# New Patient Application

**Thank you for your trust and for giving Complete Chiropractic Life Center the opportunity to help. It is our pleasure to greet you and, likewise, our honor to serve you.**

**Our desire is to determine how we might be of the greatest help to you while doing our best to aid you with your health and healing goals.**

**Please be advised that this office is NOT like most other chiropractic offices, in that we are one of only a few that specialized in the type of care that we provide.**

**We continually receive high praise from our patients because we take time to search for the underlying cause of any given condition while delivering the highest level of care possible. It is our belief that when both parties agree and to excellence, optimum results are achieved.**

**Because our office is highly specialized in our approach to improved neurological adaptation, function and health, it is important that you understand a few things about us:**

- **Care will begin only after each patient has been properly examined and care recommendations have been determined, reviewed and agreed upon.**

- **Our New Patient Examination fee is $165 and will include all necessary diagnostic testing that our doctor(s) determine are needed, which may include examination, neurological testing, and/or x-rays. THIS IS OUR TIME OF SERVICE DISCOUNTED cash fee.**

- **We have intentionally chosen to remain OUT of MOST insurance networks,including being a Medicare 'Non-participating' Provider. We currently are in network with Medical Mutual of Ohio SuperMed PPO, Buckeye Medicaid, CareSource Medicaid, United HealthCare Community Medicaid and Paramount Medicaid. We do not bill out of network plans.**

- **Medicare beneficiaries: the Medicare Benefit Policy Manual States in Chapter 15, Section 240 that maintenance therapy includes services that seek to prevent disease, promote health, and prolong and enhance the quality of life, or maintain or prevent deterioration of a chronic condition. Medicare only pays for acute/active treatment.**

- **We offer time of service discounts, payment plans, family discounts, and cash fees which allow our patients to receive the care that they need. Many patients also find Care Credit (third-party) interest-free financing helpful when it is approved.**

- **We DO NOT accept all patients. We only accept patients who our doctor(s) feel we can help and who have agreed to follow all terms relating to care recommendations.**

**Please sign that you have read and understand the above statements:**

**Patient Signature:_____ Date:_____**

**APPLICATION FOR CARE AT COMPLETE CHIROPRACTIC LIFE CENTER**

Today's Date: _____

**PATIENT DEMOGRAPHICS**

Name: _____ Birthdate: _____-_____-_____ Age: _____ ○ Male ○ Female

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____ Mobile Phone: _____

E-mail Address: _____

Marital Status: ○ Single ○ Married ○ Divorced ○ Widowed ○ Separated

Employer: _____ Occupation:_____

Spouse's Name _____ Spouse's Employer_____

Number of children and ages:_____

Name & Number of Emergency Contact: _____

How did you hear about us? _____

Who may we thank for referring you?_____

**HISTORY OF COMPLAINT**

Please identify the condition(s) that brought you to this office: Primary: _____

Secondary: _____ Third: _____ Fourth: _____

On a scale of **0** to **10** with **10** being the worst pain and **zero** being no pain, rate your above complaints by ***circling the number***:

**Primary** or chief complaint is: 0 – 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10

**Second** complaint is: 0 – 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10

**Third** complaint is: 0 – 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10

**Fourth** complaint is: 0 – 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10

When did the problem(s) begin? _____ When is the problem at its worst? ○ AM ○ PM ○ mid-day ○ late PM

How long does it last? ○ It is constant **OR** ○ I experience it on and off during the day **OR** ○ It comes and goes throughout the week

How did the injury happen? _____

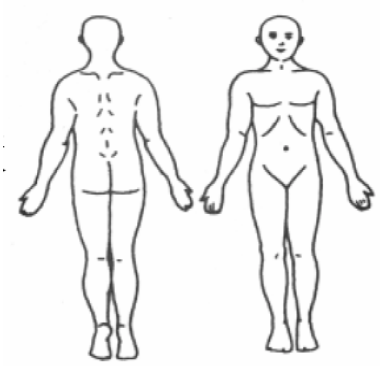
Condition(s) ever been treated by a chiropractor in the past? ○ No ○ Yes

**If yes,** when? _____ by whom?_____

How long were you under care? _____ What were the results? _____

_____

Did your previous chiropractor take before & after x-rays?: □ **Yes** □ **No**



**PLEASE MARK** the areas on the body diagram with the following **letters** to describe your symptoms:

**R = R**adiating **B = B**urning **D = D**ull **A =** Aching **N = N**umbness **S = S**harp/**S**tabbing **T = T**ingling

What relieves your symptoms? _____

What makes your symptoms feel worse? _____

| LIST RESTRICTED ACTIVITY | CURRENT ACTIVITY LEVEL | USUAL ACTIVITY LEVEL |
|---|---|---|
| _____ | _____ | _____ |
| _____ | _____ | _____ |

Is your problem the result of ANY type of accident? ○ Yes ○ No
Identify any other injury(s) to your spine, minor or major, that the doctor should know about: _____
_____

## PAST HISTORY

Have you suffered with any of this or a similar problem in the past? ○ No ○ Yes **If yes,** how many times? _____ When was the last episode? _____ How did the injury happen?_____
Other forms of treatment tried: ○ No ○ Yes **If yes,** please state what type of treatment and the provider:
_____
How long ago? _____ What were the results. ○ Favorable ○ Unfavorable Please explain:_____
_____
Please identify any and all types of jobs you have had in the past that have imposed any physical stress on you or your body:
_____
If you have ever been diagnosed with any of the following conditions, please indicate with:
**P** for in the ***Past*** **C** for ***Currently*** have **N** for ***Never*** have had
___ Broken Bone ___ Dislocations ___ Tumors ___ Rheumatoid Arthritis ___ Fracture ___ Disability
___ Cancer ___ Heart Attack ___ Osteo Arthritis ___ Diabetes ___ Cerebral Vascular ___ Other serious conditions:
_____
**PLEASE IDENTIFY ALL PAST** and any **CURRENT** conditions you feel may be contributing to your present problem:

| | HOW LONG AGO | TYPE OF CARE | PROVIDED BY WHOM |
|---|---|---|---|
| **INJURIES** | | | |
| **SURGERIES** | | | |
| **CHILDHOOD DISEASES** | | | |
| **ADULT DISEASES** | | | |

## FAMILY HISTORY

1. Does anyone in your family suffer with the same condition(s)? ○ No ○ Yes **If yes,** whom?
○ grandmother ○ grandfather ○ mother ○ father ○ sister(s) ○ brother(s) ○ son(s) ○ daughter(s)
Have they ever been treated for their condition? ○ No ○ Yes ○ I don't know
2. Any other hereditary conditions the doctor should be aware of? ○ No ○ Yes: _____

## SOCIAL HISTORY

**1. Smoking**: ○ cigars ○ pipe ○ cigarettes How often?○ Daily ○ Weekends ○ Occasionally ○ Never
**2. Alcoholic Beverage**: consumption occurs ○ Daily ○ Weekends ○ Occasionally ○ Never
**3. Recreational Drug use**: ○ Daily ○ Weekends ○ Occasionally ○ Never
**4. Do you exercise? Y / N How often?_____ Type of activity:_____**
**5. Do you take any supplements (I.e. vitamins, minerals,herbs)?** _____
**_____**
Have you ever felt like, or have been told, that you carry your head forward, noticed a rounding of your shoulders, or a developing "hump" at the base of your neck? Y / N

Has your doctor ever recommended you to lose weight or do you desire to lose weight? Y / N

How would you describe your typical diet? _____

Rest/sleep is important - how would you describe your time at rest? _____

**If you woke tomorrow and were completely free of any pain or discomfort, how would you like to be different:_____**
**_____**

**_____**

## ACTIVITIES OF LIFE

Please identify how your current condition is affecting your ability to carry out activities that are routinely part of your life:

| **ACTIVITIES:** | | | **EFFECT:** | |
|---|---|---|---|---|
| Carry Children/Groceries | ○ No Effect | ○ Painful (can do) | ○ Painful (limits) | ○ Unable to Perform |
| Sit to Stand | ○ No Effect | ○ Painful (can do) | ○ Painful (limits) | ○ Unable to Perform |
| Climb Stairs | ○ No Effect | ○ Painful (can do) | ○ Painful (limits) | ○ Unable to Perform |
| Pet Care | ○ No Effect | ○ Painful (can do) | ○ Painful (limits) | ○ Unable to Perform |
| Extended Computer Use | ○ No Effect | ○ Painful (can do) | ○ Painful (limits) | ○ Unable to Perform |
| Lift Children/Groceries | ○ No Effect | ○ Painful (can do) | ○ Painful (limits) | ○ Unable to Perform |
| Read/Concentrate | ○ No Effect | ○ Painful (can do) | ○ Painful (limits) | ○ Unable to Perform |
| Getting Dressed | ○ No Effect | ○ Painful (can do) | ○ Painful (limits) | ○ Unable to Perform |
| Shaving | ○ No Effect | ○ Painful (can do) | ○ Painful (limits) | ○ Unable to Perform |
| Sexual Activities | ○ No Effect | ○ Painful (can do) | ○ Painful (limits) | ○ Unable to Perform |
| Sleep | ○ No Effect | ○ Painful (can do) | ○ Painful (limits) | ○ Unable to Perform |
| Static Sitting | ○ No Effect | ○ Painful (can do) | ○ Painful (limits) | ○ Unable to Perform |
| Static Standing | ○ No Effect | ○ Painful (can do) | ○ Painful (limits) | ○ Unable to Perform |
| Yard work | ○ No Effect | ○ Painful (can do) | ○ Painful (limits) | ○ Unable to Perform |
| Walking/Exercising | ○ No Effect | ○ Painful (can do) | ○ Painful (limits) | ○ Unable to Perform |
| Washing/Bathing | ○ No Effect | ○ Painful (can do) | ○ Painful (limits) | ○ Unable to Perform |
| Sweeping/Vacuuming | ○ No Effect | ○ Painful (can do) | ○ Painful (limits) | ○ Unable to Perform |
| Dishes | ○ No Effect | ○ Painful (can do) | ○ Painful (limits) | ○ Unable to Perform |
| Laundry | ○ No Effect | ○ Painful (can do) | ○ Painful (limits) | ○ Unable to Perform |
| Garbage | ○ No Effect | ○ Painful (can do) | ○ Painful (limits) | ○ Unable to Perform |
| Driving | ○ No Effect | ○ Painful (can do) | ○ Painful (limits) | ○ Unable to Perform |
| Other: _____ | ○ No Effect | ○ Painful (can do) | ○ Painful (limits) | ○ Unable to Perform |

**List Prescription & Non-Prescription drugs you take:** _____

_____

_____

## REVIEW OF SYSTEMS

Please mark: **P** for in the **Past** **C** for **Currently** have **N** for **Never**

| | | | | |
|---|---|---|---|---|
| ___ Headache | ___ Pregnant (Now) | ___ Dizziness | ___ Prostate Problems | ___ Ulcers |
| ___ Neck Pain | ___ Frequent Colds/Flu | ___ Loss of Balance | ___ Impotence/Sexual Dysfun | ___ Heartburn |
| ___ Jaw Pain, TMJ | ___ Convulsions/Epilepsy | ___ Fainting | ___ Digestive Problems | ___ Heart Problem |
| ___ Shoulder Pain | ___ Tremors | ___ Double Vision | ___ Colon Trouble | ___ High Blood Pressure |
| ___ Upper Back Pain | ___ Chest Pain | ___ Blurred Vision | ___ Diarrhea/Constipation | ___ Low Blood Pressure |
| ___ Mid Back Pain | ___ Pain w/Cough/Sneeze | ___ Ringing in Ears | ___ Menopausal Problems | ___ Asthma |
| ___ Low Back Pain | ___ Foot/ Knee Problems | ___ Hearing Loss | ___ Menstrual Problem | ___ Difficulty Breathing |
| ___ Hip Pain | ___ Sinus/Drainage Issues | ___ Depression | ___ PMS | ___ Lung Problems |
| ___ Back Curvature | ___ Swollen/Painful Joints | ___ Irritable | ___ Bed Wetting | ___ Kidney Trouble |
| ___ Scoliosis | ___ Skin Problems | ___ Mood Changes | ___ Learning Disability | ___ Gall Bladder Trouble |
| ___ Numb/Tingling arms, hands, fingers | | ___ ADD/ADHD | ___ Eating Disorder | ___ Liver Trouble |
| ___ Numb/Tingling legs, feet, toes | | ___ Allergies | ___ Trouble Sleeping | ___ Hepatitis (A,B,C) |

## CONSENT TO XRAY

I hereby grant Complete Chiropractic Life Center permission to perform an x-ray evaluation, if needed. I understand x-rays are being performed to locate vertebral subluxation and not to diagnose or treat any other disease or condition.

Signature_____ Date_____

**FEMALES ONLY:** *Please read carefully, check the boxes, include the appropriate date, then sign below if you understand and have no further questions, otherwise see our front desk staff for further explanation.*

☐ The first day of my last menstrual cycle was on ____-____-____ (Date) ☐ To the best of my knowledge, I am not pregnant.

By my signature below, I am acknowledging that the doctor and or a member of the staff has discussed the effects of xray to an unborn child, and I have conveyed my understanding of the risks associated with exposure to x-rays. After careful consideration, I therefore do hereby consent to have the diagnostic x-ray examination the doctor has deemed necessary in my case.

Signature/Parent (if minor)_____ Date_____

Physician's Signature_____ Date_____

## POLICIES

1. Our normal fee for your first visit is $165, which includes an exam, digital scans, and x-rays, and is due at the time of service, unless other arrangements have been made.
2. The fee paid for treatment x-rays is for analysis only. X-rays are the property of this office and are used for treatment purposes. (A copy of your x-rays may be requested for a $20 fee.)
3. I understand and agree that if I suspend or terminate my care at this clinic, any outstanding charges for professional services rendered to me will be immediately due and payable. I agree that I will be responsible for all attorney and legal fees if legal action becomes necessary to collect this account. Intials_____

## TERMS OF ACCEPTANCE

When a person seeks chiropractic and rehabilitation health care and is accepted for such care, it is essential for both parties to be working towards the same objective. As a Chiropractic facility we have one main goal, to detect and correct/reduce the vertebral subluxation complex. It is important that each person understand both the objective and the method that will be used to attain this goal. This will prevent any confusion or disappointment.

**Adjustment:** An adjustment is the specific application of forces to facilitate the body's correction of vertebral subluxation. Our chiropractic method is by specific adjustments of the spine.

**Health:** A state of optimal physical, mental and social well-being, not merely the absence of disease or infirmity.

**Vertebral Subluxation:** A misalignment of one or more of the 24 vertebrae in the spinal column which causes alteration of nerve function and interference to the transmission of mental impulses, resulting in a lessening of the body's innate ability to express its maximum health potential.

We do not offer to diagnose or treat a disease or condition other than vertebral subluxation. Regardless of what a disease is called, we do not offer to treat it. Nor do we offer advice regarding treatment prescribed by others. **Our Only Practice Objective** is to eliminate a major interference to the expression of the body's innate wisdom and ability to heal. Our only method is specific adjusting to correct vertebral subluxations combined with the rehabilitation process. Intials_____

## INSURANCE

I clearly understand that I must provide a copy of any insurance I have, whether or not I plan to utilize that insurance, and will provide updated insurance information as it arises. I hereby authorize Complete Chiropractic Life Center to release necessary information to my insurance to obtain the information needed to provide a Good Faith Estimate for the cost of my care, including, but not limited to: name, date of birth, address, benefits summary, coverage limits, expenses paid towards deductibles/coinsurance, and submission of diagnosis and services provided in order to process claims. I understand that all insurance coverage is an arrangement between my insurance carrier and me, and that you will do your best to estimate the cost of my care based on my specific care plan and needs, and that you will provide that information to me before starting my care plan. If this office chooses to bill any services to my insurance carrier they are performing these services strictly as a convenience for me. This office will provide any necessary report or required information to aid in insurance reimbursement of services, but I understand that insurance carriers may deny any claim and that I am ultimately held responsible for any unpaid balances. Any monies received will be credited to my account. I understand that I am responsible for all fees incurred for the services provided, and agree to ensure full payment of all charges. I further understand that a fee for services rendered will be charged and that I am responsible for this fee whether results are obtained or not. Intials_____

## INFORMED CONSENT REGARDING: Chiropractic Adjustments, Modalities, and Therapeutic Procedures

I do hereby authorize the Doctors of Complete Chiropractic Life Center to administer such care that is necessary for my particular case. This care may include consultation, examination, spinal adjustments and other Chiropractic procedures, including various modes of spinal therapy and diagnostic x-rays or any other procedure that is advisable, and necessary for my health care.

Furthermore, I authorize and agree to allow the Doctor of Chiropractic and/or other licensed Doctors of Chiropractic who now or in the future treat me while employed by, working or associated with or serving as back-up for the Doctor of Chiropractic, including those working at the clinic or office listed below, to work with my spine through the use of spinal adjustments and rehabilitative exercises for the sole purpose of postural and structural restoration to allow for normal biomechanical motion and neurological function.

I have been advised that chiropractic care, like all forms of health care, holds certain risks. While the risks are most often minimal, complications such as sprain/strain injuries, irritation of a disc condition, dislocations of joints, and although very rare, fractures, and possible stroke have been associated with chiropractic adjustments. I do not expect the Doctor to be able to anticipate and explain all risks and complications, and I wish to rely on the Doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known, is in my best interests. The Doctor 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 treated at this clinic.

I also clearly understand that if I do not follow the Doctor's specific recommendations at this clinic that I will not receive the full benefit from the programs offered, 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 to be directed to Complete Chiropractic for all services rendered. I also understand any sum of money paid under assignment by any insurance company shall be credited to my account, and I shall be personally liable for any and all of the unpaid balance to Complete Chiropractic.

Treatment objectives, as well as the risks associated with chiropractic adjustments and all other procedures provided at Complete Chiropractic Life Center have been explained to me to my satisfaction and I have conveyed my understanding of both to the doctor. I have had the opportunity to ask questions about this consent, and by signing below I agree to the above- named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future conditions(s) for which I seek treatment. After careful consideration, I do hereby consent to treatment by any means, method, and or techniques, the doctor deems necessary to treat my condition at any time throughout the entire clinical course of my care.

Signature_____ Date _____ *(If under age 18) Parent's Signature*

# Health Information Portability and Accountability Act of 1966 (HIPAA)

I, _____, hereby authorize Complete Chiropractic Life Center to discuss with and/or release information to the following people concerning my appointments, insurance, billing, and health treatment rendered.

- ⚪ Spouse Name: _____
- ⚪ Significant Other Name: _____
- ⚪ Parent/Legal Guardian Name: _____
- ⚪ Child(ren) Name(s): _____
- ⚪ Any Specified Person Name: _____
- ⚪ My insurance carrier on file.
- ⚪ Information is not to be discussed with or released to anyone.

**Restrictions:**

- ⚪ No Restrictions
- ⚪ Only discuss my appointment time with the above-named individual(s).
- ⚪ Only discuss issues concerning my account, including insurance and/or billing with the above-named individual(s).
- ⚪ Only discuss the health treatment rendered to me with the above-named individual(s).

**Messages:**

Please call ⚪ my home ⚪ my work ⚪ my cell phone
Phone Number: _____ - _____ - _____

If unable to reach me:

- ⚪ you may leave a detailed message
- ⚪ please leave a message asking me to return your call
- ⚪ _____

I understand I may terminate this consent at any time by giving written notice to the Complete Chiropractic Life Center. Any changes to this form will require a new consent form to be completed, signed, and dated.

Signature: _____ Date: _____

*(If your care is related to a Workers Compensation Claim, a Motor Vehicle Accident, a Personal Injury Claim, or an attorney will be involved in payment of your care, please ask the front desk for an additional disclosure form to be completed in relation to sharing information with a specific person or entity.)*

Effective Date: _____ Complete Chiropractic Life Center Notice of Privacy Practices

**Complete Chiropractic Life Center** **Kara Vellaccio, Office Manager**
**5225 Cleveland Road, Suite A** **Phone 330-345-3336**
**Wooster, Ohio 44691** **kara@completechirolife.com**

This office is required, by law, to maintain the privacy and security of your Protected Health Information. We must provide you with written notice concerning your rights to your health information, and the potential circumstances under which, by law, or as dictated by our office policy, we are permitted to use and disclose information about you to a third party without your authorization. Below is a brief summary of these circumstances. If you would like a more detailed explanation, one will be provided to you. Please review carefully, sign receipt of acknowledgement, and return to our front desk staff. Keep this page for your records.

***YOUR RIGHTS:***

1. To inspect or obtain a copy of your records within 15 days of your request. We may charge a reasonable, cost-based fee for a copy. X rays are original records, and you are therefore not entitled to them. If you would like us to outsource them to have copies made, we will be happy to accommodate you. However, you will be responsible for this cost.
2. To ask for amendments to your health information you think is incomplete or incorrect. We may say "no" to your request, but we'll tell you why in writing within 60 days.
3. To request confidential communications (contact you in a specific way or send mail to a different address). 4. To request restrictions on certain uses and disclosures, and with whom we release information to, although we are not required to comply. If we do agree, the restriction is in place until receiving written notice of your intent to remove the restriction. 5. To receive an accounting of disclosures (those with whom we've shared your information).
6. To receive a paper copy of the extended detail Notice of Privacy Practices.
7. To choose someone to act for you. If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
8. To file a complaint if you feel your rights are violated

***USES AND DISCLOSURES:***

1. Treatment purposes - use your health information and share it with other health care providers who are treating you.
2. Run our organization - use and share your health information to run our practice, improve your care, and contact you when necessary.
3. Bill for your services - use and share your health information to bill and get payment from health plans or other entities.
4. Inadvertent disclosures – an open treating area means open discussion. If you need to speak privately with the doctor, please let our staff know so we can place you in a private room.
5. Help with public health and safety issues - in order to prevent or lessen a serious or imminent threat to the health or safety of a person or general public.
6. For health research purposes.
7. Comply with the law - share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.
8. Work with a medical examiner or funeral director - share health information with a coroner, medical examiner, or funeral director in the event of a patient's death.
9. For workers' compensation claims, law enforcement purposes or with a law enforcement official, and other government requests – including health oversight agencies for activities authorized by law, special government functions such as military, national security, and presidential protective services.
10. Respond to lawsuits and legal actions - share health information about you in response to a court or administrative order, or in response to a subpoena.
11. Emergency – in the event of a medical emergency we may notify a family member.
12. Phone calls and/or emails – we may call your home and leave messages regarding appointment reminders or apprise you of changes in practice hours or upcoming events.
13. Change of ownership - in the event this practice is sold your health information will become the property of the new owner. You maintain the right to request copies of your health information be transferred to another provider.

***COMPLAINT:***

If you wish to make a complaint about how we handle your health information, please contact our privacy official using the information noted above. If you are still not satisfied with the manner in which this office handles your complaint, you can submit a formal complaint to:

U.S. Dept. of Health and Human Services, Office of Civil Rights , 200 Independence Avenue, SW, Washington DC 20201, 877-696-6775
www.hhs.gov/ocr/privacy/hipaa/complaints/

**ACKNOWLEDGEMENT OF PRIVACY NOTICE**

- I hereby acknowledge I have read and received a copy of Complete Chiropractic Life Center's Privacy Practices Notice.
- I understand my rights as well as the practice's duty to protect my health information, and have conveyed my understanding of these rights and duties to the doctor. I further understand that this office reserves the right to amend this "Notice of Privacy Practices" at any time in the future and will make the new provisions effective for all information that it maintains past and present.
- I am aware the practice will not use or share my information other than as described here unless I have provided written authorization stating otherwise. I understand I may change my mind at any time by providing written notification to the practice.
- I am aware an extended detailed version of this "Notice" is available to me upon request.
- At this time, I do not have any questions regarding my rights or any of the information I have received.

Signature: _____ Date:_____

Printed Name: _____Phone:_____

If not signed by the patient, please indicate relationship:

_____Parent/Guardian of minor patient _____Guardian/Conservator of an incompetent patient _____Benificiary/personal representative of deceased patient

**For Office Use Only**

Signed form received by:_____

Reason Acknowledgement not obtained:_____

Efforts to obtain:_____

## QUADRUPLE VISUAL ANALOGUE SCALE

Patient Name _____ Date _____

**Please read carefully:**

**Instructions:** Please circle the number that best describes the question being asked.

**Note:** If you have more than one complaint, please answer each question for each individual complaint and indicate the score for each complaint. Please indicate your pain level right now, average pain, and pain at its best and worst.

**Example:**

Headache Neck Low Back

**No pain** _____ **worst possible pain**

**0 1 (2) 3 4 (5) 6 7 (8) 9 10**

---

**1 – What is your pain RIGHT NOW?**

**No pain** _____ **worst possible pain**

**0 1 2 3 4 5 6 7 8 9 10**

**2 – What is your TYPICAL or AVERAGE pain?**

**No pain** _____ **worst possible pain**

**0 1 2 3 4 5 6 7 8 9 10**

**3 – What is your pain level AT ITS BEST (How close to "0" does your pain get at its best)?**

**No pain** _____ **worst possible pain**

**0 1 2 3 4 5 6 7 8 9 10**

**4 – What is your pain level AT ITS WORST (How close to "10" does your pain get at its worst)?**

**No pain** _____ **worst possible pain**

**0 1 2 3 4 5 6 7 8 9 10**

**OTHER COMMENTS:**

_____

_____

_____

Examiner

Reprinted from *Spine*, 18, Von Korff M, Deyo RA, Cherkin D, Barlow SF, Back pain in primary care: Outcomes at 1 year, 855-862, 1993, with permission from Elsevier Science.

Complete Chiropractic Life Center
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