



## PATIENT APPLICATION FORM

WELCOME TO OUR CLINIC. We specialize in assisting our patients to achieve their highest level of health through our spinal and postural corrective programs. Our approach is very unique and advanced from other rehabilitative programs. This allows our patients to achieve far superior results compared to most other systems.

**Please fill out the following information thoroughly**

This will allow the doctor to determine if you are a case we can accept. Please feel free to ask any questions if you need assistance. We look forward to serving you.

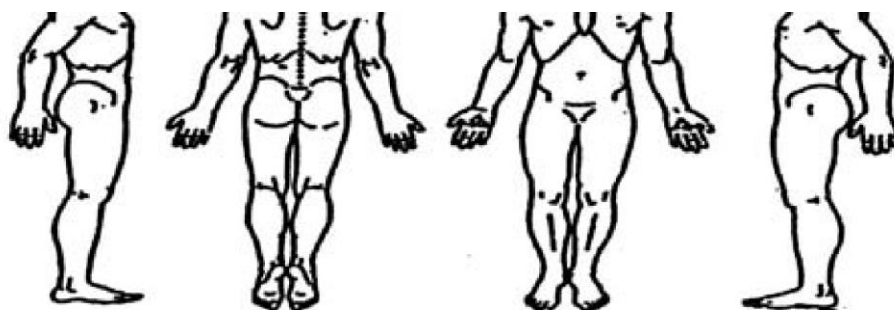
Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

### PATIENT APPLICATION SURVEY

Name: \_\_\_\_\_ (Age) \_\_\_\_\_ Gender: M F  
Home Address: \_\_\_\_\_ Home Phone: ( ) \_\_\_\_\_  
City, State, Zip: \_\_\_\_\_ Work Phone: ( ) \_\_\_\_\_  
Email Address: \_\_\_\_\_ Cell Phone: ( ) \_\_\_\_\_  
Birth Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ Social Security #: \_\_\_\_ - \_\_\_\_ - \_\_\_\_  
Marital Status: S M D W Height: \_\_\_\_\_ Ft. \_\_\_\_\_ in Weight: \_\_\_\_\_  
Occupation: \_\_\_\_\_ Employer Name: \_\_\_\_\_  
Spouse's Name: \_\_\_\_\_ Work Phone: ( ) \_\_\_\_\_ Cell Phone: ( ) \_\_\_\_\_  
Spouse's Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_

### PURPOSE OF THIS VISIT

1. Reason for **TODAYS** visit: \_\_\_\_\_
2. Is this purpose related to an auto accident / work injury? Yes No If so, when: \_\_\_\_\_
3. Please **describe the pain & its location**: \_\_\_\_\_



4. When did this condition begin? \_\_\_\_/\_\_\_\_/\_\_\_\_ what caused it? \_\_\_\_\_
5. Do you consider your problem to be severe? (Circle One) Yes No
6. How often do you experience your symptoms? Constantly (76-100% of the time)  
Frequently (51-75%) Occasionally (26-50%) intermittently (1-25%)
7. How would you describe the type of pain? Sharp Dull Diffuse Achy Burning Shooting  
 Stiff Numb Tingly Sharp with motion Shooting with motion Stabbing with motion  
 Electric like with motion Other: \_\_\_\_\_
8. Using a scale of 0-10 (10 being the worst) how would you rate your problem?  
**0 1 2 3 4 5 6 7 8 9 10**
9. Have you experienced this condition before? Yes No If so, please explain:  
\_\_\_\_\_
10. How much has the problem interfered with your work/social life? Not at all A little bit  
Moderately  Quite a bit Extremely
11. Who else have you seen for your problem? Chiropractor ER physician Massage  
Therapist  Neurologist Orthopedist Physical Therapist Primary care Physician  
Other No one
12. Who have you seen for this? \_\_\_\_\_ What did they do?  
\_\_\_\_\_ How did you respond? \_\_\_\_\_ What activities aggravate  
your symptoms? \_\_\_\_\_ Is there anything, which has relieved  
your symptoms? Yes No Describe: \_\_\_\_\_

## EXPERIENCE WITH CHIROPRACTIC

- Have you seen a Chiropractor before? Yes No who? \_\_\_\_\_ When? \_\_\_\_\_  
Reason for visits: \_\_\_\_\_  
How did you respond? \_\_\_\_\_  
Did your previous chiropractor take **before and after** x-rays? Yes  No  
Did you know posture determines your health?  Yes  No  
Are you aware of any of your poor posture habits?  Yes  No Explain: \_\_\_\_\_  
Are you aware of any poor posture habits in your spouse or children?  Yes No  
Explain: \_\_\_\_\_

The most common postural weakness is Forward Head Syndrome (head and neck starting to bend forward and progressively moving downward weakening your whole body). Even less severe forms of this posture can cause many adverse affects on your overall health. Have you ever been told or felt like you carry your head forward, noticed a rounding of your shoulders or a developing "hump" at the base of your neck? **Yes No**

## HEALTH LIFESTYLE

1. Do you exercise? Yes No how often? 1X 2X 3X 4X 5X per week other:
2. What activities? Running Jogging Weight Training Cycling Yoga Pilates Swimming
3. Do you smoke? Yes No How much? \_\_\_\_\_
4. Do you drink alcohol? Yes No How much / week? \_\_\_\_\_
5. Do you drink coffee? Yes No How many cups / day? \_\_\_\_\_
  
6. Do you take any supplements (i.e. vitamins, minerals, herbs)? \_\_\_\_\_
7. What activities do you do outside of work? \_\_\_\_\_
8. Have you ever been hospitalized? Yes No If yes, why: \_\_\_\_\_
9. Have you had significant past trauma? Yes No When? \_\_\_\_\_
10. **Anything else pertinent to your visit today?** \_\_\_\_\_

### Health History: (Check all that you currently have or have had in the past)

Joint Pain/Stiffness	Arthritis	Rheumatoid
Cancer	Tumor	High Blood Pressure
Stroke	Kidney Stones	Kidney Disorders
Prostate Problems	Abnormal weight changes	Loss of Appetite
Ulcer	Hepatitis	Liver/ Gall Bladder
Muscular Incoordination	Diabetes	Excessive Thirst
Depression	Systemic Lupus	Epilepsy
HIV/AIDS	Birth Control Pills	Hormonal Replacement
Pregnancy		

Please list any health conditions not mentioned:

\_\_\_\_\_  
Please list any surgeries: \_\_\_\_\_  
Please list any allergies: \_\_\_\_\_

## Integrative Chiropractic Health & Wellness

**PLEASE LIST ALL MEDICATIONS YOU ARE CURRENTLY TAKING**

(PRESCRIPTION AND OVER THE COUNTER)

MEDICATION:

REASON:

HOW OFTEN:

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\_\_\_\_\_  
PATIENT/CLIENT NAME  
TODAY'S DATE

\_\_\_\_\_  
PATIENTS SIGNATURE

## HEALTH LIFESTYLE

### HEALTH CONDITIONS

Abnormal postural habits or distortions are the result of trauma or stress to the body that have misaligned the vertebrae in your spine. When these vertebrae are twisted from their normal position, they will cause stress to the spinal cord and the delicate nerves that pass between the vertebrae. These misalignments are called subluxations (sub-lux-a-shuns). It has been extensively documented that subluxations, causing stress to your nerves, will weaken and distort the overall structure of your spine. This results in a weakened and distorted POSTURE. Postural distortions have many serious and adverse affects on your overall health. The most common and detrimental postural distortion is called Forward Head Syndrome (a "hunched forward" posture starting in the neck and progressively moving down your spine weakening the entire body).

**Please Underline any health condition you may be experiencing, NOW or in the PAST.**

#### CERVICAL SPINE (NECK):

Postural distortions from subluxations, (causing Forward Head Syndrome), in your neck will weaken the nerves into your arms, hands and head affecting these parts of your body. Do you experience...?

Neck Pain	Headaches	Sinusitis
Pain into your shoulders/arms/hands	Dizziness	Allergies/Hay fever
Numbness/tingling in arms/hands	Visual disturbances	Recurrent colds/Flu
Hearing disturbances	Coldness in hands	Low Energy/Fatigue
Weakness in grip	Thyroid conditions	TMJ/Pain/Clicking
Wrist Pain		

#### THORACIC SPINE (UPPER BACK):

Postural distortions from subluxations (resulting from Forward Head Syndrome) in the upper back will weaken the nerves to the heart and lungs and affect these parts of your body. Do you experience...?

Heart Palpitations	Heart Murmurs	Recurrent Lung Infections/Bronchitis
Asthma/Wheezing	Tachycardia	Shortness of Breath
Heart Attacks/Angina	Upper Back Pain	Pain on Deep Inspiration/Expiration

#### THORACIC SPINE (MID BACK):

Postural distortions from subluxations (resulting from Forward Head Syndrome) in the mid back will weaken the nerves into your ribs/chest and upper digestive tract, and affect these parts of your body. Do you experience...?

Mid Back Pain	Nausea	Pain Into Your Ribs/Chest
Ulcers/Gastritis	Indigestion/Heartburn	Hypoglycemia
Reflux	Tired/Irritable after eating or when you haven't eaten for a while	

#### LUMBAR SPINE (LOW BACK):

Postural distortions from subluxations in the low back (resulting from Forward Head Syndrome) will weaken the nerves into your legs/feet and pelvic organs and affect these parts of your body. Do you experience...?

Pain into your hips/legs/feet	Constipation/Diarrhea	Low back pain
Numbness/tingling in your legs/feet	Recurrent bladder infections	Coldness legs/feet

Frequent/difficulty urinating      Muscle cramps in your legs/feet      Sexual dysfunction  
Weakness/injuries in your hips/knees/ankles      Menstrual irregularities/cramping

## FAMILY HEALTH HISTORY

Have any of your **family members** ever been diagnosed with the following:

- |   |   |  |                                       |
|---|---|--|---------------------------------------|
| <input type="checkbox"/> Diabetes               | <input type="checkbox"/> Varicose veins       | <input type="checkbox"/> Neurological problems | <input type="checkbox"/> Lung Disease |
| <input type="checkbox"/> Rheumatic fever        | <input type="checkbox"/> Circulatory problems | <input type="checkbox"/> Stroke                | <input type="checkbox"/> Heart murmur |
| <input type="checkbox"/> High blood pressure    | <input type="checkbox"/> Heart Disease        | <input type="checkbox"/> Cancer                | <input type="checkbox"/> Osteoporosis |
| <input type="checkbox"/> Kidney disease         | <input type="checkbox"/> Epilepsy/seizures    | <input type="checkbox"/> Migraine Headaches    | <input type="checkbox"/> Arthritis    |
| <input type="checkbox"/> Liver disease          | <input type="checkbox"/> Metal Implants       | <input type="checkbox"/> Infectious disease    | <input type="checkbox"/> Gall bladder |
| <input type="checkbox"/> Broken bones/fractures | <input type="checkbox"/> Appendectomy         | <input type="checkbox"/> Tonsillectomy         | <input type="checkbox"/> Hernia       |
| <input type="checkbox"/> Pneumonia              | <input type="checkbox"/> Polio                | <input type="checkbox"/> Tuberculosis          | <input type="checkbox"/> Anemia       |
| <input type="checkbox"/> Whooping Cough         | <input type="checkbox"/> Chicken Pox          | <input type="checkbox"/> Mumps                 | <input type="checkbox"/> Measles      |
| <input type="checkbox"/> Thyroid                | <input type="checkbox"/> Small Pox            | <input type="checkbox"/> Influenza             | <input type="checkbox"/> Pleurisy     |
| <input type="checkbox"/> Lumbago                | <input type="checkbox"/> Eczema               | <input type="checkbox"/> ALS                   | <input type="checkbox"/> Lupus        |
| <input type="checkbox"/> Rheumatoid Arthritis   | <input type="checkbox"/> Other:               |  |                                       |
- 

## AUTHORIZATION CARE

I authorize and agree to allow the doctor and/or assistant to work with my spine through the use spinal adjustments and rehabilitative exercises for the sole purpose of postural and structural restoration of normal biomechanical and neurological function.

**I understand that I am responsible for all fees incurred for the services provided, and agree to ensure full payment of all charges.**

The Doctor and/or assistant will not be held responsible for any health conditions or diagnoses which are pre-existing, given by another health care practitioner, or are not related to the spinal structural conditions diagnosed at this clinic.

I also clearly understand that if I do not follow the doctors and/or assistant's specific recommendations at this clinic that I will not receive the full benefit from these programs, and that if I terminate my care prematurely that all fees incurred will be due and payable at that time. I authorize the assignment of all insurance benefits be directed to the doctor and/or assistant for all services rendered.

\_\_\_\_\_  
Patient's Name Printed

\_\_\_\_\_  
Date

\_\_\_\_\_  
Patient's Signature

\_\_\_\_\_  
Minors Name

\_\_\_\_\_  
Guardian/Spouse's Signature of Authorizing care for minor

### IN CASE OF EMERGENCY

Name \_\_\_\_\_  
Relationship \_\_\_\_\_  
Work Phone \_\_\_\_\_  
Home Phone \_\_\_\_\_  
Cell Phone \_\_\_\_\_

#### MASTER ASSIGNMENT, LIEN, AND AUTHORIZATION OF INSURANCE /ATTORNEY PAYMENTS

To Whom It May Concern:

I, \_\_\_\_\_, hereby authorize and direct you, my insurance company, and/or my attorney to pay directly to **Integrative Chiropractic Health & Wellness** such sums as may be due and owed to **Integrative Chiropractic Health & Wellness** for services rendered to me, both by reason of an accident or illness, and by reason of any other bills that are due to **Integrative Chiropractic Health & Wellness**, and to withhold such sums from any disability benefits, medical payment benefits, No-Fault benefits, health and accident benefits, worker's compensation benefits, or any other insurance benefits obligated to reimburse me, or from any settlement, judgment or verdict on my behalf as may be necessary to adequately protect **Integrative Chiropractic Health & Wellness**. I hereby further give a lien to **Integrative Chiropractic Health & Wellness** against any and all insurance benefits name herein, and any and all proceeds of 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 **Integrative Chiropractic Health & Wellness** This is to act as an assignment of my rights and benefits to the extent of **Integrative Chiropractic Health & Wellness's** services rendered.

In the event my insurance company is obligated to make payments to me upon the charges made by **Integrative Chiropractic Health & Wellness** for their services, refuses to make such payments, upon demand by me or **Integrative Chiropractic Health & Wellness**, I hereby



assign and transfer to **Integrative Chiropractic Health & Wellness** any and all causes of action that I might have or that might exist in my favor against such company, and authorize **Integrative Chiropractic Health & Wellness** to prosecute said cause of action either in my name or in the **Integrative Chiropractic Health & Wellness's** name, and further I authorize **Integrative Chiropractic Health & Wellness** to compromise, settle, or otherwise resolve said claim or cause of action as they see fit.

**I understand that I remain personally responsible for the total amounts due to Integrative Chiropractic Health & Wellness for their services rendered.** I further understand and agree that this Master Assignment, Lien, and Authorization does not constitute any consideration for **Integrative Chiropractic Health & Wellness** to await payments and may demand payments from me immediately upon rendering services at their option.

I authorize **Integrative Chiropractic Health & Wellness** to release any information pertinent to my case to any insurance company, adjuster or attorney to facilitate collection under this Master Assignment, Lien and Authorization.

I hereby state and agree that a photocopy of this document we be as valid and binding on all parties involved as the original copy.

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

Integrative Chiropractic Health & Wellness  
1580 Montgomery Hwy Suite 14  
Hoover, AL 35216

**(YOUR COPY)**  
**FORMS OF PAYMENT**

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and me. I clearly understand and agree that all services rendered after my insurance's contracted annual agreement, are charged directly to me and that I am personally responsible for payments.

I understand that I am responsible for my contracted payment at the time of service. I also understand that if I suspend or terminate my care and treatment any fees for professional services rendered me will be immediately due and payable. I will be responsible for any costs of collection, attorney's fee or court costs required to collect my bill.

We accept cash, personal checks, VISA, MasterCard, American Express, and DISCOVER. Any bounced checks and fees will be my responsibility and will be paid in full. Any credit arrangements must be authorized in advance.

Other options are available if your care is covered by Workers Compensation, Medicare, Personal Injury, or the result of an automobile accident. We will not become involved in disputes with your insurance company or attorney regarding deductible, co-payments, covered charges, secondary insurance, "usual and customary" charges, "medical necessity", etc. other than to supply factual information.

### **HIPAA GUIDELINES**

We are very concerned with protecting your privacy. While the law requires us to give you this disclosure, please understand that we have, and always will respect the privacy of your health information. There are several circumstances in which we may have to use or disclose your health care information. We may have to disclose your PHI to another healthcare provider or hospital if it is necessary to refer you to them for the diagnosis, assessment, or treatment. We may have to disclose your health information and billing records to another party if they are potentially responsible for the payment of your services.

We may need to use your health information within our own practice for quality control or other operational purposes. We may need to use your PHI to remind you of appointments, send you a birthday card, send you a thank you, acknowledge your referral, send you a welcome to the office letter, invite you to participate in office workshops, or send promotional information. We have a more complete notice that provides a detailed description of how your PHI may be used or disclosed. You have the right to revise that notice before you sign this consent form. We reserve the right to change our privacy practices as described in that notice.

### **YOUR RIGHTS**

You have the right to request that we do not disclose your PHI to specific individuals, companies, or organizations. If you would like to place any restrictions on the use or disclosure of your PHI please let us know in writing. We are not required to agree with your restrictions. However, if we agree with your restrictions, the restriction is binding upon us. You may revoke your consent to us at any time; however, your revocation must be in writing. We will not be able to honor your revocation request if we have already released your PHI before we receive your request. If you were required to give your authorization as a condition of obtaining insurance, they may have the right to your PHI if they decide to contest any of your claims. I have read your consent policy and agree to its terms. I am also acknowledging that I have received a copy of this notice if requested.

## **(YOUR COPY) HEALTHCARE AUTHORIZATION FORM**

**THE FOLLOWING AUTHORIZES INTEGRATIVE CHIROPRACTIC HEALTH &  
WELLNESS TO USE AND/OR DISCLOSE PROTECTED HEALTHCARE  
INFORMATION IN ACCORDANCE WITH THE FOLLOWING SPECIFIC  
AUTHORIZATIONS:**

I give permission to Integrative Chiropractic Health & Wellness to use my name, address, phone numbers and clinical records to contact them with birthday cards, holiday related cards, health related e-mails messages and information about treatment

alternatives or other health related information as well as any advertisements, newsletters or patient of the week/month postings. I also give Integrative Chiropractic Health & Wellness permission to use pre/post posture pictures and x-rays for awareness and office teaching.

I give permission to Integrative Chiropractic Health & Wellness to treat me in an open room where other patients are also being treated. I am aware that other persons in the office may overhear some of their protective health care information during the course of my treatment. Should I need to speak with a doctor or physical therapist in private, the doctor or therapist will provide a private room for these conversations.

By signing the following you are giving Integrative Chiropractic Health & Wellness permission to use and disclose their protected health information in accordance with the directives listed above

### FORMS OF PAYMENT

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and me. **I clearly understand and agree that all services rendered after my insurance's contracted annual agreement, are charged directly to me and that I am personally responsible for payments.**

I understand that I am responsible for my contracted payment at the time of service. I also understand that if I suspend or terminate my care and treatment any fees for professional services rendered me will be immediately due and payable. I will be responsible for any costs of collection, attorney's fee or court costs required to collect my bill.

We accept cash, personal checks, VISA, MasterCard, American Express, and DISCOVER. Any bounced checks and fees will be my responsibility and will be paid in full. Any credit arrangements must be authorized in advance.

Other options are available if your care is covered by Workers Compensation, Medicare, Personal Injury, or the result of an automobile accident. We will not become involved in disputes with your insurance company or attorney regarding deductible, co-payments, covered charges, secondary insurance, "usual and customary" charges, "medical necessity", etc. other than to supply factual information.

\_\_\_\_\_ Initial

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We may need to use your health information within our own practice for quality control or other operational purposes. We may need to use your PHI to remind you of appointments, send you a birthday card, send you a thank you, acknowledge your referral, send you a welcome to the office letter, and invite you to participate in office workshops, or send promotional information. We have a more complete notice that provides a detailed description of how your PHI may be used or disclosed. You have the right to revise that notice before you sign this consent form. We reserve the right to change our privacy practices as described in that notice.

\_\_\_\_\_ Initial

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\_\_\_\_\_  
Sign Name

\_\_\_\_\_  
Date

\_\_\_\_\_  
Provider Representative

**HEALTH CARE AUTHORIZATION FORM**

THE FOLLOWING AUTHORIZES INTEGRATIVE CHIROPRACTIC HEALTH & WELLNESS TO USE AND/OR DISCLOSE PROTECTED HEALTHCARE INFORMATION IN ACCORDANCE WITH THE FOLLOWING SPECIFIC AUTHORIZATIONS:

I give permission to Integrative Chiropractic Health & Wellness to use my name, address, phone numbers and clinical records to contact me with birthday cards, holiday related cards, health related e-mails messages and information about treatment alternatives or other health related information as well as any advertisements, newsletters or patient of the week/month postings. I also give Integrative Chiropractic Health & Wellness permission to use pre/post posture pictures and x-rays for awareness and office teaching.

I give permission to Integrative Chiropractic Health & Wellness to treat me in an open room where other patients are also being treated. I am aware that other persons in the office may overhear some of my protective health care information during the course of

my treatment. Should I need to speak with a doctor or physical therapist in private, the doctor or therapist will provide a private room for these conversations.

By signing the following you are giving Integrative Chiropractic Health & Wellness permission to use and disclose your protected health information in accordance with the directives listed above

## ACKNOWLEDGEMENT OF RECEIPT & NOTICE OF PRIVACY PRACTICES

I, \_\_\_\_\_ understand and have been provided with a notice of  
(print name)

information practices that provides me a more complete description of information uses and disclosures, I understand that I have the following rights and privileges:

- \* The right to review the notice prior to signing this consent
- \* The right to object to the use of my health care information for directory purpose
- \* The right to request restrictions as to how my health care information may be Used or disclosed in this office to carry out treatment, payment, or health care Operations

### INSURANCE INFORMATION

I clearly understand that all insurance coverage, whether accident, work related, or general coverage is an arrangement between my insurance carrier and myself. If this office chooses to bill any services to my insurance carrier that they are performing these services are strictly as a convenience to me. The Doctor's office will provide any necessary reports or required information to aid in insurance reimbursement of services, but **I understand that insurance carriers may deny my claims and that I am ultimately responsible for any unpaid balances.** Any monies received will be credited to my account.

**I understand there could be some services that my insurance company does not cover, if this is the case are you willing to pay for these services [ ] YES [ ] NO**

Patients Signature \_\_\_\_\_ Date \_\_\_\_\_

Guardian or Spouse's Signature Authorizing Care \_\_\_\_\_ Date \_\_\_\_\_

I hereby authorize Integrative Chiropractic Health & Wellness to administer care as deemed necessary to my child, a minor under the age of 18 years old.

Name of Insurance Co. \_\_\_\_\_ Policy# \_\_\_\_\_

Address \_\_\_\_\_ Phone # \_\_\_\_\_

Insured's Name \_\_\_\_\_ Insured's SS# \_\_\_\_\_

Relationship to Insured \_\_\_\_\_ Insured's Birthdate \_\_\_/\_\_\_/\_\_\_

Employer \_\_\_\_\_

Who should receive charges on your account?

- Patient      Spouse      Parent/Guardian      Workers Comp      Auto Insurance
- Medicare    Personal Health Insurance

### RADIOGRAPH CONSENT (X-Ray)

I, \_\_\_\_\_ do hereby give my consent to allow Integrative Chiropractic Health & Wellness and its representatives, as deemed by the examining physician to take radiographs of my spine and/or extremities.

Signature of Patient/or Guardian of Minor \_\_\_\_\_ Date \_\_\_\_\_

**FOR FEMALES ONLY**

I also hereby declare that to my knowledge that I am not pregnant \_\_\_\_\_

**WORK HISTORY**

Name: \_\_\_\_\_ Today's Date: \_\_\_\_\_

Current Employer: \_\_\_\_\_ Current Occupation: \_\_\_\_\_

**What limitations have you experienced as a result of your pain/condition? (Choose all that apply)**

cannot use left arm   cannot use right arm   cannot use left leg   cannot use Right leg  
cannot drive   Increased fatigue   Lifting makes it worse   Pain limits amount of movement  
cannot sit   cannot walk

**UNABLE TO LIFT:**

0-10lbs   11-15lbs   16-20lbs   21-25lbs   26-50lbs   NO RESTRICTIONS

**YOUR PRESENT JOB INVOLVES:**

STANDING FOR \_\_\_\_\_ MIN/HOURS



DRIVING FOR \_\_\_\_\_ MIN/HOURS

WALKING FOR \_\_\_\_\_ MIN/HOURS

SITTING FOR \_\_\_\_\_ MIN/HOURS

LIFTING FOR \_\_\_\_\_ MIN/HOURS

REPETITIVE MOTION Yes or No

**HAVE YOU MISSED ANY WORK AS A RESULT OF YOUR CONDITION?**

**YES**, HOW MANY DAYS DID YOU MISS? \_\_\_\_\_ DAYS

**NO**, LAST FULL DAY OF WORK WAS ON \_\_\_\_\_

***I UNDERSTAND THAT THE INFORMATION I HAVE PROVIDED IS CURRENT AND COMPLETE TO THE BEST OF MY KNOWLEDGE.***

**PATIENT SIGNATURE:** \_\_\_\_\_

**ROLAND-MORRIS LOW BACK PAIN INDEX**

NAME: \_\_\_\_\_ DATE: \_\_\_\_\_

This list contains some sentences that people have used to describe themselves when they have **BACK PAIN**. When you read them, you may find that some stand out because they describe you. As you read the list, think of yourself **TODAY**. Fill in the box next to any sentence that describes you **today**.

- I stay at home most of the time because of my back
- I change positions frequently to try and get my back comfortable
- I walk more slowly than usual because of my back
- Because of my back, I am not doing any of the jobs that I usually do around the house
- Because of my back, I use a handrail to get upstairs
- Because of my back, I lie down to rest more often
- Because of my back, I have to hold on to something to get out of a chair
- Because of my back, I try to get other people to do things for me
- I get dressed more slowly than usual because of my back
- I only stand up for short periods of time because of my back
- Because of my back, I try not to bend or kneel down
- My back is painful almost all of the time
- I find it difficult to turn over in bed because of my back
- My appetite is not very good because of my back pain
- I have trouble putting on socks/stockings because of the pain in my back
- I only walk for short distances because of my back pain
- I sleep less well because of my back
- Because of my back pain I get dressed with the help of someone else
- I avoid heavy jobs around the house because of my back
- Because of my back pain, I am more irritable and bad tempered
- Because of my back pain, I go upstairs more slowly than usual
- I stay in bed most of the time because of my back

**I understand that the information I have provided above is current and complete to the best of my knowledge.**

**Signature:** \_\_\_\_\_