problems ☐ Blurred vision ☐ Glaucoma

GASTROINTESTINAL: ☐ Heartburn/Reflux ☐ Nausea/Vomiting ☐ Constipation ☐ Change in BMs ☐ Diarrhea ☐ Black or bloody BM ☐ Gallbladder problem ☐ Liver problem ☐ Hepatitis ☐ Distress from greasy food ☐ Ulcers ☐ Heartburn ☐ Hiatal hernia ☐ Colitis ☐ Blood in the stool ☐ Colon cancer ☐ Abdominal pain ☐ Burning in stomach ☐ Pancreatitis ☐ Jaundice ☐ Pain over stomach ☐ Mucus in stool

GENITOURINARY: ☐ Burning/Frequency ☐ Blood in urine ☐ Erectile dysfunction ☐ Abnormal discharge ☐ Leakage
☐ Incontinence ☐ Kidney infection ☐ Sexual difficulty ☐ Kidney stones ☐ Loss of libido

HEMATOLOGY/LYMPH: ☐ Easy bruising ☐ Gums bleed easily ☐ Enlarged glands ☐ Anemia ☐ Bleeding disorder ☐ Sickle cell anemia ☐ Lymphoma

MUSCULOSKELETAL: ☐ Joint Pain/Swelling ☐ Stiffness ☐ Muscle pain ☐ Neck pain ☐ Stiff neck ☐ Back pain ☐ Osteoarthritis ☐ Rheumatoid arthritis ☐ Bone spurs ☐ Broken bones ☐ Compression fracture ☐ Head injury ☐ Back injury ☐ Spinal trauma ☐ Birth trauma ☐ Birth defects ☐ Cancer ☐ Muscle weakness ☐ Muscular dystrophy ☐ Scheuerman's disease ☐ Scoliosis ☐ Lupus ☐ Spina bifida ☐ Spondylolisthesis ☐ Arthritis ☐ Neck injury ☐ Osteoporosis

NEUROLOGICAL: ☐ Loss of strength ☐ Numbness ☐ Headaches ☐ Heavy head ☐ Tremors ☐ Memory loss ☐ Difficulty speaking ☐ Multiple sclerosis ☐ Parkinson's disease ☐ Fainting ☐ Concussion ☐ Migraines ☐ Disorientation ☐ Loss of coordination ☐ Difficulty in walking ☐ Stroke ☐ Alzheimer's disease ☐ Weakness ☐ Disk problem ☐ Light Headed/Dizzy ☐ Epilepsy/Seizure ☐ Tingling

PSYCHIATRIC: ☐ Anxiety ☐ Depression ☐ Mood swings ☐ Difficult sleeping ☐ Nervousness ☐ Tension

RESPIRATORY: ☐ Cough ☐ Coughing blood ☐ Wheezing ☐ Chills ☐ Chronic cough ☐ Pneumonia ☐ Asthma ☐ Superficial breathing ☐ Chest pain ☐ Tuberculosis ☐ Bronchitis ☐ Emphysema ☐ Difficulty breathing ☐ Lung cancer

SKIN: ☐ Rash/Sores ☐ Lesions ☐ Itching/Burning ☐ Skin problem ☐ Slow healing ☐ Bruise easily ☐ Psoriasis ☐ Change in moles ☐ Change in skin color ☐ Skin cancer ☐ Scars ☐ Discolorations

MEN'S HEALTH ISSUES: ☐ Burning on urination ☐ Difficulty in starting urine ☐ Dripping urination ☐ Prostate trouble
☐ Prostate cancer
WOMEN'S HEALTH ISSUES: ☐ Hot flashes ☐ Vaginal discharge ☐ Nipple discharge ☐ Menstrual cramps
☐ Premenstrual depression ☐ Lumps in breast ☐ Hysterectomy
The date of last mammogram test was ___/___/_____ ☐ Mammogram is normal ☐ Mammogram is abnormal
The date of last pap test was ___/___/_____ ☐ Pap is normal ☐ Pap is abnormal
The age of onset for periods was ___ ☐ Periods are regular ☐ Periods are irregular
The age of onset for menopause was ___ Number of pregnancies ___
GENERAL: ☐ Recent weight gain ☐ Loss of sleep ☐ Recent weight loss ☐ Loss of appetite ☐ Fatigue ☐ Polio ☐ Rheumatic fever ☐ Cancer of any kind ☐ Metal Rods ☐ Pins ☐ Screws ☐ Staples ☐ Any type of Metal Beneath Skin
OTHER:

_____
_____
_____
_____
_____

WOMEN ONLY: Are you pregnant or is there any possibility you may be pregnant? ☐ YES ☐ NO ☐ UNCERTAIN

Due Date: _____

Have you ever been in our office before? ☐ Yes ☐ No

List any previous accidents (automobile, on the job injuries, slips, falls, sports, etc.) and provide the accident date:

1) _____ _____/_____/_____
2) _____ _____/_____/_____
3) _____ _____/_____/_____

Surgeries/Hospitalizations: _____

Allergies (please list all): _____

What medications or drugs are you taking? _____

VALRICO
Spine & Rehab Center

ACKNOWLEDGE OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

By signing below I acknowledge that I have received and reviewed a copy of Valrico Spine and Rehab Centers Notice of Privacy Practices.

The effective date of this agreement is this _____ day of _____, 20_____

_____ _____
Signature of patient or personal representative Date

_____
If signed by personal representative, relationship to patient

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Office Use Only:

Our organization has made a good faith effort to obtain a written acknowledgement of receipt of the Notice provided to the individual named below.

Patient name: _____

Refused to sign ☐ Physically unable to sign ☐

(Other)_____

_____

_____

_____

Employee Signature:_____ Date:_____

1103 Lithia Pinecrest Rd, Brandon, FL 33511
(813) 868-1138 Office
(813) 868-1137 Fax
ValricoChiropractor.com
FrontOffice@ValricoChiropractor.com

VALRICO
Spine & Rehab Center

Informed Consent -- Chiropractic Care

Dr. Frank R. Fabbiano, DC State of Florida Department of Health License # CH9904
Dr. Ethan DeWeerd, DC State of Florida Department of Health License # CH12589

Patient's Name: _____

Date of Care Plan: _____/_____/_____

Instructions: This document relates to your Informed Consent for care.
Please read carefully before signing.

General. I, the below-signed patient/individuals, have read this document and Care Plan in their entirety and understand the potential benefits and risks of the Care which you are recommending. I understand that there may be other forms of care which I may wish or need to seek provided by other health care practitioners. I also understand that there may be significant risks of not seeking any care for my condition.

I understand that while the Care Plan lists you as the "Rendering Provider," at any moment, other associates or staff in your office with appropriate scopes of practice and training may need to provide the Recommended Care based on factors which are not necessarily within anyone's ability to predict. You have made it clear that every health care practitioner who is licensed under state law may have different scopes of practice relating diagnoses and treatment and that the licenses of the primary Rendering Provider are listed below.

I do not expect you to be able to anticipate and explain all risks and complications, or forms of treatment, and I wish to rely on you to exercise judgment within your scope of practice during the course of the Care Plan which you feel at the time based upon the facts known. I understand that in rare cases, underlying physical defects, deformities or pathologies may render me susceptible to injury. It is my responsibility to make known before and throughout the Care whether I am suffering from any latent pathological defects, illnesses, or deformities that would otherwise not come to your attention, as well as any pathological defects, illnesses, or deformities I may be experiencing.

Possible Risks of the Care; Alternatives

Chiropractic manipulation / adjustment. As with any healthcare procedure, I understand that there are certain complications, which may arise during chiropractic manipulation, and that those complications include: fractures, disc injuries, dislocations, muscle strain, Horner's syndrome, diaphragmatic paralysis, cervical myelopathy and costovertebral strains and separations. Some types of manipulation of the neck have been associated with injuries to the arteries in the neck leading to or contributing to serious complications including stroke. Some patients will feel some stiffness and soreness following the first few days of treatment. I understand that fractures are rare occurrences and generally result from some underlying weakness of the bone. I also understand that stroke and other complications are also generally described as "rare."

X-Rays. I have been advised that x-rays can be hazardous to an unborn child. To the best of my knowledge. I am not pregnant.

Other Potential Alternatives. I understand that other treatment options for my condition may include: Self-administered, over-the-counter analgesics and rest; medical care with prescription drugs such as anti-inflammatories, muscle relaxants and painkillers; hospitalization with traction; and surgery.

Contraindications to Manipulation / Adjustment. I understand that you will not give me an adjustment / manipulation, x-rays, modalities, or therapies if you feel that such are contraindicated. In the event that the Care does not include such procedures, I have discussed all contraindications with you and fully understand them.

Definitions. "You" and "office" refer to any provider who renders care to me at the Location above. "Care" includes all care outlined in my Care Plan as well as any other care I receive from you in the future, including care related to other conditions.

Patient's Consent. I have thoroughly discussed and reviewed my recommended Care with you, as well as your examination, diagnoses, and thoughts regarding my condition, and also all of the information in this Informed Consent. I have had ample opportunity to explore other potential forms of care, have asked you all of the questions that I have, and have no additional questions. I voluntarily and knowingly elect to receive the recommended Care.

Patient's Name: _____

Patient's Signature: _____

Date of Signature: ___/___/___

Name of Parent / Guardian / Authorized Representative: _____

Signature: _____

Date of Signature: ___/___/___

VALRICO
Spine & Rehab Center

Medical Release of Information Form

TO WHOM IT MAY CONCERN:

Please furnish to Valrico Spine and Rehab Center and/or any or all of its personnel, information, copies of any and all hospital and medical record or reports of any sort, charts, notes, x-rays, lab reports, and prescription information. Valrico Spine and Rehab is to be furnished with any and all other information without limitation pertaining to any examination, treatment or condition of myself, including medical, examinations, or counseling for any condition, medical, dental, or psychological.

This AUTHORIZATION shall be considered as continuing and you may rely upon it in all respects unless you have previously been advised by me in writing to the contrary. It is expressly understood by the undersigned and you are hereby authorized to accept a copy of photocopy of this medical authorization with the same validity as though an original had been presented to you.

Requesting Records from _____DOA_____

Patient Name: _____

DOB: _____ Last 4 of SSN: _____

Signature: _____Date: _____

<u>If patient is under 18 years of age:</u>

Name of Parent / Guardian: _____

Parent / Guardian Signature: _____

ASSIGNMENT OF BENEFITS, LIENS, DIRECT PAYMENT AUTHORIZATION, AUTHORIZATION TO RELEASE INSURANCE INFORMATION, AND AUTHORIZATION TO ESCROW UNPAID MEDICAL & PIP BENEFITS

Valrico Spine and Rehab Center

INSURANCE CARRIER: _____ POLICY NUMBER: _____DATE OF LOSS: _____

For and in consideration of Valrico Spine and Rehab Center agreeing to pursue the responsible automobile insurance carrier for payment of benefits due and not requiring prepayment for services, I hereby irrevocably assign all rights and benefits to Valrico Spine and Rehab Center for Personal Injury Protection, extended Personal Injury Protection, Medical Payment Coverage, and other benefits which I may have in accordance with Florida Statute §627.736. This includes any benefits from my insurance company and any other entity which may be responsible for medical expenses incurred. I further authorize Valrico Spine and Rehab Center to collect payments & prosecute any necessary actions to collect payment for services as they see fit and allowable by law and contract. THIS DOCUMENT CONSTITUTES AN ASSIGNMENT OF RIGHTS AND BENEFITS.

I hereby further give a lien to Valrico Spine and Rehab Center against any and all insurance benefits named herein, and any and all proceeds of any settlement, judgment or verdict which may be paid to me as a result of the injuries or illness for which I have been treated by Valrico Spine and Rehab Center as a result of the above stated loss date. This document acts as an irrevocable absolute assignment of my rights and benefits to the extent of the charges for services provided. I agree to cooperate with Valrico Spine and Rehab Center and their attorney's (at their choosing), and to do all things reasonable to effect payment of the bills by the insurance company or other entity to Valrico Spine and Rehab Center including, but not limited to, disclosing my medical condition, being available for factual discovery or other cooperation.

This assignment concerns only the bills for Valrico Spine and Rehab Center and those costs including, but not limited to, attorney's fees, other costs, and interest necessary in procuring payment from the above-named insurance company and/or other entities. This assignment is not intended to assign any other causes of action that may belong to the undersigned patient. I agree to pay any applicable deductible or co-payment not covered by any policy of insurance cited above. I understand that as a benefit and convenience to me, Valrico Spine and Rehab Center will bill and pursue collection against the insurance company or other responsible entity on my behalf. I hereby instruct and direct my insurance company to pay my benefits directly to Valrico Spine and Rehab Center at the address provided on the bill. If my current policy prohibits direct payment to doctors, then I hereby instruct and direct my insurance company or other responsible entity to make the check payable to me and mail it to Valrico Spine and Rehab Center at the address on the bill. Valrico Spine and Rehab Center's medical care is being provided for a reasonable fee for treatment causally related to the above loss date and is medically necessary. I instruct my insurance carrier or other responsible entity to pay these bills to the full extent of my available benefits under the insurance policy and Florida law. If any portion of the charge for these services is either reduced or denied in whole or in part, my insurance company or other entity is to place funds equal to the amount of the reduced or denied charges into escrow and hold the escrowed funds until agreement or resolution of legal action by Valrico Spine and Rehab Center. I further instruct my insurance company to make payment for charges submitted by Valrico Spine and Rehab Center in priority to any other requests to escrow benefits, including a request by myself to reserve benefits for pending disability claims. I hereby give Valrico Spine and Rehab Center limited power of attorney to endorse and sign my name on any draft for payment to either Valrico Spine and Rehab Center or myself if said draft represents payment for charges related to services rendered by Valrico Spine and Rehab Center.

I further direct my insurance carrier or responsible other entity to provide information to Valrico Spine and Rehab Center which is otherwise available to me including but not limited to a copy of any applicable insurance policy, declaration page, all applicable endorsements, transcripts and/or copies of any recorded statements, examinations under oath and requests for same, independent medical evaluations and requests for same, peer review reports, and a listing of all PIP benefits paid to date which shall include when claims were made, when the claims were received, the payment or denial of each claim, the amount of the deductible and the claims applied thereto, and whether benefits have been exhausted and the amount of PIP benefits available, commonly known as a "PIP log". This request includes the name of other medical providers to whom payments have been under my policy of insurance. This agreement is intended to serve as an assignment of rights and benefits under my policy of insurance in favor of Valrico Spine and Rehab Center. If any language within this agreement has the effect of invalidating this agreement, that language shall be deemed void and the remainder of the assignment shall maintain full force and effect. A photocopy of this assignment shall be considered as effective and valid as the original.

_____	_____	_____
Patient Signature	Date	Patient Name

If patient is incapacitated or under the age of 18, please indicate the patient name, guardian name and relation to patient, and obtain guardian signature.

VALRICO
Spine & Rehab Center

Notification of Initiation of Treatment

To Whom It May Concern:

Let this Serve as notice that_____(Name) has initiated evaluation and treatment at our clinic, Valrico Spine and Rehab Center, on _____(Date) for injuries sustained in a motor vehicle accident which occurred on_____(DOA)
If you require any additional information, please do not hesitate to contact the office.

_____ _____

Dr Frank Fabbiano, D.C. Patient
Dr Ethan DeWeerd, D.C.

Insurance Carrier: _____

Claim Number: _____

NECK BOURNEMOUTH QUESTIONNAIRE

Patient Name _____ Date _____

Instructions: The following scales have been designed to find out about your neck pain and how it is affecting you. Please answer ALL the scales, and mark the ONE number on EACH scale that best describes how you feel.

1. Over the past week, on average, how would you rate your neck pain?

No pain Worst pain possible

0 1 2 3 4 5 6 7 8 9 10

2. Over the past week, how much has your neck pain interfered with your daily activities (housework, washing, dressing, lifting, reading, driving)?

No interference Unable to carry out activity

0 1 2 3 4 5 6 7 8 9 10

3. Over the past week, how much has your neck pain interfered with your ability to take part in recreational, social, and family activities?

No interference Unable to carry out activity

0 1 2 3 4 5 6 7 8 9 10

4. Over the past week, how anxious (tense, uptight, irritable, difficulty in concentrating/relaxing) have you been feeling?

Not at all anxious Extremely anxious

0 1 2 3 4 5 6 7 8 9 10

5. Over the past week, how depressed (down-in-the-dumps, sad, in low spirits, pessimistic, unhappy) have you been feeling?

Not at all depressed Extremely depressed

0 1 2 3 4 5 6 7 8 9 10

6. Over the past week, how have you felt your work (both inside and outside the home) has affected (or would affect) your neck pain?

Have made it no worse Have made it much worse

0 1 2 3 4 5 6 7 8 9 10

7. Over the past week, how much have you been able to control (reduce/help) your neck pain on your own?

Completely control it No control whatsoever

0 1 2 3 4 5 6 7 8 9 10

Patient Signature_____**Examiner**_____

With Permission from: Bolton JE, Humphreys BK: The Bournemouth Questionnaire: A Short-form Comprehensive Outcome Measure. II. Psychometric Properties in Neck Pain Patients. *JMPT* 2002; 25 (3): 141-148.

BACK BOURNEMOUTH QUESTIONNAIRE

Patient Name _____ Date _____

Instructions: The following scales have been designed to find out about your back pain and how it is affecting you. Please answer ALL the scales, and mark the ONE number on EACH scale that best describes how you feel.

1. Over the past week, on average, how would you rate your back pain?

No pain Worst pain possible

0 1 2 3 4 5 6 7 8 9 10

2. Over the past week, how much has your back pain interfered with your daily activities (housework, washing, dressing, walking, climbing stairs, getting in/out of bed/chair)?

No interference Unable to carry out activity

0 1 2 3 4 5 6 7 8 9 10

3. Over the past week, how much has your back pain interfered with your ability to take part in recreational, social, and family activities?

No interference Unable to carry out activity

0 1 2 3 4 5 6 7 8 9 10

4. Over the past week, how anxious (tense, uptight, irritable, difficulty in concentrating/relaxing) have you been feeling?

Not at all anxious Extremely anxious

0 1 2 3 4 5 6 7 8 9 10

5. Over the past week, how depressed (down-in-the-dumps, sad, in low spirits, pessimistic, unhappy) have you been feeling?

Not at all depressed Extremely depressed

0 1 2 3 4 5 6 7 8 9 10

6. Over the past week, how have you felt your work (both inside and outside the home) has affected (or would affect) your back pain?

Have made it no worse Have made it much worse

0 1 2 3 4 5 6 7 8 9 10

7. Over the past week, how much have you been able to control (reduce/help) your back pain on your own?

Completely control it No control whatsoever

0 1 2 3 4 5 6 7 8 9 10

Patient Signature _____ **Examiner** _____

With Permission from: Bolton JE, Breen AC: The Bournemouth Questionnaire: A Short-form Comprehensive Outcome Measure. I. Psychometric Properties in Back Pain Patients. JMPT 1999; 22 (9): 503-510.