Tricity Pain Associates
Quality Care, Delivered.

Welcome to our Practice

Today's Date:_____

PATIENT INFORMATION				
Last Name	**First**	**MI**	**Maiden Name**	**Gender** M / F
Date of Birth	**Social Security**	**Marital status** ○ Single ○ Married ○ Widowed ○ Divorced ○ Other		
Address	**City**	**State**	**Zip Code**	
Primary Number ( )	**Alternate Number** ( )	**E-Mail**		
Ethnicity	**Race**	**Employer Name and Phone Number**		
Emergency Contact	**Phone Number**	**Preferred Language**		

INSURANCE INFORMATION		
Primary Insurance	**Policy Number**	**Group Number**
Subscriber's Name	**Social Security**	**Relationship to Patient**

Worker's Compensation, Motor Vehicle or Injury Claim Information

Is your pain the result of a Worker's Compensation Injury? □ Yes □ No

Worker's Comp Company_____**Phone Number** _____

Is your pain the result of a Motor Vehicle Accident or Personal Injury? □ Yes □ No
(A separate page will be given to you to describe details of your accident)

Date of Accident _____

Preferred Pharmacy

Pharmacy Name_____**Phone Number** _____

Address _____

(List cross streets if not sure the exact address)

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Financial Policies

Private and Group Accident and Health Insurance Assignment for Direct Payment to Doctor

All Patients are expected to provide identification and if insured, a current insurance card(s) at time of service. Patients are financially responsible for all services provided and are expected to pay for services at the time of service, including any past due balance from a prior date of service. If the patient is a minor child, the parent or other adult accompanying the child will be financially responsible regardless of legal guardianship. Returned checks will be subject to fees.

Medicare: The Practice will bill the Medicare intermediary. Patients are responsible for the following:

- Annual Medicare deductible
- All applicable co-pays of the allowed charge
- Any non-covered services
- Any covered service ordered by the physician which does not meet Medicare's medical necessity and for which the beneficiary signed an Advanced Beneficiary Notice (ABN).

Medicare Supplemental and Secondary Insurances: The Practice will bill both Medicare and secondary insurances.

Medicaid: Patients must provide the Practice with a current Medicaid card at each visit. Medicaid patients are responsible for applicable co-pays and for all non-covered services. Medicaid patients are responsible for securing necessary referrals from their primary care physicians.

HMOs and PPOs, Commercial Insurance Plans: Patients are responsible for payment of the co-pay, co-insurance and/or deductible, or non-covered amounts at the time of service as well as for any charges for which the patient failed to secure prior authorization, if authorization is necessary. Insurance is filed as a courtesy and benefits are authorized to be paid directly to the Practice. Patients are responsible for the balance in full if not paid by the insurance within 30 days. If the patient is not prepared to pay the co-pay or deductible, a member of the clinical staff will determine if it is medically necessary for the patient to see the physician. If the patient's condition allows, the appointment will be rescheduled.

Self-Pay: Patients are responsible for payment in full at the time of services for all services rendered.

Worker's Compensation: Employer authorization must be obtained before treatment is rendered or the patient will be responsible for payment in full at the time of services for all services rendered. Once authorized, patients are not responsible for any charges unless the workers compensation case is dismissed or denied.

Out of State Insurance: If the patient presents with an out of state HMO/PPO insurance card, we will need to verify the patient's benefits for out-of-state or out-of-network benefits. The patient may be required to make payment in full or pay any co-pay, co-insurance or deductible.

I hereby instruct and direct my insurance company to pay by check made out and mailed directly to: ***Tricity Pain Associates (Physician Practice)***, for professional or medical expense benefits allowable, and otherwise payable to me under my current insurance policy as payment toward the total charges for professional services rendered.

PAYMENTS DUE AT TIME OF SERVICE AND OUTSTANDING BALANCES

I understand that I am responsible for payment of the co-pay, co-insurance and/or deductible, or non-covered amounts at the time of service as well as for any charges for which I failed to secure prior authorization, if authorization is necessary. If I have an outstanding balance, I understand that I will be responsible for payment of the co-pay, co-insurance and/or deductible, or non-covered amounts for today's visit and in addition, I will be expected to pay 50% of any balance at the time of service and will pay the remaining balance in 2 equal payments 30 days apart unless I have a payment plan on file and I am making regular payments to that plan. If no payment plan is in place, I will be offered an opportunity to set one up, or reschedule my appointment to a later date when I can meet my financial obligations.

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Authorizations and Consent

ASSIGNMENT AND RELEASE: I hereby assign my insurance or other third-party carrier benefits to be paid directly to the Physician Practice, realizing I am responsible for any resulting balance. I also authorize the Physician to release any information required to process claims to my insurance carrier and/or to my employer or prospective employer (for employer sponsored/paid for claims). I acknowledge that I am financially responsible for services rendered, and failure to pay any outstanding balances may result in collection procedures being taken. Further, I agree that if this account results in a credit balance, the credit amount will be applied to any outstanding accounts of mine, or to a family member whose account I am guarantor for.

ELECTRONIC CHECK CONVERSION: When you provide a check as payment, you authorize us either to use information from your check to make a one-time electronic fund transfer from your account or to process the payment as a check transaction. When we use information from your check to make an electronic fund transfer, funds may be withdrawn from your account the same day.

CONSENT FOR TREATMENT: I hereby authorize the physicians, midlevel providers, nurses, medical assistants, and other Practice staff to conduct such examinations, and to administer treatment and medications as they deem necessary and advisable.

This Is Direct Assignment of My Rights and Benefits under This Policy

This payment will not exceed my indebtedness to the above-mentioned assignee, and I have agreed to pay any balance of said professional service charges over and above this insurance payment, except in instances where No-Fault or Workers' Compensation insurance fee schedules apply.

I also understand and agree that I am ultimately responsible for all fees including reasonable collection costs. This assignment of benefits does not release me from obligation to pay professional fees.

A Photo Copy of This Assignment Shall Be Considered As Effective and Valid As the Original

I authorize the release of any information pertinent to my case to any insurance company, adjuster or attorney involved in this case.

Appointment and No Show Policy

In effort to provide efficient treatment to all of our patients, it is the policy of this company that if you are unable to make your scheduled appointment, you must call to cancel the appointment no later than 24 hours before the scheduled time. If you fail to cancel your office appointment or fail to show up to your appointment, you will be charged a "NO SHOW" fee of $30.00 per occurrence. If you are scheduled for a procedure and fail to cancel the appointment no later than 24 hours before or no show to your procedure, you will be charged a fee of $100.00 per occurrence. For most insurance plans and Workers Compensation carriers "NO SHOW" charges are a non-covered service. You will be solely responsible for payment of this charge. Repeated "NO SHOWS" and cancellations of your scheduled appointments may result in you being DISCHARGED from care at ***Tricity Pain Associates***.

If you arrive **15 minutes late** after your scheduled appointment, your appointment will be rescheduled for the next available appointment. If you have any questions regarding our policy, please speak to our staff before signing.

Notice of Privacy Practices Acknowledgement

A **Notice of Privacy Practices (NPP)** is provided to all patients. This Notice of Privacy Practices identifies: 1) how medical information about you may be used or disclosed; 2) your rights to access your medical information, amend your medical information, request an accounting of disclosures of your medical information, and request additional restrictions on our uses and disclosures of that information; 3) your rights to complain if you believe your privacy rights have been violated; and 4) our responsibilities for maintaining the privacy of your medical information.

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The undersigned certifies that he/she has read the foregoing financial policies, agrees to be bound by the policies and has received a copy of the Notice of Privacy Practices, and is the patient or the patient's personal representative.

_____ _____

Patient Signature Date

I (we) the undersigned patient and/or responsible party hereby authorize this office to release medical, billing and appointment information to the following family members in lieu of myself:

1._____ Relationship:_____

2._____ Relationship:_____

3._____ Relationship:_____

***Please understand that unless the name appears on this form, we <u>CANNOT</u> disclose any of the patient's information. ***

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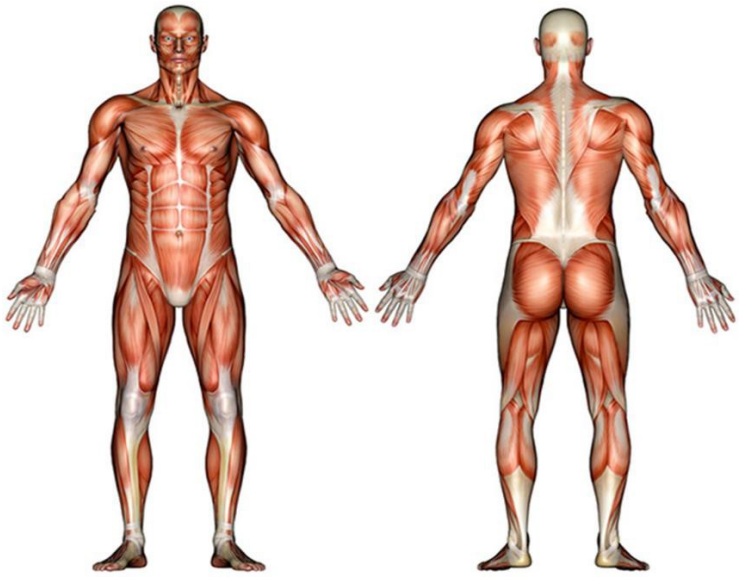
CONFIDENTIAL NEW PATIENT QUESTIONNAIRE

Mark on the picture where you are having pain. Also mark (X) for Numbness, (T) for Tingling, (B) for Burning.



Where is your pain? ☐ Neck ☐ Arm ☐ Lower Back ☐ Leg ☐ Other _____

How bad are your symptoms at their:

Best	0	1	2	3	4	5	6	7	8	9	10
Worst	0	1	2	3	4	5	6	7	8	9	10
Today	0	1	2	3	4	5	6	7	8	9	10

Duration of pain:
☐ < 1 week ☐ 1-4 weeks ☐ 1-3 months
☐ 6-12 months ☐ > 1 year

How/When did the pain begin?_____(Month/year)
☐ Work Accident ☐ Following Surgery
☐ Home Accident ☐ Unknown
☐ Auto Accident ☐ Other _____

How has your pain intensity changed since it began?
☐ Continuously ☐ Constantly (Most of the Day) ☐ Occasionally (Less than half of the Day) ☐ Few Times a Week

Select one or more items below to describe the nature of your pain:
☐ Throbbing ☐ Shooting ☐ Sharp ☐ Cramping ☐ Hot/Burning
☐ Aching ☐ Stabbing ☐ Tingling ☐ Numbing ☐ Dull Ache

How do the following factors affect your pain?

	Better	**Worse**	**No Effect**		**Better**	**Worse**	**No Effect**
Heat Compresses	☐	☐	☐	Climate Changes	☐	☐	☐
Cold Compresses	☐	☐	☐	Lying Down	☐	☐	☐
Coughing	☐	☐	☐	Sitting	☐	☐	☐
Massage	☐	☐	☐	Walking	☐	☐	☐
Lifting	☐	☐	☐	Sex	☐	☐	☐
Alcohol	☐	☐	☐				

Have you had imaging done in the past year (MRIs, CT scans, etc.)? If so, where? _____
Do you have any metal, pins, screws, foreign objects in your body? Yes ☐ No ☐ _____

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CONFIDENTIAL NEW PATIENT QUESTIONNAIRE (cont.)

Which of the following are affected by your pain?

☐ Mood ☐ Activities of Daily Living ☐ Social Interaction ☐ Household chores ☐ Falling Sleep
☐ Staying Asleep ☐ Work ☐ Sexual Activity

Have you had any of the following treatments for your pain?

Treatment	Dates	Treatment	Dates
Acupuncture		Massage	
Exercise		Brace	
Facet Blocks		Psychotherapy	
Trigger Point		Epidurals	
Chiropractor		TENS unit	
Physical Therapy		Nerve Blocks	

Past Medical History

☐AIDS OR HIV ☐Anemia ☐Arthritis ☐Asthma ☐Bleeding Disorder ☐Cancer ☐Depression
☐Diabetes Type I or Type II ☐Emphysema ☐Fibromyalgia ☐Gout ☐Headaches/Migraines ☐Heart Disease
☐Hepatitis (A, B, C) ☐High Blood Pressure ☐Thyroid Disease ☐Insomnia ☐Kidney Disease ☐ Kidney Stones
☐Liver Disease ☐Lupus ☐Pacemaker ☐Panic Attacks ☐Peripheral Vascular Disease ☐Prostate Enlargement
☐Mental Disorder(s) ☐Shingles ☐Stroke ☐Tuberculosis

Please tell us about any SURGERIES you have had, you may indicate the date/year if known:

Surgery	Date

Please tell us about your FAMILY HISTORY:

☐ I HAVE NO SIGNIFICANT FAMILY MEDICAL HISTORY ☐ I AM ADOPTED (Family History Unknown)

	Cancer	Diabetes	Heart Disease	Kidney Problems	Mental Disorders	Spine Problems	Stroke
Mother							
Father							
Brother(s)							
Sister(s)							
Other Conditions							

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SOCIAL HISTORY

Occupation: _____

Do You Smoke? Yes ☐ No ☐ How Many Pack/Day? _____ Years? _____

Did You Smoke in the Past but Quit? Yes ☐ No ☐ When? _____

Drink Alcohol? Yes ☐ No ☐ If Yes, How Much? _____

Do You Use Any Other Drugs (Marijuana, Cocaine, Etc.?) Yes ☐ No ☐

If Yes, Please Name: _____

Marital Status ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Do You Live Alone? Yes ☐ No ☐ If No, Who Do You Live With? _____

FOR FEMALES ONLY:

Are you pregnant? ☐ **Yes** ☐ **No** ☐ **Not Sure** **Patient's Initials** _____

CURRENT MEDICATIONS

Are you taking a prescribed **blood thinning** medication? Yes ☐ No ☐

Please list ALL medications you are currently taking. Attach an additional sheet, if required.

Name of Medication	**Dosage** (i.e. milligram)	**How taken** (i.e. 1 tablet daily)

List any Pain Medications that you have tried in the past? _____

Are you **allergic** to any medications**?** _____

REVIEW OF SYSTEMS

Are you experiencing any of the following?

General ☐ Loss of appetite ☐ Recent Weight Loss ☐ Fever/Chills ☐ Fatigue ☐ Night Sweats

Endocrine/Hematologic ☐ Heat/Cold Intolerance ☐ Easy Bruising ☐ Easy Bleeding ☐ Visual Changes

Cardiovascular ☐ Chest Pain ☐ Palpitations ☐ Leg Swelling

Respiratory ☐ Difficulty Breathing ☐ Cough ☐ Wheezing

Eyes ☐ Blurred Vision ☐ Double Vision ☐ Loss of Vision ☐ Eye Pain

Genitourinary ☐ Painful Urination ☐ Blood in Urine ☐ Frequent Urination

Skin ☐ Rash ☐ Itching ☐ Other Skin Changes

Gastrointestinal ☐ Nausea and/or Vomiting ☐ Heartburn ☐ Blood in Stool ☐ Constipation

Ear/Nose/Throat ☐ Hoarseness ☐ Hearing Loss ☐ Trouble Swallowing ☐ Ear Pain

Neurological ☐ Tremors ☐ Dizziness ☐ Tingling ☐ Seizures

Psychiatric ☐ Depression / Anxiety ☐ Suicidal Thoughts ☐ Drug/Alcohol Addiction ☐ Trouble Sleeping

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OFFICE PROTOCOL AGREEMENT

The following protocols are necessary to provide appropriate care to all our patients. Please review, initial each entry and sign below indicating that you understand these office protocols and agree to abide by them. Lack of signature does not invalidate these protocols.

- I understand that refills are given at the time of the office visit. Refills are not done over the phone. _____(Initial)
- I understand with controlled substance therapy (narcotics), it is expected that I may need to undergo random urine drug testing as part of my treatment plan._____(Initial)
- I understand that I am an active participant in my health care and agree to abide by the treatment plan given and reviewed with me at each visit. I understand that any changes in condition may need an office visit for reassessment. For acute changes in my condition, I may need to access care through the emergency room. _____(Initial)
- I understand that this practice utilizes mid-level practitioners such as Physician's Assistants. They provide care in terms of assessing new patients: assessing patients on routine follow-ups; assessing any changes in conditions; education of patient on condition, meds and treatment options._____(Initial)
- I understand that my access to care via telephone or on site will require my behavior to be in a manner that is not abusive to staff. I agree to refrain for behavior that reflects yelling, cursing, name-calling or multiple calls in same day. I understand that this behavior may terminate my relationship with this practice. _____(Initial)
- I agree to cancel my established appointments in advance to benefit other patients that are in need of earlier appointments. I understand that not showing up for an appointment without calling in advance, may be a factor in the continuation or discontinuation of my care with this group._____(Initial)
- I understand that I am to arrive 15 minutes before my appointment time to check in for follow up appointments and 45 minutes before a new patient appointment._____(Initial)

Patients Name: _____
(Print name)

Patients Signature:_____ Date: _____

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CONTROLLED SUBSTANCE AGREEMENT

I_____ am entering into contract with Tricity Pain Associates and their providers:
Dr. Bill Murphy, Dr. David Kim, Dr. Brandon Nguyen, Dr. Joshua Shroll, Dr. Justin Vigil
Dr. Jack Chapman, Dr. Carl Wang, Dr. Jason Williams, Dr. James Davis, Dr. David Riegleman, Christopher Watson PA, John Cadrain PA,Ying Frappolli PA, Nancy Turnball PA, Vanessa Cox FNP, Chyrissa Staley FNP

I agree to the following:

1. All controlled substances must come from the physician who is assigned to your care, or during his or her absence, by covering provider, unless specific authorization is obtained for an exception. You are **not** to receive **any** prescriptions for narcotics or sedative drugs from any other provider.

2. The prescribing provider has permission to discuss all diagnostic and treatment detail with dispensing pharmacists or other professionals who provide your health care for purposes of maintaining

3. All controlled substances must be obtained at the same pharmacy, where possible. Should the need to arise to change pharmacies, our office must be informed. The pharmacy you have selected is:

   Pharmacy Name:_____ Pharmacy #: _____

4. Random urine or serum toxicology screens will be requested, and your cooperation is REQUIRED. Presence of unauthorized substances may prompt termination of your opioid treatment and referral for assessment for addictive behavior.

5. Refills will occur on a monthly basis and **ONLY** after a visit and physical examination. **NO REFILLS WILL BE MADE OVER THE TELEPHONE. NO REFILLS WILL BE GIVEN AFTER HOURS, ON WEEKENDS AND/OR HOLIDAYS.** Renewals are contingent on keeping scheduled appointments. Please do not phone for prescriptions after hours or on weekends.

6. If refill requests are made after hours, you will be instructed by the answering service to go to an emergency room of your choice.

7. You are expected to inform our office of any new medications, or medical conditions, and of any adverse effects you experienced from any medications that you take.

8. Prescriptions may be issued early if the physician or patient will be out of town when refill is due. These prescriptions will contain instructions to the pharmacist that they not be filled prior to the appropriate date. There will be NO early refills or pre-dated prescriptions.

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Any evidence of prescription, forged prescriptions, substance abuse, or aberrant behavior (including verbal abuse to our office staff) will result in termination of patient –physician relationship.

9. Medications will **not** be replaced if they are lost, stolen, destroyed, left on airplane, etc. It is YOUR responsibility to protect your medications.

10. An official prescription, written for a Schedule II controlled substance, must be filled within 21 days after the date the prescription was issued. If you hold on to the prescription longer than 21 days or forget to pick it up from the pharmacy, it will not be re-written until you are seen in an office visit. **No Exceptions!**

11. Prescriptions are to be used **ONLY** as written. Use of increased amount of medication without consultation with a physician will not be allowed.

12. You may **NOT** share, sell, or otherwise permit others to have access to these medications.

13. Originals containers of medication should be brought to each office visit.

14. Since the drugs may be hazardous or lethal to a person who is not tolerant to their effects, especially a child, you must keep them out of reach of such people.

15. Termination terms will include a written letter to you and fulfillment of your medical needs, one month after the date of termination.

16. PLEASE ALLOW 48 – 72 HOURS FOR MEDICATION REFILLS.

17. Due to overwhelming phone calls for prescription refills, if you call Tricity Pain Associates for medication refills you are allowed one phone call per day, if you call multiple times a day, you will be charged a $5 fee per call.

Your pain is **YOUR** responsibility. Making appointments for medication refills is **YOUR** responsibility. Tricity Pain Associates will provide medical support in your quest to minimize your pain. You must make new efforts to improve sleep habits, nutrition, body weight, conditioning and psychological state. Narcotics are **not** the answer to chronic pain, but can be used to effectively to improve your pain.

Patient Signature _____ Date _____

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MEDICAL RECORD RELEASE FORM
THE PURPOSE OF THIS RELEASE IS AT THE REQUEST OF THE PATIENT.

Date: _____

Patient Name:_____DOB:_____

Patient Address:_____City/State/Zip:_____

Patient Phone #_____Social Security # _____

I hereby authorize:_____

Address:_____

Phone:_____Fax:_____

To release my medical records to: **Tricity Pain Associates:**

David Kim, M.D.
Joshua Shroll, M.D.
Jack Chapman, M.D.
Brandon Nguyen, M.D.
David Riegleman, M.D.

Bill Murphy, M.D
Carl Wang, M.D.
Justin Vigil, M.D.
James Davis, M.D.
Jason Williams, M.D.

Ph: 844-789-7246 Fax: 888-880-9323

The following is authorized for release:

- ☐ ALL medical records, Including Clinical, Progress, and Procedure Reports/Notes
- ☐ Demographics and Insurance Card
- ☐ Lab Results, Imaging Reports, Urine Toxicology Results

I understand that the information in my health record may include information related to sexually transmitted disease (AIDS/HIV). It may also include information about behavioral, or mental service, and treatment for alcohol and drug abuse.

_____ _____
Signature of Patient/ Legal Representative Date

_____
Print Name

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URINE DRUG SCREENING PROTOCOL

1. UDS first visit if patient on opioids or would like IPM/TPA to manage their medications.
2. UDS (random) 3-4 times/year thereafter for low risk patients.
   Low Risk=previous UDS have all be compliant. Patient does not exhibit abnormal behavior.
3. UDS every 2-3 months for moderate risk patients.
   Moderate Risk=history of incarceration, domestic violence, depression, anxiety disorder and general mental illness.
4. UDS monthly and random for high risk patients.
   High Risk=history of opioid abuse, history of alcohol abuse, on high doses of opioids, history of lost/stolen medications.

FAILED URINE DRUG SCREEN:

- Cocaine - immediate termination on first offense
- Methamphetamine - immediate termination on first offense
- Heroin and Phencyclidine – immediate termination on first offense
- THC- patient should be seen and counseled, and then patient should be seen monthly with random testing performed. Patient should be informed that the second offense might lead to non-opioid management only (injections, NSAIDS) or termination.
- 2 failed UDS- Patient placed on non-opioid management only (injections, NSAIDS) or termination.

_____ _____

Patient Signature Date

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PRESCRIPTION REFILL POLICY

1. When it is time for a prescription refill, ask your pharmacy to call our office.
2. It is our policy that we do not fill early or lost prescriptions for any reason.
3. Patients should call 3 business days in advance for a refill to ensure that you do not run out of medications.
4. The Drug Enforcement Agency and the Texas Department of Public Safety carefully monitor triplicate medications.
5. The following narcotic pain medications require Triplicate and cannot be called into pharmacy:
    - Morphine (MS Contin, Avinza), Dilaudid (Hydromorphine), Kadian Oxycodone, Oxycontin, Percocet, Methodone, Duragesic or Fentanyl patches, Norco/Vicodin (Hydrocodone/Acetaminophen)
6. Patients on Triplicate pain medications MUST be seen at least every 2 months.
7. Medications will be filled:
    - After 4:00pm weekdays
8. Medications will NOT be filled:
    - Weekends and Holidays
9. It is important for you to take responsibility for keeping track of your medications.
10. Obtain narcotic medications from only one doctor.
11. You can only use one pharmacy for prescribed medications.

_____ _____

Patient Signature Date

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Oswestry Disability Index

Section 1 – Pain Intensity

- ☐ I have no pain at the moment.
- ☐ The pain is very mild at the moment.
- ☐ The pain is moderate at the moment.
- ☐ The pain is fairly severe at the moment.
- ☐ The pain is very severe at the moment.
- ☐ The pain is the worst imaginable at the moment.

Section 2 – Personal Care (washing, dressing, etc.)

- ☐ I can look after myself normally but it is very painful.
- ☐ I can look after myself normally but it is very painful.
- ☐ It is painful to look after myself and I am slow and careful.
- ☐ I need some help but manage most of my personal care.
- ☐ I need help every day in most aspects of my personal care.
- ☐ I need help every day in most aspects of self-care.
- ☐ I do not get dressed, wash with difficulty, and stay in bed.

Section 3 - Lifting

- ☐ I can lift heavy weights without extra pain.
- ☐ I can lift heavy weights but it gives extra pain.
- ☐ Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned (i.e. on a table).
- ☐ 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 walking any distance.
- ☐ Pain prevents me walking more than 1mile.
- ☐ Pain prevents me walking more than ¼ of a mile.
- ☐ Pain prevents me walking more than 100 yards.
- ☐ 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 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 more than 1 hour.
- ☐ Pain prevents me from standing for more than ½ an hour.
- ☐ Pain prevents me from standing for more than 10 minutes.
- ☐ Pain prevents me from standing at all.

Section 7 – Sleeping

- ☐ My sleep is never disturbed by pain.
- ☐ My sleep is occasionally disturbed by pain.
- ☐ Because of pain, I have less than 6 hours sleep.
- ☐ Because of pain, I have less than 4 hours sleep.
- ☐ Because of pain, I have less than 2 hours sleep.
- ☐ Pain prevents me from sleeping at all.

Section 8 – Sex life (if applicable)

- ☐ My sex life is normal and causes no extra pain.
- ☐ My sex life is normal but causes some 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 cause 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 limitingmy more energetic interests, i.e. sports.
- ☐ Pain has restricted my social life and I do not go out as often.
- ☐ Pain has restricted social life to my home.
- ☐ I have no social life because of pain.

Section 10 – Traveling

- ☐ I can travel anywhere without pain.
- ☐ I can travel anywhere but it gives extra pain.
- ☐ Pain is bad but I manage journeys of over two hours.
- ☐ Pain restricts me to short necessary journeys under 30 minutes.
- ☐ Pain prevents me from traveling except to receive treatment.

Section 11 - Previous Treatment

Over the past three months have you received treatment, tablets or medicines of any kind for your back or leg pain?

Please check the appropriate box.

- ☐ No
- ☐ Yes (if yes, please state the type of treatment you have received)

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Neck Disability Index

This questionnaire has been designed to give the doctor information as to how your neck pain has affected your ability to manage in everyday life. Please answer every section and mark in each section only the ONE box which applies to you. We realize you may consider that two of the statements in any one section relate to you, but please just mark the box which most closely describes your problem.

Section 1 – Pain Intensity

- ☐ I have no pain at the moment.
- ☐ The pain is very mild at the moment.
- ☐ The pain is moderate at the moment.
- ☐ The pain is fairly severe at the moment.
- ☐ The pain is very severe at the moment.
- ☐ The pain is the worst imaginable at the moment.

Section 2 – Personal Care (Washing, Dressing, etc.)

- ☐ 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 manage most of my personal care.
- ☐ I need help every day in most aspects of self-care.
- ☐ I do not get dressed, I wash with difficulty and stay in bed.

Section 3 – Lifting

- ☐ I can lift heavy weights without extra pain.
- ☐ I can lift heavy weights but it gives extra pain.
- ☐ Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned, for example on a table.
- ☐ Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
- ☐ I can lift very light weights.
- ☐ I cannot lift or carry anything at all.

Section 4 – Reading

- ☐ I can read as much as I want to with no pain in my neck.
- ☐ I can read as much as I want to with slight pain in my neck.
- ☐ I can read as much as I want with moderate pain in my neck.
- ☐ I cannot read as much as I want because of moderate pain in my neck.
- ☐ I can hardly read at all because of severe pain in my neck.
- ☐ I cannot read at all.

Section 5 – Headaches

- ☐ I have no headaches at all.
- ☐ I have slight headaches that 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 6 – Concentration

- ☐ I can concentrate fully when I want to with no difficulty. (0)
- ☐ 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.
- ☐ I cannot concentrate at all.

Section 7 – Work

- ☐ I can do as much work as I want to.
- ☐ I can 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 8 – Driving

- ☐ I can drive my car without any neck pain.
- ☐ I can drive my car as long as I want with slight pain in my neck.
- ☐ I can drive my car as long as I want with moderate pain in my neck.
- ☐ I cannot drive my car as long as I want because of moderate pain in my neck.
- ☐ I can hardly drive at all because of severe pain in my neck.
- ☐ I cannot drive my car at all.

Section 9 – Sleeping

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

Section 10 – Recreation

- ☐ I am able to engage in all my recreation activities with no neck pain at all.
- ☐ I am able to engage in all my recreation activities, with some pain in my neck.
- ☐ I am able to engage in most, but not all, of my usual recreation activities because of pain in my neck.
- ☐ I am able to engage in a few of my usual recreation activities because of pain in my neck.
- ☐ I can hardly do any recreation activities because of pain in my neck.
- ☐ I cannot do any recreation activities at all.

Functional Strength of the Cervical Spine

Starting Position	Action	Functional Test
Supine lying	Lift head keeping chin tucked in (neck flexion)	6 to 8 repetitions: functional 3 to 5 repetitions: functionally fair 1 to 2 repetitions: functionally poor 0 repetitions: nonfunctional
Prone lying	Lift head backward (neck extensions)	Hold 20 to 25 seconds: functional Hold 10 to 19 seconds: functionally fair Hold 1 to 9 seconds: functionally poor Hold 0 seconds: nonfunctional
Side lying (pillows under head so head is not side flexed)	Life head sideways away from pillow (neck side flexion) (must be repeated or other side)	Hold 20 to 25 seconds: functional Hold 10 to 19 seconds: functionally fair Hold 1 to 9 seconds: functionally poor Hold 0 seconds: nonfunctional
Supine lying	Lift head off bed and rotate to one side keeping head off bed or pillow (neck rotation) (must be repeated both ways)	Hold 20 to 25 seconds: functional Hold 10 to 19 seconds: functionally fair Hold 1 to 9 seconds: functionally poor Hold 0 seconds: nonfunction

ZURICH CLAUDICATION QUESTIONNAIRE

In the Last Month, How Would You Describe:

The pain you have had on average including pain in your back, buttocks and pain that goes down the legs?

1- None
2- Mild
3- Moderate
4- Severe
5- Very Severe

How often have you had back, buttock, or leg pain?

1- Less than once a week
2- At least once a week
3- Every day, for at least a few minutes
4- Every day, for most of the day
5- Every minute of the day

The pain in your back or buttocks?

1- None
2- Mild
3- Moderate
4- Severe
5- Very Severe

The pain in your legs or feet?

1- None
2- Mild
3- Moderate
4- Severe
5- Very Severe

Numbness or tingling in your legs or feet?

1- None
2- Mild
3- Moderate
4- Severe
5- Very Severe

Weakness in your legs or feet?

1- None
2- Mild
3- Moderate
4- Severe
5- Very Severe

Problems with your balance?

1- No, I've had no problems with balance
3- Yes, sometimes I feel my balance is off, or that I am not sure-footed
5- Yes, often I feel my balance is off, or that I am not sure-footed

In the Last Month, on a Typical Day:

How far have you been able to walk?

1- Over 2 miles
2- Over 2 blocks, but less than 2 miles
3- Over 50 feet, but less than 2 blocks
4- Less than 50 feet

Have you taken walks outdoors or in malls for pleasure?

1- Yes, comfortably
2- Yes, but sometimes with pain
3- Yes, but always with pain
4- No

Have you been shopping for groceries or other items?

1- Yes, comfortably
2- Yes, but sometimes with pain
3- Yes, but always with pain
4- No

Have you walked around the different rooms in your house or apartment?

1- Yes, comfortably
2- Yes, but sometimes with pain
3- Yes, but always with pain
4- No

Have you walked from your bedroom to the bathroom?

1- Yes, comfortably
2- Yes, but sometimes with pain 3-
Yes, but always with pain
4- No

How Satisfied Are You With:

The overall result of back operation?

1- Very satisfied
2- Somewhat satisfied
3- Somewhat dissatisfied
4- Very dissatisfied

Relief of pain following the operation?

1- Very satisfied
2- Somewhat satisfied
3- Somewhat dissatisfied
4- Very dissatisfied

Your ability to walk following the operation 1-
Very satisfied
2- Somewhat satisfied
3- Somewhat dissatisfied
4- Very dissatisfied

Your ability to do housework, yard work, or job following the operation?

1- Very satisfied
2- Somewhat satisfied
3- Somewhat dissatisfied
4- Very dissatisfied

Your strength in the thighs, legs, and feet?

1- Very satisfied
2- Somewhat satisfied
3- Somewhat dissatisfied
4- Very dissatisfied

Your balance, or steadiness on your feet?

1- Very satisfied
2- Somewhat satisfied
3- Somewhat dissatisfied
4- Very dissatisfied