Employer: _____ Length of Employment: _____
Job Title: _____ Are you currently working? □ Yes □ No
Check all that are appropriate: □ Full Time □ Full Duty □ Part Time □ Light Duty
What is your work schedule when you are working? _____
Describe your job duties: _____

Maximum Lifting up to: _____ lbs Occasional Lifting up to: _____ lbs
If newly employed, list employer's name, your job title and duties: _____

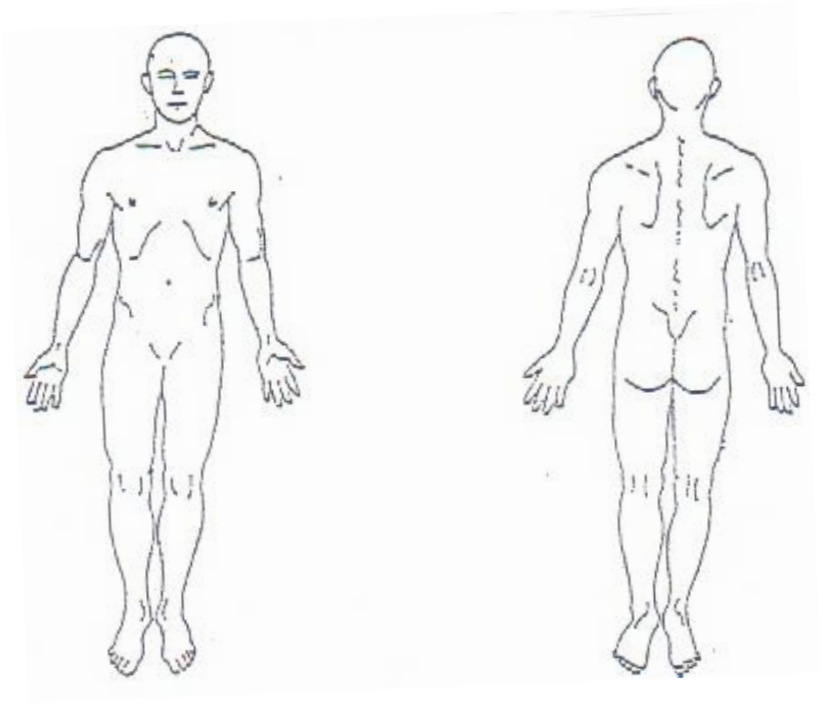
RATE YOUR FUNCTION: COMPLETE FUNCTION _____ NO FUNCTION

RATE YOUR PAIN: NO PAIN _____ PAIN AS BAD AS IT COULD BE

Please read carefully:

Mark the areas on your body where you feel your pain. Include all the affected areas. Mark the areas of radiation. If your pain radiates, draw an arrow where it starts to where it stops. Please extend the arrow as far as the pain travels. Use the appropriate symbol(s) listed below.

Ache >>> Numbness === Pins & Needles ○○○ Burning XXX Stabbing ///// Throbbing ~~~
>>> === ○○○ XXX ///// ~~~



Pain

The pain is the worst: □ first awake □ morning □ mid-day □ afternoon □ evening □ bedtime
The pain is the least: □ first awake □ morning □ mid-day □ afternoon □ evening □ bedtime

Frequency

□ Intermediate <25% □ Occasional 25-50% □ Frequent 50-75% □ Constant >75%
Average time in the day in pain: □ <1 hour □ 1-4 hours □ 4-8 hours □ anytime not lying down □ 24 hours

What activities make the pain better: _____
What activities make the pain worse: _____

RATE YOUR FAVORITE COMPLETE FUNCTION _____ NO FUNCTION

Patient Name: (Print) _____ Date: _____

Patient Signature: _____

OSWESTRY QUESTIONNAIRE

Name: _____ Date of Birth: _____ Age: _____ Date: _____

***Please read carefully*:** *This questionnaire has been designed to give the doctor information as to how pain has affected your ability to manage every day life. Please answer ever section and mark in each section only the* **ONE BOX** *that most closely describes your problems.*

SECTION 1 - Pain Intensity
- □ I can tolerate the pain I have without having to use pain killers.
- □ The pain is bad but I manage without taking painkillers.
- □ Painkillers give complete relief from pain.
- □ Painkillers give moderate relief from pain.
- □ Painkillers give very little relief from pain.
- □ Painkillers have no effect on the pain, and I do not use them.

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

SECTION 3 - Lifting
- □ I can lift heavy weights without causing extra pain.
- □ I can lift heavy weights but it gives me extra pain.
- □ Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned.
- □ Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
- □ I can lift only very light weights.
- □ I cannot lift or carry anything at all.

SECTION 4 - Walking
- □ Pain does not prevent me from walking any distance.
- □ Pain prevents me from walking more than 1 mile.
- □ Pain prevents me from walking more than ½ mile.
- □ Pain prevents me from walking more than ¼ mile.
- □ I can only walk using a stick or crutches.
- □ I am in bed most of the time and have to crawl to the toilet.

SECTION 5 - Sitting
- □ I can sit in any chair as long as I like.
- □ I can only sit in my favorite chair as long as I like.
- □ Pain prevents me from sitting for more than 1 hour.
- □ Pain prevents me from sitting for more than ½ hour.
- □ Pain prevents me from sitting for more than 10 minutes.
- □ Pain prevents me from sitting at all.

SECTION 6 - Standing
- □ I can stand as long as I want without extra pain.
- □ I can stand as long as I want but it gives me extra pain.
- □ Pain prevents me from standing for more than 1 hour.
- □ Pain prevents me from standing for more than ½ hour.
- □ Pain prevents me from standing for more than 10 minutes.
- □ Pain prevents me from standing at all.

SECTION 7 - Sleeping
- □ Pain does not prevent me from sleeping well.
- □ I can sleep well only by using tablets.
- □ Even when I take tablets I have less than 6 hours of sleep.
- □ Even when I take tablets I have less than 4 hours of sleep.
- □ Even when I take tablets I have less than 2 hours of sleep.
- □ Pain prevents me from sleeping at all.

SECTION 8 - Sex Life
- □ My sex life is normal and causes no extra pain.
- □ My sex life is normal but causes extra pain.
- □ My sex life is nearly normal but is very painful.
- □ My sex life is severely restricted by pain.
- □ My sex life is nearly absent because of pain.
- □ Pain prevents any sex life at all.

SECTION 9 - Social Life
- □ My social life is normal and gives me no extra pain.
- □ My social life is normal but increases the degree of pain.
- □ Pain has no significant effect on my social life apart from limiting my more energetic interests (i.e. dancing, etc.)
- □ Pain has restricted my social life and I do not go out as often.
- □ Pain has restricted my social life to my home.
- □ I have no social life because of pain.

SECTION 10 - Traveling
- □ I can travel anywhere without extra pain.
- □ I can travel anywhere but it gives me extra pain.
- □ Pain is bad but I manage journeys over 2 hours.
- □ Pain restricts me to journeys of less than 1 hour.
- □ Pain restricts me to short necessary journeys under 30 minutes.
- □ Pain restricts me from traveling except to the doctor or hospital.

SECTION 11 - Reading
- □ I can read as much as I want with no pain.
- □ I can read as much as I want with slight pain.
- □ I can read as much as I want with moderate pain.
- □ I cannot read as much as I want because of moderate pain.
- □ I can hardly read at all because of severe pain.
- □ I cannot read at all due to the pain.

SECTION 12 - Headaches
- □ I have no headaches at all.
- □ I have slight headaches which come infrequently.
- □ I have moderate headaches which come infrequently.
- □ I have moderate headaches which come frequently.
- □ I have severe headaches which come frequently.
- □ I have headaches almost all the time.

SECTION 13 - Concentration
- □ I can concentrate fully when I want to with no difficulty.
- □ I can concentrate fully when I want to with slight difficulty.
- □ I have a fair degree of difficulty in concentrating when I want to.
- □ I have a lot of difficulty in concentrating when I want to.
- □ I have a great deal of difficulty in concentrating when I want to.

SECTION 14 - Work
- □ I can do as much work as I want to.
- □ I can only do my usual work, but no more.
- □ I can do most of my usual work, but no more.
- □ I cannot do my usual work.
- □ I can hardly do any work at all.
- □ I cannot do any work at all.

SECTION 15 - Recreation
- □ I am able to engage in all recreational activities with no pain at all.
- □ I am able to engage in all my recreational activities with some pain.
- □ I am able to engage in most but not all rec. activities due to pain.
- □ I am able to engage in few of my recreational activities due to pain.
- □ I can hardly do any recreational activities because of pain.
- □ I cannot do any recreational activities at all.

PATIENT MEDICAL INFORMATION

Name: _____ Date: _____
Referred by: _____ Physician: _____
Have you been treated by a chiropractor before? _____

The following questions will help the doctor evaluate your needs. Please complete both sides and be as accurate as possible. All information is confidential.

Age: _____ Sex: _____ Height: _____ Weight: _____
If injured, date of injury: _____ Type of injury: _____ sports _____ at home _____other
If not injured, approximately when did your pain begin: _____
Have you been treated for this same problem before? _____Yes _____ No
If yes, who treated you? _____ When? _____
Who is your primary care physician? _____ Phone: (____) _____
Please describe how your symptoms started: _____
_____

CHIEF COMPLAINTS:

_____ Headaches	_____ Low Back Pain	_____ Disorientation	_____ Stiffness
_____ Neck Pain	_____ Mid Back Pain	_____ Cold Hands/Feet	_____ Dizziness
_____ Sore Muscles	_____ Upper Back Pain	_____ Other: _____	
_____ Numbness	_____ Tingling (circle one: hands or feet)		

PAST MEDICAL HISTORY:

Do you take any medication on a regular basis? If yes, please list with dosage: _____
_____
Have you ever had surgery? If yes, please describe with dates: _____
_____
Do you have any permanent disabilities? If yes, please explain: _____
_____
Do you have any physical impairments that keep you from working or doing things you enjoy? If yes, please explain: _____
_____
Have you ever been admitted into the hospital? If yes, for what and when: _____
_____
Have you ever needed treatment in an emergency room and not been admitted? If yes, what was your condition:
_____
Have you had any injuries that required treatment from a medical professional? If yes, please explain: _____
_____
Have you ever lost consciousness? If yes, for how long: _____
Was this a result of an injury? If yes, please explain: _____
_____
Have you had x-rays taken within the last two years? If yes, where and for what body part(s)? _____
_____
If there is anything else you feel the doctor may need to be aware of please explain: _____
_____
_____
_____
_____

PLEASE INDICATE IF YOU HAVE ANY OF THE FOLLOWING SYMPTOMS:

_____ Headaches	_____ Hand Pain	_____ Weakness	_____ Loss of Sleep
_____ Neck Pain	_____ Leg Pain	_____ Fainting	_____ Loss of Appetite
_____ Chest Pain	_____ Cold Sweats	_____ Earaches	_____ Heart Condition

HOW ARE YOU ABLE TO PERFORM THE FOLLOWING AFTER YOUR PAIN BEGAN?
INDICATE BY USING: N - normal L - limited D - difficult P - painful U - unable to perform

_____ Coughing	_____ Bending Forward	_____ Turning over (in bed)
_____ Sneezing	_____ Standing	_____ Lying on Stomach
_____ Pushing	_____ Kneeling	_____ Lying on Back
_____ Balancing	_____ Pulling	_____ Sexual Activity
_____ Reaching	_____ Walking	_____ Dressing Yourself

_____ Other: _____

For office use only: _____

Name: _____ Date: _____
Date of Birth: _____ Age: _____

Please answer the following questions. Please check the appropriate YES *or* NO *box.*

1.	Has your doctor ever told you that you have heart or lung problems?	□ Yes	□ No
2.	Have you ever had any heart-related problems?	□ Yes	□ No
3.	Do you frequently feel any chest discomfort or pain?	□ Yes	□ No
4.	Do you often feel faint or have spells of severe dizziness?	□ Yes	□ No
5.	Has your doctor ever told you that you have high blood pressure, have you ever had high blood pressure in the past, or are you presently taking any medication(s) for blood pressure?	□ Yes	□ No
6.	Are you aware of any bone, back or joint problems that may be or could be aggravated by exercise? (e.g. arthritis, surgery)	□ Yes	□ No
7.	Have you ever had an episode of exercise-induced asthma that is severe wheezing, coughing, or severe shortness of breath brought on by exercise or shortness of breath at rest or with mild exertion?	□ Yes	□ No
8.	Do you ever have episodes of labored or difficult breathing during the night?	□ Yes	□ No
9.	Have you ever been told by your doctor that you have diabetes?	□ Yes	□ No
10.	Are you over the age of 65 and not involved in any regular exercise?	□ Yes	□ No
11.	Is there a good reason not mentioned here why you should not engage in exercise or rehabilitation even if you wanted to?	□ Yes	□ No
12.	Are you pregnant?	□ Yes	□ No

Additional comments: _____

_____

_____

*Any "*YES*" response concerning cardiovascular, pulmonary, or metabolic problems may not engage in any fitness test or exercise program until a medical clearance form is completed and signed by a physician.*

MEDICAL CLEARANCE FORM

- I hereby certify that, to the best of my knowledge, this person examined has no contraindication to participate in a guided rehabilitation or fitness program.
- I recommend the following limitations/precautions: _____

_____

_____

Physician Signature: _____ Date: _____