Spine and Sports Rehabilitation
Pain Management

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Patient Profile

Personal Information

Full Name: ____
Last *First* *M.I.* *Jr / Sr*

Address: ____
Street Address *Apartment/Unit #*

____
City *State* *ZIP Code*

Primary Phone: ______________ H / M / B **Alternate Phone:** ______________ H / M / B

Birth Date: ____ / ____ / ____

Social Security Number #: ____ - ____ - ____

Gender: ☐ Male ☐ Female

Race: ☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American
☐ Native Hawaiian or Other Pacific Islander ☐ White ☐ Declined ☐ Unknown/Unavailable
☐ Other ______________________________

Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Declined ☐ Unknown/Unavailable

Prim. Language: ☐ Arabic ☐ Chinese ☐ English ☐ French ☐ German ☐ Greek ☐ Hebrew ☐ Italian
☐ Japanese ☐ Korean ☐ Spanish ☐ Vietnamese ☐ Declined ☐ Unknown/Unavailable
☐ Other ______________________________

Email Address: ______________________________

Emergency Contact: ______________________ **Emergency Contact Phone:** ______________________

Time Zone: ______________________________

Does your time zone participate in Daylight Savings Time? ☐ Yes ☐ No

Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced

Do you have any dependents? ☐ Yes ☐ No

Are you a full-time student? ☐ Yes ☐ No

Health Insurance? ☐ Yes ☐ No

Responsible Party: ☐ You ☐ Other (parent, spouse, etc.) ______________________________

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Patient: ____________________

Chief Complaint Form

Chief Complaint

Case Title: ____________________

Describe the reason for your visit: ____________________

When did your symptoms begin? (select one)

☐ Today ☐ This Week ☐ Within last 3 months
☐ 3 months to 6 months ☐ 6 months to one year ☐ More than one year

For Women Only: Most recent menstrual cycle: ___/___/___

Are you pregnant? ☐ Yes ☐ No

Which word describes the frequency of your discomfort? (select one)

☐ Constant ☐ Intermittent ☐ Occasional ☐ Rare

Which phrases best describe *changes* in your discomfort during the day? (select one or more)

☐ It is worse in the morning ☐ It is worse in the afternoon ☐ It is worse at night
☐ It changes with the weather ☐ It does not change

What helps *relieve* your discomfort? (select one or more)

☐ Ice ☐ Heat ☐ Medication ☐ Other (please describe) ____________

What activities are limited by your discomfort? (select one or more)

☐ Bending ☐ Bowel Movements ☐ Coughing ☐ Daily Routine
☐ Driving ☐ Getting Up ☐ Lifting ☐ Lying Down
☐ Pulling ☐ Pushing ☐ Reading ☐ Sitting
☐ Sleeping ☐ Sneezing ☐ Standing ☐ Turning my head
☐ Urination ☐ Walking ☐ Working ☐ Other (please describe) ____________

Where applicable, specify the approximate date of your most recent: (month / year)

Physical Exam: ___/___ Dental X-rays: ___/___
Spinal X-ray: ___/___ CT Scan: ___/___
MRI: ___/___ Other Scans or X-rays: ___/___

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Review of Systems/Medical and Family History Update

Patient Name: ______________________ Date: ______________

Required questions for insurance compliance

Do you have an advance directive? .... no yes
Are you a victim of violence or abuse? .... no yes
Had a flu shot this year? .... no yes
Had a pneumonia shot? .... no yes

NAME OF PRIMARY CARE PROVIDER (for correspondence): ______________________

HAVE YOU OR MEMBERS OF YOUR FAMILY RECENTLY BEEN HOSPITALIZED FOR ANY REASON? NO YES

PLEASE INDICATE BELOW. ARE YOU CURRENTLY EXPERIENCING ANY OF THESE SYMPTOMS:

General, constitutional

Good general health lately .... no yes
Recent weight change .... no yes
Fever .... no yes
Fatigue .... no yes

Eyes and vision

Eye disease or injury .... no yes
Wear glasses or contact lenses .... no yes
Blurred or double vision .... no yes
Glaucoma .... no yes

Ears, nose, throat

Hearing loss .... no yes
Ringing in the ears .... no yes
Earaches or drainage .... no yes
Sinus problems .... no yes
Nose bleeds .... no yes
Mouth sores .... no yes
Bleeding gums .... no yes
Bad breath or bad taste .... no yes
Sore throat or voice change .... no yes
Swollen glands in neck .... no yes

Heart and Cardiovascular

Heart trouble .... no yes
Chest pains .... no yes
Sudden heartbeat changes .... no yes
Swelling of feet, ankles, hands .... no yes

Respiratory

Frequent coughing .... no yes
Spitting up blood .... no yes
Shortness of breath .... no yes
Asthma or wheezing .... no yes

Gastrointestinal

Loss of appetite .... no yes
Change in bowel movements .... no yes
Nausea or vomiting .... no yes
Frequent diarrhea .... no yes
Painful bowel movements or constipation .... no yes
Blood in stool .... no yes
Stomach pain .... no yes

Genitourinary

Frequent urination .... no yes
Burning or painful urination .... no yes
Blood in urine .... no yes
Change in force or strain with urination .... no yes
Incontinence or dribbling .... no yes
Kidney stones .... no yes
Sexual difficulty .... no yes
Painful periods .... no yes
Irregular periods .... no yes
Vaginal discharge .... no yes

Musculoskeletal

Joint pain .... no yes
Joint stiffness or swelling .... no yes
Weakness of muscles/joints .... no yes
Muscle pain or cramps .... no yes
Back pain .... no yes
Cold extremities .... no yes
Difficulty in walking .... no yes

Skin and breasts

Rash or itching .... no yes
Change in skin color .... no yes
Change in hair or nails .... no yes
Varicose veins .... no yes
Breast pain .... no yes
Breast lump .... no yes
Breast discharge .... no yes

Neurological

Frequent or recurrent headaches .... no yes
Light headed or dizzy .... no yes
Convulsions or seizures .... no yes
Numbness or tingling sensations .... no yes
Tremors .... no yes
Paralysis .... no yes
Stroke .... no yes
Head injury .... no yes

Psychiatric

Memory loss or confusion .... no yes
Nervousness .... no yes
Depression .... no yes
Sleep problems .... no yes

Endocrine

Glandular or hormone problem .... no yes
Thyroid disease .... no yes
Diabetes .... no yes
Excessive thirst or urination .... no yes
Heat or cold intolerance .... no yes
Dry skin .... no yes
Change in hat or glove size .... no yes

Hematologic/Lymphatic

Slow to heal after cuts .... no yes
Easily bruise or bleed .... no yes
Amemia .... no yes
Phlebitis .... no yes
Transfusion .... no yes
Swollen glands .... no yes

If you have not had a hysterectomy, please give the date of your last menstrual period ______________

Patient sign here: ______________________

Physician/PA sign here: ______________________

FREDRIC V. PRICE, M.D or SHARON SAGINAW, PA-C

WORKER COMPENSATION INFORMATION

Date__________

PATIENT INFORMATION

Name__________ Birthdate__________ Soc. Sec.#__________

Address__________

Telephone__________ Occupation__________

EMPLOYER

Employer Name__________

Employer Address__________

Employer Telephone__________ Injury Verified By (For Office Use)__________

Contact Person__________

WORKER COMPENSATION CARRIER (FOR OFFICE USE)

Worker Compensation Carrier__________

Carrier Address__________

Carrier Phone Number__________ Coverage Verified by__________

Adjuster's Name__________ Claim Number__________

INJURY INFORMATION

Date of Injury__________ Time__________ ☐ AM ☐ PM

Place of Injury__________

Accident reported to employer? ☐ Yes ☐ No Name of person you reported accident to__________

Give full description of how accident happened__________

Have you lost time from work? ☐ Yes ☐ No How much?__________

Other doctors seen for this condition:

Doctor's Name__________ Diagnosis__________

Were X-Rays taken? ☐ Yes ☐ No Other Tests? ☐ Yes ☐ No

If yes, by whom? Please list test(s) and result(s)__________

Any previous Worker Compensation injuries? ☐ Yes ☐ No Date(s) of previous injuries__________

Describe previous Worker Compensation injuries__________

AUTHORIZATION

I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment in the event that my claim for Workers Compensation benefits is denied.

Patient's Signature__________ Date__________

#20141 – Medical Arts Press 1-800-328-2179

Authorization for Treatment, Release of information, Assignment of Benefits & Acknowledgement of Receipt of Notice of Privacy Practices, Financial Policy and/or Medicare Financial Responsibility Disclosure Release of Information & Consent for Treatment

PATIENT NAME:______________________________ DATE OF BIRTH:______________

Release of Information & Consent for Treatment

All information provided herein is true and correct. I am aware of my diagnosis and wish to receive treatment from **Spine and Sports Rehabilitation Pain Management** and permit its employees and all other persons caring for me to treatment they judge are beneficial to me. I consent to services and I understand, acknowledge and affirm that services may involve bodily contact and/or direct contact of a sensitive nature. I understand that this care can include an evaluation, testing and treatment. No guarantees have been made to me about the outcome of this care.

I give permission to **Spine and Sports Rehabilitation Pain Management** to release information, verbal and written, contained in my medical record, and other released information, to my insurance company, rehab curse, case manager, attorney, employer, school, related health care provider, assignees and/or beneficiaries, and all other relented person's as it relates to my treatment and/or payment for services provided. I authorize **Spine and Sports Rehabilitation Pain Management** to obtain medical records and/or professional information from my physician or other medical professional as it relates to my treatment the signature below certifies that I have read and understand the above information.

Initial__________

Assignment of Benefits

I authorize payment directly to **Spine and Sports Rehabilitation Pain Management** for services and to bill and release payment directly to **Spine and Sports Rehabilitation Pain Management** for any services provided, this is a direct assignment of my rights and benefits under this policy. A photocopy of this assignment shall be considered as effective and valid as the original.

Initial__________

Notice of Privacy Practices (HIPAA Acknowledgment/Consent)

I hereby acknowledge that I have been given the opportunity to receive and/or review the office Notice of Privacy Practices. In addition, I hereby consent to the use and disclosure of my personal health information for the purposes of treatment, payment and healthcare operations.

Initial__________

Payment Guarantee

I agree to pay **Spine and Sports Rehabilitation Pain Management** for the services provided to me or the party named above, if any law, such as Worker's Compensation, or insurance contract prohibits payment for these services, I will cooperate and assist in the provision of information, authorizations, releases, or any other type of information necessary to allow for speedy collection from my third-party payer, where the law or insurance contract does not prohibit payment by me, I acknowledge responsibility for all account balances. The Intake Verification of Benefits Form is only an explanation of coverage obtained from my insurance company and it is not a guarantee of coverage, I will be responsible for payment of services. I understand that my good faith payment may not be inclusive of all payments for which I am responsible, and I may be billed for any remaining balance. I further understand that this agreement is binding regardless of any legal transaction currently progress or initiated during or after the course of my treatments unless agreed to in writing by myself and a representative of **Spine and Sports Rehabilitation Pain Management**.

Initial__________

Financial Policy and/or Medicare Financial Responsibility Disclosure (Acknowledgment)

I hereby acknowledge that I have received a copy of the Financial Policy and/or Medicare Financial Responsibility.

Initial__________

Your Name & Address

Comprehensive Exam and Treatment Order

Patient's Name: ______________________ ID #: ____________ Date: __________

Date of Birth: _____/_____/_____ Age: _____ Sex: M F

☐ MM ☐ WC ☐ NF/PI ☐ MCR ☐ LIEN ☐ CASH

■ HISTORY OF PRESENT CONDITION(S)

____

____

____

____

____

■ PRIMARY and/or ASSOCIATED COMPLAINT(S) – Pain rating scale #1 - #10 with #10 being the worst pain

☐ Headache ☐ Right: ____________ ☐ Left: ____________

☐ Neck
☐ Right ☐ Pain ___ ☐ Pain Scale # ___ ☐ Numb ___
☐ Left ☐ Pain ___ ☐ Pain Scale # ___ ☐ Numb ___

☐ Trapezius
☐ Right ☐ Pain ___ ☐ Pain Scale # ___ ☐ Numb ___
☐ Left ☐ Pain ___ ☐ Pain Scale # ___ ☐ Numb ___

☐ Shoulder
☐ Right ☐ Pain ___ ☐ Pain Scale # ___ ☐ Numb ___
☐ Left ☐ Pain ___ ☐ Pain Scale # ___ ☐ Numb ___

☐ Elbow
☐ Right ☐ Pain ___ ☐ Pain Scale # ___ ☐ Numb ___
☐ Left ☐ Pain ___ ☐ Pain Scale # ___ ☐ Numb ___

☐ Wrist
☐ Right ☐ Pain ___ ☐ Pain Scale # ___ ☐ Numb ___
☐ Left ☐ Pain ___ ☐ Pain Scale # ___ ☐ Numb ___

☐ Hand
☐ Right ☐ Pain ___ ☐ Pain Scale # ___ ☐ Numb ___
☐ Left ☐ Pain ___ ☐ Pain Scale # ___ ☐ Numb ___

☐ Finger(s)
☐ Right ☐ Pain ___ ☐ Pain Scale # ___ ☐ Numb ___
☐ Left ☐ Pain ___ ☐ Pain Scale # ___ ☐ Numb ___
List Digits: ____________

☐ Mid-Back
☐ Right ☐ Pain ___ ☐ Pain Scale # ___ ☐ Numb ___
☐ Left ☐ Pain ___ ☐ Pain Scale # ___ ☐ Numb ___

☐ Low Back
☐ Right ☐ Pain ___ ☐ Pain Scale # ___ ☐ Numb ___
☐ Left ☐ Pain ___ ☐ Pain Scale # ___ ☐ Numb ___

☐ Buttocks
☐ Right ☐ Pain ___ ☐ Pain Scale # ___ ☐ Numb ___
☐ Left ☐ Pain ___ ☐ Pain Scale # ___ ☐ Numb ___

☐ Hip
☐ Right ☐ Pain ___ ☐ Pain Scale # ___ ☐ Numb ___
☐ Left ☐ Pain ___ ☐ Pain Scale # ___ ☐ Numb ___

☐ Knee
☐ Right ☐ Pain ___ ☐ Pain Scale # ___ ☐ Numb ___
☐ Left ☐ Pain ___ ☐ Pain Scale # ___ ☐ Numb ___

☐ Ankle
☐ Right ☐ Pain ___ ☐ Pain Scale # ___ ☐ Numb ___
☐ Left ☐ Pain ___ ☐ Pain Scale # ___ ☐ Numb ___

☐ Foot
☐ Right ☐ Pain ___ ☐ Pain Scale # ___ ☐ Numb ___
☐ Left ☐ Pain ___ ☐ Pain Scale # ___ ☐ Numb ___

☐ Toe(s)
☐ Right ☐ Pain ___ ☐ Pain Scale # ___ ☐ Numb ___
☐ Left ☐ Pain ___ ☐ Pain Scale # ___ ☐ Numb ___
List Digits: ____________

☐ Ant. Tragus (Pre-auricular)
☐ Right ☐ Pain ___ ☐ Pain Scale # ___ ☐ Click ___
☐ Left ☐ Pain ___ ☐ Pain Scale # ___ ☐ Click ___

☐ Weakness ☐ Right: ________ ☐ Left: ________
☐ UE: ________ ☐ LE: ________

☐ Coldness ☐ Right: ________ ☐ Left: ________
☐ UE: ________ ☐ LE: ________

☐ Burning ☐ Right: ________ ☐ Left: ________
☐ UE: ________ ☐ LE: ________

☐ Tingling ☐ Right: ________ ☐ Left: ________
☐ UE: ________ ☐ LE: ________

☐ Pain Radiating To ☐ Right: ________ ☐ Left: ________
☐ UE: ________ ☐ LE: ________

TBI/MTBI /PTSD

Symptom	Frequency
☐ Nausea	☐ (O)occasional ☐(S)sometimes ☐ (P)persistent
☐ Vomiting	☐ (O) ☐(S) ☐ (P)
☐ Disoriented	☐ (O) ☐(S) ☐ (P)
☐ Amnesia	☐ (O) ☐(S) ☐ (P)
☐ Irritability	☐ (O) ☐(S) ☐ (P)
☐ Lethargy	☐ (O) ☐(S) ☐ (P)
☐ Cognitive Changes	☐ (O) ☐(S) ☐ (P)
☐ Vision Blurred	☐ (O) ☐(S) ☐ (P)
☐ Altered Breathing	☐ (O) ☐(S) ☐ (P)
☐ Loss of Consciousness	☐ (O) ☐(S) ☐ (P)
☐ Headache	☐ (O) ☐(S) ☐ (P)
☐ Migraine	☐ (O) ☐(S) ☐ (P)
☐ Personality Changes	☐ (O) ☐(S) ☐ (P)
☐ Ataxia/Walking Difficulty	☐ (O) ☐(S) ☐ (P)
☐ Deviated Gaze / Eye Movement	☐ (O) ☐(S) ☐ (P)
☐ Ringing in Ears	☐ (O) ☐(S) ☐ (P)
☐ Light Sensitivity	☐ (O) ☐(S) ☐ (P)
☐ Balance	☐ (O) ☐(S) ☐ (P)

TBI = Traumatic Brain Injury MTBI = Mild Traumatic Brain Injury
PTSD = Post Traumatic Stress Disorder

SEXUAL RELATIONS

☐ No Change ☐ Painful/ Limited ☐ Unable due to pain

Other ______________________

____

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Patient's Name: ______________________ ID #: ______________ Date: ______________

■ ALLERGIES ☐ No Allergies ☐ Allergic To:

____

____

■ MEDICATION ☐ Patient Denies Taking Any Medication ☐ Medications Taken: (include non-prescription)

____

____

■ REVIEW OF SYSTEMS

CONSTITUTIONAL: ☐ No weight loss, fever, chills, weakness or fatigue. ☐ Other ______________

HEENT: ☐ No visual loss, blurred vision, double vision or yellow sclera. ☐ No hearing loss, sneezing, congestion, runny nose or sore throat.

SKIN: ☐No rash or itching. ☐ Other ______________

CARDIOVASCULAR: ☐ No chest pain, chest pressure or chest discomfort. No palpitations or edema. ☐Other ______________

RESPIRATORY: ☐ No shortness of breath, cough or sputum ☐ Other ______________

GASTROINTESTINAL: No anorexia, nausea, vomiting or diarrhea. No abdominal pain or blood.

GENITOURINARY: ☐Burning on urination. Pregnancy. Last menstrual period, __________. ☐ Other ______________

NEUROLOGICAL: ☐ No headache, dizziness, syncope, paralysis, ataxia, numbness or tingling in the extremities. No change in bowel or bladder control ☐ Other ______________

MUSCULOSKELETAL: ☐ No muscle, back pain, joint pain or stiffness ☐ Other ______________

HEMATOLOGIC: ☐No anemia, bleeding or bruising ☐ Other ______________

LYMPHATICS: ☐ No enlarged nodes. No history of splenectomy ☐ Other ______________

PSYCHIATRIC: ☐ No history of depression or anxiety ☐ Other ______________

ENDOCRINOLOGIC: ☐ No reports of sweating, cold or heat intolerance. ☐ No polyuria or polydipsia ☐ Other ______________

ALLERGIES: ☐ No history of asthma, hives, eczema or rhinitis ☐ Other ______________

■ RESULTS OF PREVIOUS TREATMENT & TESTS PERFORMED ☐ None (include last date of treatment)

____

____

■ SOCIAL/FAMILY MEDICAL HISTORY (M=Mother, F=Father S= Sibling)

☐ Heart Disease __ ☐ Stroke __ ☐ Circulatory Disorder __ ☐ Blood Pressure __ ☐ Diabetes __ ☐ Other:

☐ Denies Smoking, Alcohol or Drug Abuse ☐ Smoker # of packs /day _____ ☐ History of drug abuse

☐ Alcohol Consumption # of glasses per day ____ ☐ Recovering Alcoholic ☐ Other: ______________

■ HISTORY OF PRE-EXISTING ILLNESSES (include last date of treatment)

____

____

■ WORKER'S COMPENSATION QUESTIONS

Date of Injury: ______________ Time: ______________ AM/PM

Location (City and state where injury occurred): ______________

Did patient go to the hospital? ☐ Yes ☐ No Via: ☐ Ambulance ☐ Other (Indicate): ______________

Did patient suffer any cuts or contusions? ☐ Yes ☐ No (Describe) ______________

Is the patient working at the present time? ☐ Yes ☐ No Date last worked: ______________

Has the patient missed any time from work? ☐ Yes ☐ No Dates: ______________

At work patient is required to (in hours): Stand: Drive: Walk: Lift: Sit: Type: Other (Describe):

What limitations does patient experience as a result of the injury? (circle affected area(s) below):

Standing Driving Walking Lifting Sitting Typing Other (Describe):

Further describe limitations: ______________

Patient's Name: ______________________ ID #: ______________ Date: ______________

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Patient's Name: ______________________ ID #: ______________ Date: __________

■ PERSONAL INJURY QUESTIONS

Date of Injury: Time: AM/PM

Was patient: □ Driver □ Passenger □ Front Seat □ Rear Seat □ Pedestrian □ Other

Was patient wearing seat belt? □ Yes □ No Did airbag deploy? □ Yes □ No

Area of impact: □ Front □ Rear □ Passenger side □ Driver Side □ Other (Describe)

Did patient go to the hospital or Urgent Care? □ Yes □ No Via: □ Ambulance □ Other (Indicate):

Did patient suffer any cuts or contusions? □ Yes □ No (Describe)

X-rays taken? □ Yes □ No Region(s)

Fractures? □ Yes □ No Region(s)/Location(s)

Is the patient working at the present time? □ Yes □ No Date last worked:

Has the patient missed any time from work? □ Yes □ No Dates:

At work patient is required to (in hours): Stand: Drive: Walk: Lift: Sit: Type: Other (Describe):

What limitations does patient experience as a result of the injury? (circle affected area(s) below):

Standing Driving Walking Lifting Sitting Typing Other (Describe):

Further describe limitations:

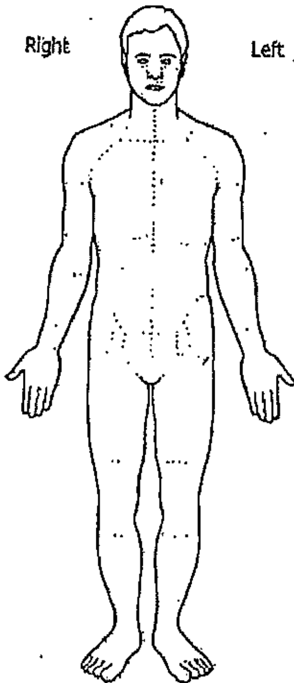
NAME: ______________________________

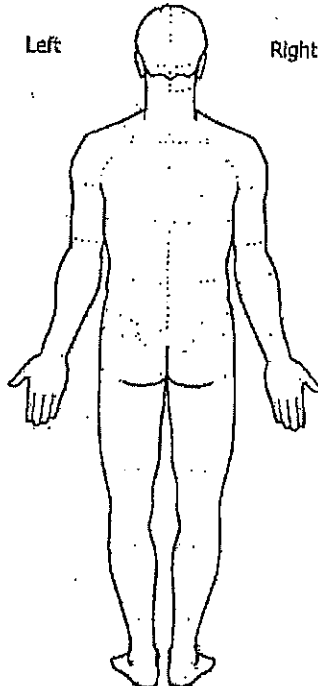
PLEASE COMPLETE THE FOLLOWING "PAIN DIAGRAM" BY USING LETTERS AT THE LEFT TO INDICATE ON THE DIAGRAM YOUR AREAS OF PAIN:

PAIN (P) TINGLING (T) BURNING (B) STIFFNESS (S) NUMBNESS (N)

Patient Symptom Illustrator

Patient Symptom Illustrator





Instructions:

1. Identify your areas of discomfort by marking the affected body parts in the illustration.
2. Indicate the area name along with your specific symptoms associated with each selected area.
3. Rate your discomfort associated with each selected area.

	Area	Burning	Dull Ache	Sharp Stabbing	Throbbing	Numbness	Pins and Needles	Spasm	Swelling	Stiffness	0 = No Discomfort 10 = Severe Discomfort
Ex.	L (R) Lower Back			X			X			X	X
1.	L R										
2.	L R										
3.	L R										
4.	L R										

PATIENT SIGNATURE ______________________________ DATE ______________

BACK BOURNEMOUTH QUESTIONNAIRE

Patient Name ____________________ Date ____________

Instructions: The following scales have been designed to find out about your back pain and how it is affecting you. Please answer ALL the scales, and mark the ONE number on EACH scale that best describes how you feel.

1. Over the past week, on average, how would you rate your back pain?

No pain — Worst pain possible

0 1 2 3 4 5 6 7 8 9 10

2. Over the past week, how much has your back pain interfered with your daily activities (housework, washing, dressing, walking, climbing stairs, getting in/out of bed/chair)?

No interference — Unable to carry out activity

0 1 2 3 4 5 6 7 8 9 10

3. Over the past week, how much has your back pain interfered with your ability to take part in recreational, social, and family activities?

No interference — Unable to carry out activity

0 1 2 3 4 5 6 7 8 9 10

4. Over the past week, how anxious (tense, uptight, irritable, difficulty in concentrating/relaxing) have you been feeling?

Not at all anxious — Extremely anxious

0 1 2 3 4 5 6 7 8 9 10

5. Over the past week, how depressed (down-in-the-dumps, sad, in low spirits, pessimistic, unhappy) have you been feeling?

Not at all depressed — Extremely depressed

0 1 2 3 4 5 6 7 8 9 10

6. Over the past week, how have you felt your work (both inside and outside the home) has affected (or would affect) your back pain?

Have made it no worse — Have made it much worse

0 1 2 3 4 5 6 7 8 9 10

7. Over the past week, how much have you been able to control (reduce/help) your back pain on your own?

Completely control it — No control whatsoever

0 1 2 3 4 5 6 7 8 9 10

____________________ Examiner

OTHER COMMENTS: ____________________

With Permission from: Bolton JE, Breen AC: The Bournemouth Questionnaire: A Short-form Comprehensive Outcome Measure. I. Psychometric Properties in Back Pain Patients. *JMPT* 1999; 22 (9): 503-510.

NECK BOURNEMOUTH QUESTIONNAIRE

Patient Name ____________________ Date ____________

Instructions: The following scales have been designed to find out about your neck pain and how it is affecting you. Please answer ALL the scales, and mark the ONE number on EACH scale that best describes how you feel.

1. Over the past week, on average, how would you rate your neck pain?

No pain — Worst pain possible

0 1 2 3 4 5 6 7 8 9 10

2. Over the past week, how much has your neck pain interfered with your daily activities (housework, washing, dressing, lifting, reading, driving)?

No interference — Unable to carry out activity

0 1 2 3 4 5 6 7 8 9 10

3. Over the past week, how much has your neck pain interfered with your ability to take part in recreational, social, and family activities?

No interference — Unable to carry out activity

0 1 2 3 4 5 6 7 8 9 10

4. Over the past week, how anxious (tense, uptight, irritable, difficulty in concentrating/relaxing) have you been feeling?

Not at all anxious — Extremely anxious

0 1 2 3 4 5 6 7 8 9 10

5. Over the past week, how depressed (down-in-the-dumps, sad, in low spirits, pessimistic, unhappy) have you been feeling?

Not at all depressed — Extremely depressed

0 1 2 3 4 5 6 7 8 9 10

6. Over the past week, how have you felt your work (both inside and outside the home) has affected (or would affect) your neck pain?

Have made it no worse — Have made it much worse

0 1 2 3 4 5 6 7 8 9 10

7. Over the past week, how much have you been able to control (reduce/help) your neck pain on your own?

Completely control it — No control whatsoever

0 1 2 3 4 5 6 7 8 9 10

____________________ Examiner

OTHER COMMENTS: ____________________

With Permission from: Bolton JE, Humphreys BK: The Bournemouth Questionnaire: A Short-form Comprehensive Outcome Measure. II. Psychometric Properties in Neck Pain Patients *JMPT* 2002; 25 (3): 141-148.