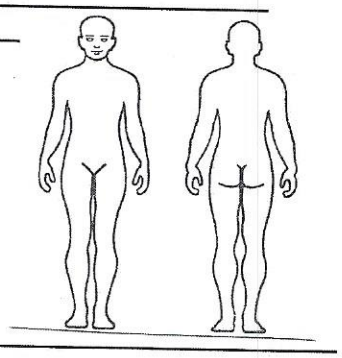
McCallie Chiropractic & Rehabilitation Center
Dr. L. Doug Adair
Daily Sheet

Name_____ Date_____
Patient Signature_____



Is today's visit related to a new condition/accident/injury? ☐Yes ☐No

SUBJECTIVE: Pain Level

Today my symptoms are: Least Most

_____ 1 2 3 4 5 6 7 8 9 10
_____ 1 2 3 4 5 6 7 8 9 10
_____ 1 2 3 4 5 6 7 8 9 10
_____ 1 2 3 4 5 6 7 8 9 10

Patient comments/Other symptoms:_____
_____

* * * * For Office Use Only * * * *

OBJECTIVE PAIN 1 2 3 4 SPASM 1 2 3 4 SWELLING 1 2 3 4 FIXATION 1 2 3 4

CERVICAL	1 2 3 4 5 6 7 8	FS	DT	ACT	PROM	
THORACIC	1 2 3 4 5 6 7 8 9 10 11 12	FS	DT	ACT	PROM	ANT
LUMBAR	1 2 3 4 5 6	FS	DT	ACT	PROM	
PELVIS	SACRUM RIL LIL	FS	DT	ACT	PROM	
EXTREMITY	_____					

☐ Exam Performed (see separate form for results)

ASSESSMENT: ☐Improving as expected ☐Slow progress ☐Exacerbation ☐Supportive care ☐Slightly worse

DX: ☐Unchanged

CERVICAL	THORACIC	LUMBAR/PELVIC	OTHER
Radiculitis	Radiculitis	Radiculitis	Headache
Neuralgia	Neuralgia	Neuralgia	TMU
Myospasms	Myospasms	Myospasms	Scollosis
DJD	DJD	DJD	Tendonitis
Pain	Pain	Pain	Bursitis
Discopathy	Discopathy	Discopathy	_____
Strain/Sprain	Strain/Sprain	Strain/Sprain	_____

TREATMENT:

ADJUSTMENT: ☐98940 ☐98941 ☐98942 ☐98943-51

THERAPY: ☐E-stem ☐Stim. Add ☐Traction ☐Ice/heat ☐ART ☐Massage

REHAB: ☐Exercise instructions given with demonstration and return demonstration

EXAM: ☐Focused ☐Expanded ☐Detailed ☐New ☐Established

X-RAY: ☐Cervical ☐Thoracic ☐Lumbar ☐Other

SUPPLIES: ☐Ice/heat pack ☐Biofreeze/Heat/Flexease ☐E-stem pads ☐Other

Home inst. ☐Ice to C T L ☐Other

Next Appt. RSAS M T W Th F Daily 1wk 2wk 1mth PRN

Reevaluation:_____

Comments: ☐Patient tolerated adjustment and/or therapy well and left office w/o incident.

Physician's signature_____

WELCOME TO MCRC

ABOUT YOU

Today's Date:_____ Social Security#_____
Patient Name:_____
☐Male ☐Female Birthdate:_____ Age:_____
Mailing Address:_____
_____
CITY STATE ZIP
Home#_____ Cell#_____
Work#_____ Other#_____
E-mail address:_____
Referred by:_____
Occupation:_____
Employer:_____
Status: ☐Single ☐Married ☐Separated ☐Divorced
Spouse's Name:_____

IN EVENT OF EMERGANCY

Whom should we contact?_____
Relation to patient:_____
Home#_____ Cell#_____
Who is your Medical Doctor?_____
Medical Doctor's #:_____

HEALTH HISTORY

Do you have or have had any of the following diseases, medical conditions or procedures?

☐Heart Attack/Stroke	☐Cancer	☐Hepatitis
☐Artificial Valves	☐Chemotherapy	☐HIV/AIDS/ARC
☐Heart Surg/Pacemaker	☐Glaucoma	☐Anemia/Diabetes
☐Heart Murmur	☐High/Low Blood Pressure	☐Headaches
☐Congenital Heart Defect	☐Arthritis	☐Kidney Problems
☐Shingles	☐Artificial Bones/Joints	☐Glaucoma
☐Bleeding Disorders	☐Breast Lump	☐Hernia
☐High Cholesterol	☐Rheumatoid Arthritis	☐Stroke
☐Tumors/Growths	☐Other_____	

FOR WOMEN

Are you pregnant?☐NO ☐YES How many weeks?____
Are you taking birth control?☐NO ☐YES
Date of last menstrual cycle:___/___/___

INSURANCE INFO

Primary Insurance
Co. Name:_____
Insured's ID #:_____Group#_____
Insured's Name:_____
Insured's Birthdate:_____
Relation to patient:_____
Insured's Employer:_____
Secondary Insurance
Co. Name:_____
Insured's ID #:_____Group#_____
Insured's Name:_____
Insured's Birthdate:_____
Relation to patient:_____
Insured's Employer:_____
☐ No Insurance (Cash Pay)

MEDICATION/ALLERGIES/SUPPLEMENTS

Medication:_____
_____
_____
Allergies:_____
Vitamin/Supplements:_____
_____

INJURIES/SURGERIES

Falls:_____
Head Injuries:_____
Broken Bones:_____
Dislocations:_____
Surgeries:_____
_____

SOCIAL HISTORY

Exercise: ☐NO ☐YES ____hours per week
Smoke: ☐NO ☐YES How much? ____per day
Drugs: ☐NO ☐YES What?____ How often?____
Caffeine/Coffee: ☐NO ☐YES How much?____per day
Alcohol: ☐NO ☐YES ____Drinks per week

REASON FOR VISIT

Reason for today's visit: ☐Emergency ☐New Injury ☐Old Injury ☐Chronic Pain ☐Wellness
Did your injury occur during: ☐Work ☐Auto Accident ☐Sports/Play ☐Routine/Household Activity
When did accident/condition occur?___/___/___ Please explain what happened_____
Have you been treated for this condition?☐NO ☐YES By Whom?_____ ☐MD ☐DC ☐PT ☐Other

MCRC Chiropractic Consent Form

CONSENT TO CHIROPRACTIC CARE:

This notice is to inform you, as a patient of this office the risks of undergoing chiropractic care. The procedures that will be performed in the course of your care will consist of chiropractic adjustments using manual or instrumental techniques.

Chiropractic is one of the safest and most natural health care programs conceived. This painless, logical, and effective approach to health has been serving everyday people for over 100 years. It is licensed in every state, and in many countries as well. Chiropractic has the least chance of side effects of any other type of health care. Mild headaches and muscle soreness may sometimes occur. Doctors who use manual therapy techniques are required to advise patients that there are or may be some risks associated with such treatment. In particular you should note: A) While rare, some patients may experience short term aggravation of symptoms, rib fractures (if you usually have low bone density), or muscle and ligament strains or sprains as a result of manual therapy techniques. There is also a risk of increased pain during the healing phase of your care. As your body begins to be restored to normal health, there may be some periods of time when you will feel symptoms that had previously been gone. Understand that this is normal and indicates healing, as such you may also risk restored health and wellness. B) There are reported cases of stroke associated with many common neck movements including adjustments of the cervical spine. Stroke is one of the most common causes of death in the U.S. Present medical and scientific evidence does not establish a definite cause and effect relationship between upper cervical adjustment and the occurrence of stroke. Furthermore, the apparent association is noted very infrequently (This risk has been determined to be a risk approximately 1 in 5.85 million). However, you are being warned of this possible association because strokes sometimes cause serious neurological impairment, and may on rare occasion result in injuries including paralysis. The possibility of such injuries resulting from upper cervical spinal adjustment is extremely rare. In 2001 the Canadian Medical Association Journal found there is a very small risk that a cervical manipulation from an MD, PT, or DC would be followed by a stroke. Author, David Cassidy, a professor of epidemiology at the University of Toronto said patients had already damaged the artery before seeking help from either a medical doctor or chiropractor, and then a stroke occurred after the visit. C) There is rare reported cases of disc injuries following cervical and lumbar spinal adjustments or chiropractic treatment. Chiropractic treatment, including spinal adjustment, has been the subject of government reports and multi-disciplinary studies conducted over many years and has demonstrated to be effective treatment for many neck and back issues involving pain, numbness, muscle spasm, loss of mobility, headaches, and other similar symptoms. Chiropractic care contributes to your overall wellbeing. The risk of injuries or complications from chiropractic treatment is substantially lower than that associated with many medical or other treatments, medications, and procedures given for the same conditions. There is no absolutely known material risk of chiropractic care being greater risk s from medical treatment. Speaking of risks associated with chiropractic, we should look at the risk associated with NOT getting adjusted. Disc degeneration, loss of mobility, loss of overall tone, decreased quality of life-these are real risks of the untreated spine as time goes by. The risks of chiropractic care will, of course, be evaluated before your care begins via x-ray examination, physical examination, and thorough history.

I understand and acknowledge the risks associated with chiropractic care. I consent to the chiropractic treatments offered or recommended to me by my chiropractor, including spinal adjustment. I intend this consent to apply to all my present and future chiropractic care at this office.

_____ _____

Signature of Patient Date

McCallie Chiropractic & Rehabilitation Center Financial Policy

PATIENTS WITHOUT INSURANCE

MCRC does offer a discounted rate for our patients that are uninsured. We request that you pay at time of service unless other arrangements have been pre-arranged and agreed upon.

GROUP OR INDIVIDUAL INSURANCE

MCRC participates with most major insurance plans. **MCRC recommend that all patients confirm coverage and benefit information before you arrive for your appointment.** When possible, we will call to verify benefits on your insurance plan. However, the benefits quotes to us by your insurance company are not a guarantee of payment. As a courtesy to our patients, MCRC will file the insurance claims with your insurance carrier. Please remember any amount not covered by your insurance is ultimately the patient's responsibility. **Your insurance policy is an arrangement between you and the insurance company NOT between MCRC and your insurance company. MCRC is not a party to that arrangement and we do NOT guarantee coverage or benefits provided by the insurance company.** All deductibles, copays, co-insurance, and non-covered amounts will be due from the patient.

SECONDARY INSURANCE

Please inform MCRC of any additional insurance coverage.

MEDICARE

MCRC does accept assignment from Medicare. Medicare will ONLY cover manual manipulation of the spine. Medicare pays 80% of the allowable fee once the deductible has been met. You are required to pay the deductible and the remaining 20% as well as any non-covered services (such as x-rays and/or modalities) MCRC completes and files the forms for Medicare at no additional charge.

SUPPLEMENTAL INSURANCE

Please inform MCRC of any additional coverage other than Medicare. Supplemental insurance will follow the same guidelines set forth by Medicare. Supplemental insurance will usually pay the 20% that Medicare does not pay. Any Medicare deductible and non-covered services will be the responsibility of the patient.

WORKER'S COMPENSATION

If you are injured on the job, you will need to inform your employer of the accident and obtain the name, address, claim number, and claim address of the employer's insurance carrier. MCRC will file the necessary paperwork and claims to their insurance carrier. If your employer does not provide MCRC with the information payment for services will be the responsibility of the patient.

PERSONAL INJURY OR AUTOMOBILE ACCIDENTS

Please notify your auto insurance carrier of your visit to our office immediately. Notify MCRC if an attorney is representing you. Although you are ultimately responsible for your bill, we will wait for settlement of your claim. Once the claim is settled any fees for services are due from you immediately.

I understand that my insurance is an agreement between myself and my insurance company and not between MCRC and my insurance company. I request that MCRC prepare the customary forms at no charge so that I may obtain benefits. I also understand that if my insurance does not respond any fees will be due and payable immediately by me. If you are unable to pay at time of service you MUST fill out the payment plan form to set up payments for your care.

_____ _____

Signature of Patient or Responsible Party **Date**

Insurance Plans Frequently Asked Questions

CO-PAYS, CO-INSURANCE, AND DEDUCTIBLES

A **co-pay** is a specific amount your health insurance plan may require you to pay for a specific medical service or supply. For example, your insurance plan may require a $15.00 copayment for an office visit or brand-name prescription drug, after which the insurance company often pays the remainder of the covered charges.

A **deductible** is a specific dollar amount that your health insurance company may require that you pay out-of-pocket each year before your health insurance plan begins to make payments for claims. Not all health insurance plans require a deductible.

A **co-insurance** is the term used by health insurance companies to refer to the amount that you are required to pay for a medical claim, apart from any co-payments or deductible. For example, if your health insurance plan has a 20% co-insurance requirement (and does not have any additional co-payment or deductible requirements), then a $100.00 medical bill would cost you $20.00, and the insurance company should pay the remaining $80.00.

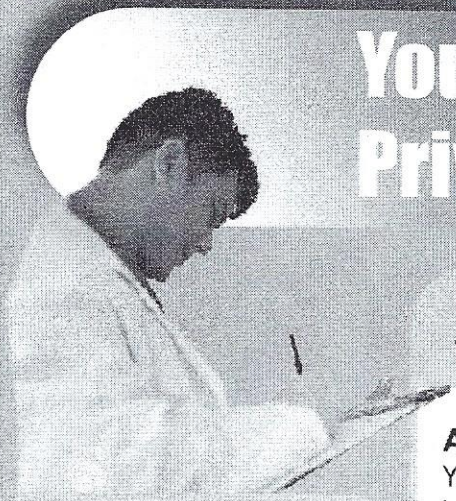
HSA, HRA, AND FSA

A **health savings account (HSA)** is a tax-advantage medical savings account available to taxpayers in the United States who are enrolled in a high deductible health plan. The funds contributed to an account are not subject to federal income tax at the time of deposit. Unlike a flexible spending account (FSA), funds roll over and accumulate year to year if not spent. HSAs are owned by the individual, which differentiates them from company-owned Health Reimbursement.

Health Reimbursement Accounts (HRAs) are Internal Revenue Services (IRS)-sanctioned employer-funded, tax-advantaged employer health benefit plans that reimburse employees for out-of-pocket medical expenses and individual health insurance premiums. Using a Health Reimbursement Account yields "tax advantages to offset health care costs" for both employees as well as employers.

A **flexible spending account (FSA)** is one of a number of tax-advantaged financial accounts that can be set up through an employer. An FSA allows an employee to set aside a portion of earnings to pay for qualified expenses as established in the plan, most commonly for medical expenses but often for dependent care or other expenses. Money deducted from an employee's pay into an FSA is not subject to payroll taxes, resulting in substantial payroll tax savings. One significant disadvantage to using an FSA is that funds not used by the end of the plan year are lost to the employee.

Your Health Information Privacy Rights



Privacy is important to all of us

You have privacy rights under a federal law that protects your health information. These rights are important for you to know. You can exercise these rights, ask questions about them, and file a complaint if you think your rights are being denied or your health information isn't being protected.

Who must follow this law?

- Most doctors, nurses, pharmacies, hospitals, clinics, nursing homes, and many other health care providers
- Health insurance companies, HMOs, most employer group health plans
- Certain government programs that pay for health care, such as Medicare and Medicaid

Providers and health insurers who are required to follow this law must comply with your right to . . .

Ask to see and get a copy of your health records

You can ask to see and get a copy of your medical record and other health information. You may not be able to get all of your information in a few special cases. For example, if your doctor decides something in your file might endanger you or someone else, the doctor may not have to give this information to you.

- In most cases, your copies must be given to you within 30 days, but this can be extended for another 30 days if you are given a reason.
- You may have to pay for the cost of copying and mailing if you request copies and mailing.

Have corrections added to your health information

You can ask to change any wrong information in your file or add information to your file if it is incomplete. For example, if you and your hospital agree that your file has the wrong result for a test, the hospital must change it. Even if the hospital believes the test result is correct, you still have the right to have your disagreement noted in your file.

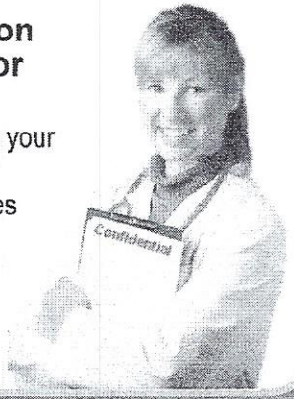
- In most cases the file should be changed within 60 days, but the hospital can take an extra 30 days if you are given a reason.

Receive a notice that tells you how your health information is used and shared

You can learn how your health information is used and shared by your provider or health insurer. They must give you a notice that tells you how they may use and share your health information and how you can exercise your rights. In most cases, you should get this notice on your first visit to a provider or in the mail from your health insurer, and you can ask for a copy at any time.

Decide whether to give your permission before your information can be used or shared for certain purposes

In general, your health information cannot be given to your employer, used or shared for things like sales calls or advertising, or used or shared for many other purposes unless you give your permission by signing an authorization form. This authorization form must tell you who will get your information and what your information will be used for.



Individual Document Acknowledgement Registration Form

I, _____ acknowledge that I received a copy of the McCallie Chiropractic and Rehabilitation Center Notice of Privacy Practices dated April 14, 2003.

_____ (Signature or initials of patient)

_____ (Personal representative of patient, if patient is unable to sign)

_____ Witness signature _____date

I hereby authorize the following: (Initial by all that apply)

- Release of medical information to other medical providers, by phone, in person, or by mail, as necessary, for continued care processes.
- Release of medical information to other medical providers, as necessary, via fax, as requested by them.
- Release of medical information, as necessary, via fax, interoffice courier, phone, in person, or by mail for claims/billing processes.
- Voicemail messages on my personal phone/answering machine regarding appointments/callbacks, etc.
- I authorize, as necessary, test results, appointments, etc., to be given to who is my _____ (relationship with person named) in my absence.
- I acknowledge that I have received for review the patient's privacy of healthcare information packet in accordance with HIPAA federal regulations.

Individual (or personal representative of the individual) did not sign the acknowledgement for the following reason:

(Please circle one of the reasons)

- Individual refused
- Individual refused, stating that he/she has already signed an acknowledgement
- Individual unable to sign because of medical condition
- There was not a personal representative of the individual available to sign
- Other: (explain)

_____ Witness _____ date

FRONT RANGE CENTER for BRAIN & SPINE SURGERY, P.C.
1313 Riverside Ave., Ft. Collins, CO 80524
(970) 493-1292

Oswestry Neck Disability Index

This questionnaire is designed to help us better understand how your neck pain affects your ability to manage everyday life activities. Please check the box for ***the one statement*** in each section that applies to you. Although you may consider that two of the statements in any one section relate to you, please mark the box that ***most closely*** describes your present-day situation. Thank you.

Patient name _____ Date _____

Please check one box in each section.

Section 1–Pain Intensity

- ☐ 0 I have no pain at the moment.
- ☐ 1 The pain is very mild at the moment.
- ☐ 2 The pain is moderate at the moment.
- ☐ 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.

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

- ☐ 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; I am slow and careful.
- ☐ 3 I need some help but 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.

Section 3–Lifting

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

Section 4–Reading

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

Section 5–Headaches

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

Score: ____ (50) Benchmark -5= _____

Section 6–Concentration

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

Section 7–Work

- ☐ 0 I can do as much work as I want to.
- ☐ 1 I can only do my usual work, but no more.
- ☐ 2 I can 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 can't do any work at all.

Section 8–Driving

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

Section 9–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).

Section 10–Recreation

- ☐ 0 I am able to engage in all my recreation activities with no neck pain at all.
- ☐ 1 I am able to engage in all my recreation activities, with some pain in my neck.
- ☐ 2 I am able to engage in most, but not all of my usual recreation activities because of pain in my neck.
- ☐ 3 I am able to engage in a few of my recreation activities because of pain in my neck.
- ☐ 4 I can hardly do any recreation activities because of pain in my neck
- ☐ 5 I can't do any recreation activities at all.

Oswestry Low Back Pain Scale

Please rate the severity of your pain by circling a number below:

No pain | 0 1 2 3 4 5 6 7 8 9 10 | *Unbearable pain*

Name _____ **Date** _____

Instructions: Please circle the **ONE NUMBER** in each section which most closely describes your problem.

Section 1 – Pain Intensity
0. The pain comes and goes and is very mild.
1. The pain is mild and does not vary much.
2. The pain comes and goes and is moderate.
3. The pain is moderate and does not vary much.
4. The pain comes and goes and is severe.
5. The pain is severe and does not vary much.

Section 2 – Personal Care (Washing, Dressing, etc.)
0. I would not have to change my way of washing or dressing in order to avoid pain.
1. I do not normally change my way of washing or dressing even though it causes some pain.
2. Washing and dressing increase the pain but I manage not to change my way of doing it.
3. Washing and dressing increase the pain and I find it necessary to change my way of doing it.
4. Because of the pain I am unable to do some washing and dressing without help.
5. Because of the pain I am unable to do any washing and dressing without help.

Section 3 – Lifting
0. I can lift heavy weights without extra pain.
1. I can lift heavy weights but it gives extra pain.
2. Pain prevents me lifting heavy weights off the floor.
3. Pain prevents me lifting heavy weights off the floor, but I can manage if they are conveniently positioned, e.g., on a table.
4. Pain prevents me lifting heavy weights but I can manage light to medium weights if they are conveniently positioned.
5. I can only lift very light weights at most.

Section 4 – Walking
0. I have no pain on walking.
1. I have some pain on walking but it does not increase with distance.
2. I cannot walk more than 1 mile without increasing pain.
3. I cannot walk more than ½ mile without increasing pain.
4. I cannot walk more than ¼ mile without increasing pain.
5. I cannot walk at all without increasing pain.

Section 5 – Sitting
0. I can sit in any chair as long as I like.
1. I can sit only in my favorite chair as long as I like.
2. Pain prevents me from sitting more than 1 hour.
3. Pain prevents me from sitting more than ½ hour.
4. Pain prevents me from sitting more than 10 minutes.
5. I avoid sitting because it increases pain immediately.

Section 6 – Standing
0. I can stand as long as I want without pain.
1. I have some pain on standing but it does not increase with time.
2. I cannot stand for longer than 1 hour without increasing pain.
3. I cannot stand for longer than ½ hour without increasing pain.
4. I cannot stand for longer than 10 minutes without increasing pain.
5. I avoid standing because it increases the pain immediately.

Section 7 – Sleeping
0. I get no pain in bed.
1. I get pain in bed but it does not prevent me from sleeping well.
2. Because of pain my normal nights sleep is reduced by less than one-quarter.
3. Because of pain my normal nights sleep is reduced by less than one-half.
4. Because of pain my normal nights sleep is reduced by less than three-quarters.
5. Pain prevents me from sleeping at all.

Section 8 – Social Life
0. My social life is normal and gives me no pain.
1. My social life is normal but it increases the degree of pain.
2. Pain has no significant effect on my social life apart from limiting my more energetic interests, e.g., dancing, etc.
3. Pain has restricted my social life and I do not go out very often.
4. Pain has restricted my social life to my home.
5. I have hardly any social life because of the pain.

Section 9 – Traveling
0. I get no pain when traveling.
1. I get some pain when traveling but none of my usual forms of travel make it any worse.
2. I get extra pain while traveling but it does not compel me to seek alternate forms of travel.
3. I get extra pain while traveling which compels to seek alternative forms of travel.
4. Pain restricts me to short necessary journeys under ½ hour.
5. Pain restricts all forms of travel.

Section 10 – Changing Degree of Pain
0. My pain is rapidly getting better.
1. My pain fluctuates but is definitely getting better.
2. My pain seems to be getting better but improvement is slow.
3. My pain is neither getting better or worse.
4. My pain is gradually worsening.
5. My pain is rapidly worsening.

TOTAL _____