



Oxford Medical Health & Wellness Center  
 5144 College Corner Pike, Suite A  
 Oxford, OH 45056  
 p 513.524.4800  
 f 513.523.8631  
 oxfordmedical.medicfusion.com

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

**Patient Profile**

**Personal Information**

Full Name: \_\_\_\_\_ Jr / Sr  
 Last First M.I.

Address: \_\_\_\_\_  
 Street Address Apartment/Unit #  
 City State ZIP Code

Primary Phone: \_\_\_\_\_ H / M / B Alternate Phone: \_\_\_\_\_ H / M / B

Birth Date: \_\_\_\_\_ / /

Social Security Number #: \_\_\_\_\_ - -

Gender:  Male  Female

Race:  American Indian or Alaska Native  Asian  Black or African American  
 Native Hawaiian or Other Pacific Islander  White  Declined  Unknown/Unavailable  
 Other \_\_\_\_\_

Ethnicity:  Hispanic or Latino  Not Hispanic or Latino  Declined  Unknown/Unavailable

Prim. Language:  Arabic  Chinese  English  French  German  Greek  Hebrew  Italian  
 Japanese  Korean  Spanish  Vietnamese  Declined  Unknown/Unavailable  
 Other \_\_\_\_\_

Email Address: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Emergency Contact Phone: \_\_\_\_\_

Time Zone: \_\_\_\_\_

Does your time zone participate in Daylight Savings Time?  Yes  No

Marital Status:  Single  Married  Widowed  Divorced

Do you have any dependents?  Yes  No

Are you a full-time student?  Yes  No

Health Insurance?  Yes  No

Responsible Party:  You  Other (parent, spouse, etc.) \_\_\_\_\_

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Oxford, Ohio 45056  
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Patient Name: \_\_\_\_\_

What is the #1 thing that brings you here today?

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How has this been affecting you:

Personally?

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Professionally?

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Have you been told this is something you have to live with?

Yes  No

Have you been told that surgery is your only option?

Yes  No

Do you take medications of any kind to ease the symptoms you are experiencing with this?

Yes  No

**CASE HISTORY**

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

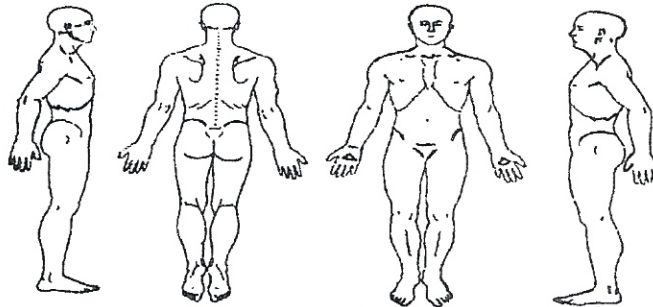
1. Circle the severity (0 = No Pain to 10 = Very Severe Pain) and Frequency of pain (% of the week you experience the pain).

Condition / Problem	Severity										Frequency (% of week)											
	Minimal					Severe					Occasional					Constant						
a. _____	0	1	2	3	4	5	6	7	8	9	10	0	10	20	30	40	50	60	70	80	90	100
b. _____	0	1	2	3	4	5	6	7	8	9	10	0	10	20	30	40	50	60	70	80	90	100
c. _____	0	1	2	3	4	5	6	7	8	9	10	0	10	20	30	40	50	60	70	80	90	100
d. _____	0	1	2	3	4	5	6	7	8	9	10	0	10	20	30	40	50	60	70	80	90	100
e. _____	0	1	2	3	4	5	6	7	8	9	10	0	10	20	30	40	50	60	70	80	90	100

(Please mark the figures where you experience pain.)

2. Symptoms are worse in the (circle what applies)

- morning                      -Increase during the day
- afternoon                    -same all day
- night                            -decrease during the day



3. Symptom (a.) is: Sharp / Dull / Burning / Aching / Throbbing / Numbness / Tingling / Pins & Needles

4. Symptom (b.) is: Sharp / Dull / Burning / Aching / Throbbing / Numbness / Tingling / Pins & Needles

5. When did your symptoms begin (onset date)? \_\_\_\_\_

6. How did your symptoms begin? \_\_\_\_\_

7. Have you experienced these before? \_\_\_\_\_

8. Do your symptoms radiate? \_\_\_\_\_

9. Has your condition?    \_\_\_ Improved    \_\_\_ Gotten Worse    \_\_\_ Stayed the same since it began

10. Circle the things that make your problems worse:

Bending - Lying - Walking - Standing - Sitting - Movement - Twisting - Lifting - Sleeping

11. Is there anything you can do to relieve the problems?    \_\_\_ No    \_\_\_ Yes Describe: \_\_\_\_\_

If No, what have you tried that has not helped? \_\_\_\_\_

12. Have you been treated for this before?    \_\_\_ No    \_\_\_ Yes How long ago? \_\_\_\_\_

13. What treatment did you receive? \_\_\_\_\_

14. Results of previous treatment?    \_\_\_ Good    \_\_\_ Poor    Comments \_\_\_\_\_

15. Were you referred to our office by anyone? \_\_\_\_\_

16. Is this condition interfering with    \_\_\_ Work    \_\_\_ Sleep    \_\_\_ Daily Routine    \_\_\_ Recreation

17. List any other major injuries you have had, other than those mentioned above: \_\_\_\_\_

18. Any other Musculoskeletal problems?    \_\_\_ No    \_\_\_ Yes    ...Neurological problems?    \_\_\_ No    \_\_\_ Yes

\_\_\_\_\_ Additional information on back side of sheet.



## Authorizations and Releases

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

### Consent to Professional Treatment

I certify that all information provided to this practice is true and correct, to the best of my knowledge. I hereby give consent to this practice and its health care providers, consultants, assistants, or designees to render care and treatment to me as they deem necessary. I recognize that the practice of medicine is not an exact science and I acknowledge that no guarantees have been made as to the result of evaluation and treatment. If the patient is a minor child, under the age of eighteen (18) at the date of treatment, I hereby stipulate that I am the legal guardian of the child, and grant my consent for the treatment of the child as provided for herein. I acknowledge that may refuse treatment at any time.

Initial \_\_\_\_

### Consent to Perform and Interpret X-rays

I hereby consent to the performance of diagnostic x-rays as deemed necessary by the attending physician of this practice and acknowledge that certain risks are associated with x-rays. If applicable, I certify that I am a parent or legal guardian of the patient and I hereby authorize the performance of diagnostic x-rays on said minor as requested by the physician. At this time, I know of no condition which the taking of x-rays would further complicate.

I further agree that this practice may seek outside interpretation of my x-rays by a qualified professional not employed by this practice. I agree to any additional fees associated with this service and assigns benefits to be paid directly to that professional by my third-party payor.

Initial \_\_\_\_

### Females: Regarding Possibility of Pregnancy

This is to certify that, to the best of my knowledge, I am NOT pregnant. The doctor and certified staff have permission to perform diagnostic x-rays. I am aware that taking x-rays, particularly those involving the pelvis, can be hazardous to a fetus.

Initial \_\_\_\_

### Females: Consent to X-Ray During Pregnancy

This is to certify that, I am or may be pregnant and that the doctor or certified staff has my permission to perform diagnostic x-rays involving any cervical spine (neck) or extremities (arms or legs), on the condition that lead shielding be used over the trunk of my body. I have been advised that certain x-rays, particularly those involving the pelvis, can be hazardous to a fetus.

Initial \_\_\_\_

### Assignment of Benefits and Release of Records

I hereby assign to this practice all of my medical and procedure benefits to which I am entitled, including major medical benefits. I hereby authorize and direct my insurance carrier(s), including Medicare and other government sponsored programs if applicable, private insurance and any other health plans to issue payment directly to this practice for medical services rendered. This assignment is irrevocable.

I hereby authorize this practice to release any medical or other information required by third party payors, including government agencies, insurance carriers, or any other entities necessary to determine insurance benefits or benefits payable for related services and supplies provided to me by the practice.

Initial \_\_\_\_

### Financial Obligation

I hereby accept full financial responsibility for services rendered by this practice. I accept full responsibility for any fees incurred, regardless of insurance coverage. I understand that my insurance carrier may not approve or reimburse my medical services in full due to usual and customary rates, benefit exclusions, coverage limits, lack of authorization, or medical necessity. I further understand that I am responsible for fees not paid in full, co-payments, and policy deductibles and co-insurance except where my liability is limited by contract or State or Federal law. In some cases, exact insurance benefits cannot be determined until the insurance company receives the claim.

Should the account be referred to an attorney or collection agency for collection, I shall pay all fees, including but not limited to legal fees, collection agency fees, and any and all other expenses incurred in the collection of past due accounts. It is my responsibility to notify this practice of any changes in my health care coverage.

You may direct any questions regarding this financial obligation to the clinic manager or physician.

Initial \_\_\_\_

Signature \_\_\_\_\_

Date \_\_\_\_\_



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

**Health Insurance Information**

Are you the insured party?  Yes  No (if no please fill out the Policy Holder Information)

**Policy Holder Information**

Full Name: \_\_\_\_\_  
*Last First M.I.*

Relationship to you: \_\_\_\_\_

Address: \_\_\_\_\_  
*Street Address Apartment/Unit #*

\_\_\_\_\_  
*City State ZIP Code*

Birth Date: \_\_\_\_\_ / \_\_\_\_ / \_\_\_\_

Social Security Number #: \_\_\_\_\_ - \_\_\_\_ - \_\_\_\_

Insured's Occupation: \_\_\_\_\_

Insured's Employer: \_\_\_\_\_

Employer Address: \_\_\_\_\_  
*Street Address Unit #*

\_\_\_\_\_  
*City State ZIP Code*

Employer Phone: \_\_\_\_\_ Ext. \_\_\_\_\_

**Insurance Company Information**

Insurance Company Name: \_\_\_\_\_

Address: \_\_\_\_\_  
*Street Address Unit #*

\_\_\_\_\_  
*City State ZIP Code*

Phone: \_\_\_\_\_ Ext. \_\_\_\_\_ Fax: \_\_\_\_\_

Group #: \_\_\_\_\_

Policy/Subscriber #: \_\_\_\_\_

Effective Date: \_\_\_\_\_ / \_\_\_\_ / \_\_\_\_ Expiration Date: \_\_\_\_\_ / \_\_\_\_ / \_\_\_\_



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## Responsible Party Form

### Responsible Party Information

Relationship to You: \_\_\_\_\_

Full Name: \_\_\_\_\_  
*First M.I. Last*

Same as your address?  Yes  No

Address: \_\_\_\_\_  
*Street Address Apartment/Unit #*

\_\_\_\_\_

*City State ZIP Code*

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# Authorization, Assignment, Acknowledgment and Understanding

**AUTHORIZATION TO RELEASE INFORMATION:** Oxford Health & Wellness Center is authorized to release any information that it deems appropriate concerning my physical condition to any insurance company, attorney or adjuster in order to process any claim for reimbursement of charges incurred by me as a result of professional services rendered by Oxford Health & Wellness Center, including its designated associates and assistants and hereby release Oxford Health & Wellness Center from any consequence and/or liability concerning the same.

**ASSIGNMENT OF PAYMENT:** My attorney and/or insurance company are hereby requested to pay directly to Oxford Health & Wellness Center any monies due it on account, the same to be deducted from any settlement made of my behalf. Further, it is understood and agreed that I shall pay the full amount of the charges, should my condition be such that is not covered by my insurance policy or if for any reason the insurance company and/or attorney refuse and/or fails to pay my claim.

**UNPAID INSURANCE BALANCE:** I understand and agree that should there be any unpaid insurance balance for sixty (60) days, such balance shall automatically become my responsibility.

**MEDICARE ASSIGNMENT:** I authorize any holder of medical or other information about me to release to the Social Security Administration and Health Care Financing Administration or its intermediaries or carriers any information needed for this or a related Medicare claim. I authorize a copy of this authorization to be used in place of the original and request payment of medical insurance benefits either to myself or to the party who accepts assignment below.

**CONSENT TO CARE FOR A MINOR:** I hereby authorize Oxford Health & Wellness Center to administer care as deemed necessary to: \_\_\_\_\_.

**OBLIGATIONS AS TO SERVICES:** I hereby acknowledge that I am receiving (or about to receive) health care services at Oxford Health & Wellness Center and that I have been advised that Oxford Health & Wellness Center is willing to wait for payment for these services so long as there continues to be a likelihood that payment will be made either by my insurance company and/or out of the settlement of my liability case.

I understand and agree that, in the event that:

- A. It is determined that there is no insurance company obligation to pay for Oxford Health & Wellness Center's services;
- B. The insurance company for the undersigned refuses to acknowledge an assignment to Oxford Health & Wellness Center or to take other actions for the protection of the interest of Oxford Health & Wellness Center.
- C. My attorney fails and/or refuses to agree to protect the interest of Oxford Health & Wellness Center as determined in its sole discretion; or
- D. I fail to retain an attorney

Then payment of services at Oxford Health & Wellness Center will be made on a current basis and my bill paid in full within sixty (60) days from my last treatment.

**INTEREST AND COLLECTION:** I acknowledge and agree that, should my account become more than thirty (30) days overdue, I will incur interest on my past due balance of ten percent (10%) per annum. I further acknowledge and agree that Oxford Health & Wellness Center shall be entitled to reimbursement from me for any legal costs, including attorney fees, for all efforts to collect on any past due account with Oxford Health & Wellness Center.

*By my signature below, I make the foregoing authorizations, assignments and agreements.*

\_\_\_\_\_  
Patient Name (Please Print)

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date Signed



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## Employer Form

### Employer Information

Your Employment Status:  Full Time  Part Time  Contract  Not Employed  Retired  Student

Occupation or Title: \_\_\_\_\_

Employer Name: \_\_\_\_\_

Employer Address: \_\_\_\_\_  
*Street Address* *Apartment/Unit #*  
 \_\_\_\_\_  
*City* *State* *ZIP Code*

Employer Phone: \_\_\_\_\_ Ext. \_\_\_\_\_ Fax: \_\_\_\_\_

Start Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ End Date: (If you are no longer working here.) \_\_\_\_/\_\_\_\_/\_\_\_\_

Your Employment Status:  Full Time  Part Time  Contract  Not Employed  Retired  Student

Occupation or Title: \_\_\_\_\_

Employer Name: \_\_\_\_\_

Employer Address: \_\_\_\_\_  
*Street Address* *Apartment/Unit #*  
 \_\_\_\_\_  
*City* *State* *ZIP Code*

Employer Phone: \_\_\_\_\_ Ext. \_\_\_\_\_ Fax: \_\_\_\_\_

Start Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ End Date: (If you are no longer working here.) \_\_\_\_/\_\_\_\_/\_\_\_\_

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

## Health History Form

### Prescription Medications

Prescription medications taken on a regular or ongoing basis:

Medication: _____	Dosage: _____	Frequency: per	<input type="checkbox"/> Day	<input type="checkbox"/> Week	<input type="checkbox"/> Month	<input type="checkbox"/> Other
(please describe): _____						
Medication: _____	Dosage: _____	Frequency: per	<input type="checkbox"/> Day	<input type="checkbox"/> Week	<input type="checkbox"/> Month	<input type="checkbox"/> Other
(please describe): _____						
Medication: _____	Dosage: _____	Frequency: per	<input type="checkbox"/> Day	<input type="checkbox"/> Week	<input type="checkbox"/> Month	<input type="checkbox"/> Other
(please describe): _____						
Medication: _____	Dosage: _____	Frequency: per	<input type="checkbox"/> Day	<input type="checkbox"/> Week	<input type="checkbox"/> Month	<input type="checkbox"/> Other
(please describe): _____						
Medication: _____	Dosage: _____	Frequency: per	<input type="checkbox"/> Day	<input type="checkbox"/> Week	<input type="checkbox"/> Month	<input type="checkbox"/> Other
(please describe): _____						
Medication: _____	Dosage: _____	Frequency: per	<input type="checkbox"/> Day	<input type="checkbox"/> Week	<input type="checkbox"/> Month	<input type="checkbox"/> Other
(please describe): _____						
Medication: _____	Dosage: _____	Frequency: per	<input type="checkbox"/> Day	<input type="checkbox"/> Week	<input type="checkbox"/> Month	<input type="checkbox"/> Other
(please describe): _____						
Medication: _____	Dosage: _____	Frequency: per	<input type="checkbox"/> Day	<input type="checkbox"/> Week	<input type="checkbox"/> Month	<input type="checkbox"/> Other
(please describe): _____						
Medication: _____	Dosage: _____	Frequency: per	<input type="checkbox"/> Day	<input type="checkbox"/> Week	<input type="checkbox"/> Month	<input type="checkbox"/> Other
(please describe): _____						

# Neck Index

Form N1-100

rev 3/27/2003

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

Date \_\_\_\_\_

*This questionnaire will give your provider information about how your neck condition affects your everyday life. Please answer every section by marking the one statement that applies to you. If two or more statements in one section apply, please mark the one statement that most closely describes your problem.*

## Pain Intensity

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

## Personal Care

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

## Sleeping

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

## Lifting

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

## Reading

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

## Driving

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

## Concentration

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

## Recreation

- ⓪ I am able to engage in all my recreation activities without neck pain.
- ① I am able to engage in all my usual recreation activities with some neck pain.
- ② I am able to engage in most but not all my usual recreation activities because of neck pain.
- ③ I am only able to engage in a few of my usual recreation activities because of neck pain.
- ④ I can hardly do any recreation activities because of neck pain.
- ⑤ I cannot do any recreation activities at all.

## Work

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

## Headaches

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

Neck  
Index  
Score

Index Score =  $\left[ \frac{\text{Sum of all statements selected}}{\text{(# of sections with a statement selected} \times 5)} \right] \times 100$

# Back Index

Form BI100

rev 3/27/2003

Patient Name \_\_\_\_\_ Date \_\_\_\_\_

*This questionnaire will give your provider information about how your back condition affects your everyday life. Please answer every section by marking the one statement that applies to you. If two or more statements in one section apply, please mark the one statement that most closely describes your problem.*

## Pain Intensity

- Ⓐ The pain comes and goes and is very mild.
- Ⓛ The pain is mild and does not vary much.
- Ⓜ The pain comes and goes and is moderate.
- Ⓨ The pain is moderate and does not vary much.
- Ⓟ The pain comes and goes and is very severe.
- Ⓡ The pain is very severe and does not vary much.

## Personal Care

- Ⓐ I do not have to change my way of washing or dressing in order to avoid pain.
- Ⓛ I do not normally change my way of washing or dressing even though it causes some pain.
- Ⓜ Washing and dressing increases the pain but I manage not to change my way of doing it.
- Ⓨ Washing and dressing increases the pain and I find it necessary to change my way of doing it.
- Ⓟ Because of the pain I am unable to do some washing and dressing without help.
- Ⓡ Because of the pain I am unable to do any washing and dressing without help.

## Sleeping

- Ⓐ I get no pain in bed.
- Ⓛ I get pain in bed but it does not prevent me from sleeping well.
- Ⓜ Because of pain my normal sleep is reduced by less than 25%.
- Ⓨ Because of pain my normal sleep is reduced by less than 50%.
- Ⓟ Because of pain my normal sleep is reduced by less than 75%.
- Ⓡ Pain prevents me from sleeping at all.

## Lifting

- Ⓐ I can lift heavy weights without extra pain.
- Ⓛ I can lift heavy weights but it causes extra pain.
- Ⓜ Pain prevents me from lifting heavy weights off the floor.
- Ⓨ Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned (e.g., on a table).
- Ⓟ Pain prevents me from lifting heavy weights off the floor, but I can manage light to medium weights if they are conveniently positioned.
- Ⓡ I can only lift very light weights.

## 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 1 hour.
- Ⓨ Pain prevents me from sitting more than 1/2 hour.
- Ⓟ Pain prevents me from sitting more than 10 minutes.
- Ⓡ I avoid sitting because it increases pain immediately.

## Traveling

- Ⓐ I get no pain while traveling.
- Ⓛ I get some pain while traveling but none of my usual forms of travel make it worse.
- Ⓜ I get extra pain while traveling but it does not cause me to seek alternate forms of travel.
- Ⓨ I get extra pain while traveling which causes me to seek alternate forms of travel.
- Ⓟ Pain restricts all forms of travel except that done while lying down.
- Ⓡ Pain restricts all forms of travel.

## Standing

- Ⓐ I can stand as long as I want without pain.
- Ⓛ I have some pain while standing but it does not increase with time.
- Ⓜ I cannot stand for longer than 1 hour without increasing pain.
- Ⓨ I cannot stand for longer than 1/2 hour without increasing pain.
- Ⓟ I cannot stand for longer than 10 minutes without increasing pain.
- Ⓡ I avoid standing because it increases pain immediately.

## 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 affect on my social life apart from limiting my more energetic interests (e.g., dancing, etc).
- Ⓨ Pain has restricted my social life and I do not go out very often.
- Ⓟ Pain has restricted my social life to my home.
- Ⓡ I have hardly any social life because of the pain.

## Walking

- Ⓐ I have no pain while walking.
- Ⓛ I have some pain while walking but it doesn't increase with distance.
- Ⓜ I cannot walk more than 1 mile without increasing pain.
- Ⓨ I cannot walk more than 1/2 mile without increasing pain.
- Ⓟ I cannot walk more than 1/4 mile without increasing pain.
- Ⓡ I cannot walk at all without increasing pain.

## 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.
- Ⓨ My pain is neither getting better or worse.
- Ⓟ My pain is gradually worsening.
- Ⓡ My pain is rapidly worsening.

Index Score = [Sum of all statements selected / (# of sections with a statement selected x 5)] x 100

Back  
Index  
Score