ROLAND F CHALIFOUX JR., D.O., PLLC
1001 W. BALTIMORE STREET
MCMECHEN,WV 26040
www.riversedgepainrelief.com
PHONE: 304-242-4004
FAX: 304-242-8004

Patient:_____ Appointment Date:_____

NEW PATIENT CHECKLIST

(X) Fill out all paper work in this packet.
(X) Read, review and sign **the pain contract.**
(X) Bring **a disc** (or films) with any and **all recent x-ray or MRI studies** to your visit.
(X) Bring your **current medications.**
(X) Bring contact information for all doctors, psychologists and surgeons that you currently see.
(X) Insurance card
(X) **VALID** Photo ID (drivers license/state ID, passport)
(X) Other_____
_____
_____

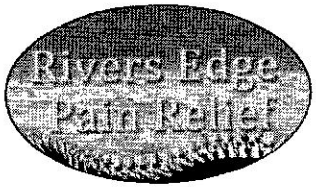
Welcome to Rivers Edge Pain Relief where we take a multidisciplinary approach to treating your pain. You can expect a combination of any of the following when it comes to your care plan.

1. Interventional pain procedures and injections.
2. Psychology referral to assist with chronic pain coping skills.
3. Physical therapy referral.
4. Medical management that includes random and scheduled urine testing and random pill counts.

****Please call if you cannot make your appointment. If you do not call or show, you will not receive another appointment and your physician will be notified of such.

We look forward to working with you and helping you to meet your health goals of less pain, improved function and improved quality of life.

See you soon!



ROLAND F CHALIFOUX JR., D.O., PLLC
1001 W. BALTIMORE STREET
MCMECHEN,WV 26040
www.riversedgepainrelief.com
PHONE: 304-242-4004
FAX: 304-242-8004

PERSONAL INFORMATION

NAME: _____ DATE OF BIRTH: _____ AGE: ____

ADDRESS: _____

CITY/STATE: _____ ZIP: _____

HOME : _____ CELL: _____ SS #: _____

EMAIL ADDRESS: _____

EMPLOYER INFORMATION

____EMPLOYED (___ PART-TIME OR ____FULL TIME) ____ UNEMPLOYED

EMPLOYER: _____ WORK #: _____

ADDRESS: _____ CITY/STATE: _____ ZIP: _____

REFERRING PHYSICIAN INFORMATION

REFERRING PHYSICIAN: _____

ADDRESS: _____

PHONE #: _____ FAX #: _____

INSURANCE INFORMATION

PRIMARY INSURANCE: _____

INSURANCE ADDRESS: _____

SUBSCRIBER: _____ DOB: _____

SOCIAL SEC. #: _____ PHONE #: _____

POLICY/ID #: _____ GROUP #: _____

SECONDARY INSURANCE: _____

ADDRESS: _____

POLICY/ID #: _____ GROUP #: _____

SUBSCRIBER: _____ DOB: _____

ROLAND F. CHALIFOUX JR., D.O., P.L.L.C.
RIVERS EDGE PAIN RELIEF
1001 W. BALTIMORE ST
MCMECHEN, WV 26040

Patient Medical History Questionnaire

Name:_____ Date:_____

Please complete as fully as possible. This questionnaire you are about to fill out is important to your doctor and will become part of your permeant health record. **ALL INFORMATION IS REGARDED AS CONFIDENTIAL**

Please circle answers yes or no

ILLNESS: Have you ever had:

Tuberculosis..... Yes No
Rheumatic Fever..... Yes No
Diabetes (sugar)..... Yes No
Pneumonia..... Yes No
High Blood Pressure..... Yes No
Thyroid Disease.....Yes No
Venereal Disease.....Yes No
Sinus infection.....Yes No
Gall Bladder Disease.....Yes No
Jaundice.....Yes No
Cancer.....Yes No
Nervous Breakdown.....Yes No
Hemorrhoids.....Yes No
Arthritis..... Yes No
Stomach ulcers..... Yes No
Recurrent headaches..... Yes No
Colitis..... Yes No
Asthma..... Yes No
Glaucoma..... Yes No
Anemia..... Yes No
Kidney Stones..... Yes No
Heart Trouble..... Yes No
Stroke..... Yes No
Lung Disease..... Yes No

Malaria..... Yes No
Scarlet Fever..... Yes No
HIV Positive, AIDS..... Yes No
Bladder infection..... Yes No
Tonsillitis..... Yes No
Eczema..... Yes No
Psoriasis..... Yes No
Recurrent sore throat..... Yes No
Electroshock therapy..... Yes No
Bone or joint disease.....Yes No
Kidney or bladder disease....Yes No
Unexplained weight loss.....Yes No
Convulsions (fits, epilepsy)..Yes No
Head or spinal injuries.....Yes No
Fainting spells.....Yes No
Gout..... Yes No
Heartburn..... Yes No
Shortness of breath..... Yes No
Persistent hoarseness..... Yes No
Meningitis..... Yes No
Liver problems..... Yes No
Prostate problems..... Yes No
Hepatitis..... Yes No
Colon infections..... Yes No

Any blood in bowel movement..... Yes No
Birth defects..... Yes No
Recurrent chest pains..... Yes No
Migraine headaches..... Yes No
Abnormal urinalysis..... Yes No
Extensive confinement by illness.....Yes No
Sleeping sickness.....Yes No
Syphilis..... Yes No
Genital Herpes.....Yes No
Chlamydia infection.....Yes No
Strep-throat.....Yes No
Bronchitis.....Yes No
Mononucleosis.....Yes No
Other_____

Ever had an electrocardiogram?..... Yes No

Ever had blood test for Venereal Disease?..... Yes No

Have you ever considered suicide?..... Yes No

DO YOU OR NOW OR HAVE YOU HAD WITHIN THE PAST YEAR:

Change in size, shape, color or texture of bowel movement.. Yes No
Pain on urination..... Yes No
Difficulty starting urination..... Yes No
Frequent urination..... Yes No
Any blood in urine..... Yes No
Any blood in bowel movement. Yes No
Loss of urine on coughing or sneezing..... Yes No
Persistent joint pain or swelling Yes No

Muscle spasms..... Yes No
Hot Flashes..... Yes No
Tiredness, fatigue, weakness without apparent reason..... Yes No
Wary bruising.....Yes No
Fainting Spells..... Yes No
Discharge from ears..... Yes No
Difficulty swallowing..... Yes No
Enlarged glands..... Yes No
Chest pains..... Yes No

Coughed up blood..... Yes No
Night Sweats..... Yes No
Wake up at night short of breath..... Yes No
Swelling of hands, feet, ankles..... Yes No
Leg Cramps..... Yes No
Purple lips or fingers..... Yes No
Vomited blood..... Yes No
Sores around sexual organs..... Yes No
Persistent nose bleeds..... Yes No

WOMEN ONLY;

Menstrual cycle regular..... Yes No
Normal menstrual flow..... Yes No
Any clots past..... Yes No
Pains or cramps during period...Yes No
Date of last period_____
Age period started_____
Date of last pelvic exam_____
Date of last Pap smear_____
Negative ___ Positive___

Any vaginal discharge..... Yes No
Any itching of vaginal area..Yes No
Do you take birth control pills Yes No
Any in between period spotting Yes No
Any pain during intercourse.... Yes No

Are you currently pregnant..... Yes No
Pregnancies_____ Children_____
Miscarriages_____ Abortions_____
Cesarean Sections_____
Multiple Births_____
Breech Deliveries_____

Please give additional information on any difficult pregnancy, delivery complications, and/or menstrual problems:_____

ALLERGIES

Penicillin	Yes	No
Aspirin	Yes	No
Codeine	Yes	No
Morphine	Yes	No
Demerol	Yes	No
Mycins	Yes	No
Tetracycline	Yes	No
Darvon	Yes	No
Tetanus shot	Yes	No
Sedatives	Yes	No
Sleeping pills	Yes	No
Asthma drugs	Yes	No
Sulfa	Yes	No
Local anesthetics	Yes	No
Any food allergy (To what?)	Yes	No
_____		
Any other drugs	Yes	No
Iodine	Yes	No

FRACTURES OR ACCIDENT INJURIES

Have you ever had:		
Broken or cracked bones	Yes	No
Where _____		
Severe lacerations	Yes	No
Where _____		
Dislocations	Yes	No
Where _____		
Concussion	Yes	No
When _____		
Head injury	Yes	No
When _____		
Ever been knocked unconscious	Yes	No

SOCIAL

Drug problem	Yes	No
Adequate dietary habits	Yes	No
Alcohol	Yes	No
How much? _____		
Tobacco	Yes	No
How much? _____		
Ever been treated for drug habits	Yes	No

Are you? Right-handed Left-handed Both

Height _____ Weight Now _____

1 yr. ago _____

What kind of work are you doing now?

_____

What was your occupation prior to this injury?

_____

Marital Status: M W S D

SURGERY: Have you ever had:

Prostate	Yes	No
Tonsillectomy	Yes	No
Appendectomy	Yes	No
Hysterectomy	Yes	No
Ovarian cysts	Yes	No
Breast Tumors, cysts	Yes	No
Ear surgery	Yes	No
Eye surgery	Yes	No
Gall bladder	Yes	No
Stomach	Yes	No
Hernia (rupture)	Yes	No
Hemorrhoids (piles)	Yes	No
Varicose veins	Yes	No
Neck surgery	Yes	No
Thyroid surgery	Yes	No
Nose surgery	Yes	No
Heart surgery	Yes	No
Wisdom teeth extractions	Yes	No
Any other operations	Yes	No
Type _____		
Type _____		
Blood transfusions	Yes	No

Have you ever been advised to have any surgery which has not been done? Yes No

Have you been hospitalized for any illnesses Yes No

Give details of yes answers: _____

_____

_____

IS THERE ANY FAMILY HISTORY OF THE FOLLOWING:

Cancer	Yes	No
Heart Trouble	Yes	No
Tuberculosis	Yes	No
Mental Health	Yes	No
High Blood Pressure	Yes	No
Stroke	Yes	No
Diabetes	Yes	No
Seizure	Yes	No
Muscle Disease	Yes	No

MEDICATIONS:

Are you now taking or have taken in the past either regularly or periodically?

Digitalis	Now	Past
Water or salt losers (Diuretics)	Now	Past
Birth Control Pills	Now	Past
Thyroid or Antithyroid	Now	Past
Anti-depressants	Now	Past
Tranquilizers	Now	Past
Allergy pills	Now	Past
Pep or diet pills	Now	Past
Blood thinner	Now	Past
Laxatives	Now	Past
Asthma medicine	Now	Past
Iron medicine	Now	Past
Aspirin	Now	Past
Nitroglycerin	Now	Past
Male Hormone	Now	Past
Female hormones	Now	Past
Sulfa Drugs	Now	Past
Antibiotics	Now	Past
Narcotic pain relievers	Now	Past
Vitamins	Now	Past
Cortisone	Now	Past
Allergy shots	Now	Past
Weight control pills	Now	Past
Cough medicine	Now	Past
Anticoagulants	Now	Past
Quinine	Now	Past
Other _____	Now	Past
_____	Now	Past
_____	Now	Past
_____	Now	Past

List all medication and dosages you are currently taking or bring list of all medications:

_____

_____

_____

_____

_____

_____

_____

VACCINATIONS, IMMUNIZATION AND/OR DISEASE:

INDICATE: V-Vaccination D-Disease

_____ Measles (3-day)	_____ Small Pox	_____ Hepatitis B	_____ Tetanus	_____ Chicken Pox
_____ Measles (10-day)	_____ Yellow Fever	_____ Mumps	_____ Pertussis	
_____ Polio	_____ Typhus Fever	_____ Diphtheria	_____ Typhoid	

Why are you here today? _____

_____

Date of onset? _____ Is your pain getting? Worse Better Remaining Constant

Where is your pain the worst? BACK NECK LEGS ARMS HEAD

What time of the day is your pain worse? _____

Circle what activities make the pain worse:

Exercise	Walking	Coughing	Sitting	Bending forward
Resting	Sneezing	Lying Down	Standing	Bending backward

Circle what reduces the pain:

Lying down	Manipulation	Muscle Relaxants	Walking
Sitting	Standing	Physical Therapy	Pain Pills

Does your pain keep you from the following?

Working	Exercising	Sleeping
Having Fun	Sports	No Limitations

Do you need to rest during the day due to your pain?

None A little Half the day Over half the day

Do you have? Numbness Where? _____

Weakness Where? _____

Do you have difficulty with? Bowel Bladder Sexual function (painful or unable)

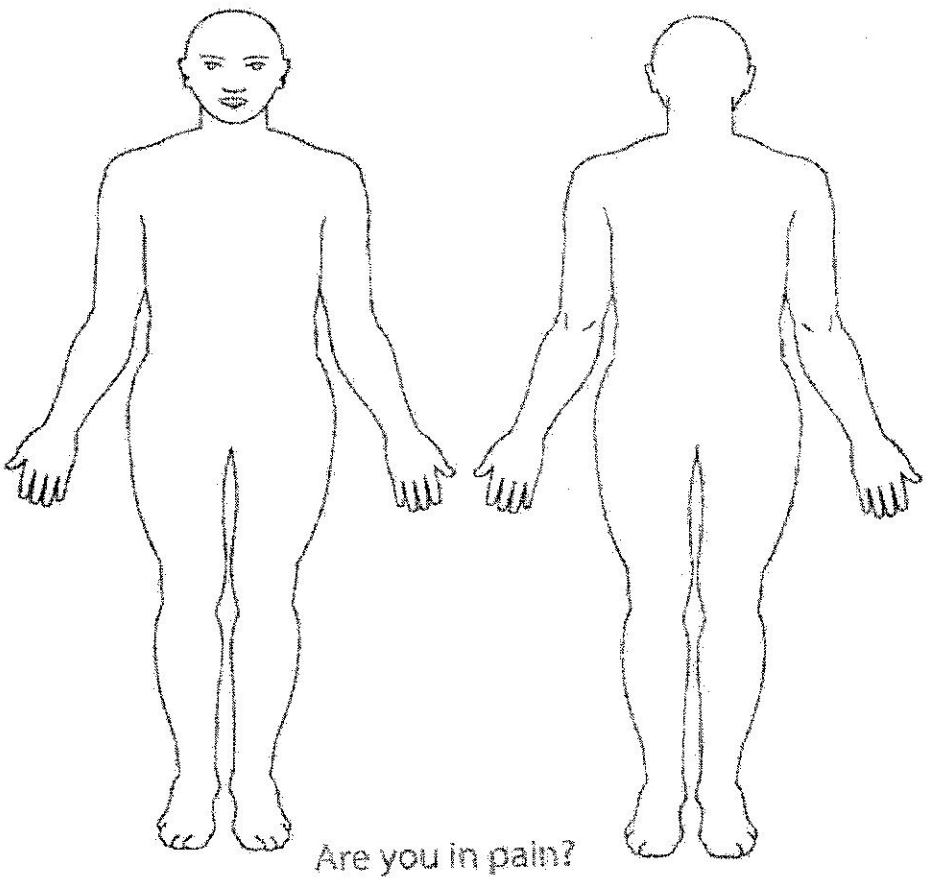
List doctors currently treating you for these problems:

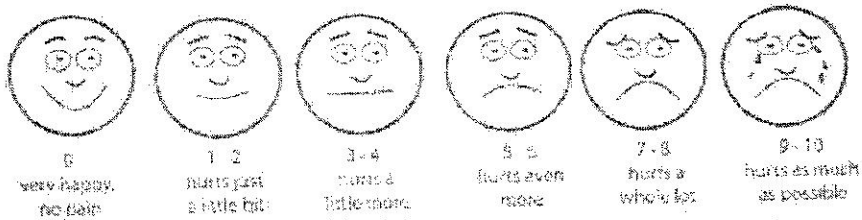
Use the body charts below and draw on them where you pain is located. Please use the following symbols to show what kind of pain you are having in these areas. At the bottom, estimate the severeness of your pain by circling on of the numbers. (1 would be no pain , and 10 would be intolerable pain.)

Ache	Burning
////	B B B
///	B B

Numbness	Pins & Needles
X X X	= = = =
X X	= = =

Stabbing	Other
Z Z Z	O O O
Z Z	O O





ROLAND F CHALIFOUX JR., D.O., PLLC
1001 W. BALTIMORE STREET
MCMECHEN,WV 26040
www.riversedgepainrelief.com
PHONE: 304-242-4004
FAX: 304-242-8004

PAIN MANAGEMENT AGREEMENT

Patient Name: _____ Date: _____

Opioid (narcotic) treatment for chronic pain is used to reduce pain and improve what you are able to do each day. Along with opioid treatment, other medical care will be prescribed to help improve your ability to do daily activities. This will include exercise, use of non-narcotic analgesics, physical therapy, psychological counseling or other therapies or treatment. Vocational counseling may be provided to assist your return to work effort.

I, _____, understand that compliance with the following guidelines is important in continuing pain treatment with Dr. Roland Chalifoux, Jr.

1. I understand that I have the following responsibilities:
   - **I will take medications only at the dose and frequency prescribed.**
   - **I will not increase or change medication without the approval of this doctor.**
   - **I will actively participate in Return to Work efforts and in any program designed to improve function. (including social, physical, psychological and daily or work activities)**
   - **I will not request opioids or any other pain medicine from physicians other than Dr. Chalifoux. Dr. Chalifoux will approve or prescribe all other mind and mood altering drugs.**
   - **I will inform Dr. Chalifoux of all medications that I am taking.**
   - **I will obtain all medications from one pharmacy. Full consent to talk with the pharmacist is given by signing this agreement.**
   - **I will protect my prescriptions and medications. Lost or stolen medicines will not be replaced.**
   - **I agree to participate in psychiatric or psychological assessments if prescribed by Dr. Chalifoux.**
   - **I will comply with requests to appear at Dr. Chalifoux's office for a pill count between scheduled visits.**
   - **I will being all medications to every visit and risk not being seen if I cannot produce medications when requested.**
   - **I understand that prescriptions will only be refilled during an office visit.**
   - **I will not use any illegal substances, including marijuana, cocaine, etc.**
   - **I will call the office as soon as possible if I feel my medication is not working or if I experience a problem.**
2. I understand that in the event of an emergency, Dr. Chalifoux should be contacted and the problem will be discussed with the emergency room or other treating physician. I am responsible

ROLAND F CHALIFOUX JR., D.O., PLLC
1001 W. BALTIMORE STREET
MCMECHEN,WV 26040
www.riversedgepainrelief.com
PHONE: 304-242-4004
FAX: 304-242-8004

for signing a consent to request record transfer to Dr. Chalifoux. **No more than 3 days of medication may be prescribed by the emergency room.**

3. I understand that I will consent to prescriptions monitoring. Monitoring involves a laboratory test in which a sample of my urine or blood is checked to see what drugs I have been taking a minimum of four times a year.
4. I will keep my scheduled appointments and/ or cancel my appointments a minimum of 24 hours prior to the appointment or will be assessed a charge of $150.00 for procedures and $50.00 for follow-up appointments.
5. I authorize the doctor and my pharmacy to cooperate fully with any city, state, or federal law enforcement agency, including the state's Board of Pharmacy, in the investigation of any possible misuse, sale or other diversions of my pain medicine. I authorize Dr. Chalifoux to provide a copy of this Agreement to any pharmacy. I agree to waive any applicable privilege to right of privacy or confidentiality with respect to these authorities.
6. I understand that Dr. Chalifoux may stop prescribing opioids or change the treatment plan if:
   - ❖ I do not should any improvement in pain from opioids or my physical activity has not improved.
   - ❖ I am inconsistent with the responsibilities outlines in #1 above.
   - ❖ I give, sell, or misuse the opioid medications.
   - ❖ I develop rapid tolerance or loss of improvement from the treatment.
   - ❖ I obtain opioids, mind or mood altering drugs from another physician.
   - ❖ I have an addiction problem identified as a result of prescribed treatment or any other addictive substance.
   - ❖ I am unable to keep follow- up appointments.

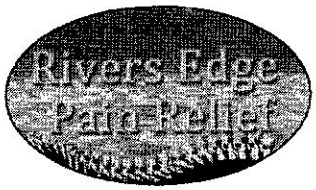
I agree to follow these guidelines that have been fully explained to me. All of my questions and concerns regarding treatment have been adequately answered.

My signature indicated that I have read and fully understand this document. Failure to follow this agreement will void it and will result in my discharge from Dr. Chalifoux's care.

_____ _____
Patient Signature Date

_____ _____
Physician Signature Date

_____ _____
Witness Signature Date



ROLAND F CHALIFOUX JR., D.O., PLLC
1001 W. BALTIMORE STREET
MCMECHEN,WV 26040
www.riversedgepainrelief.com
PHONE: 304-242-4004
FAX: 304-242-8004

Date:_____

Patient Name: _____ DOB:_____

To: Dr. _____ Fax:_____

Dear Doctor:

This letter is to inform you that your patient:

- ☐ Has been scheduled for an appointment on: _____
- ☐ Did not have proper paperwork and has been rescheduled to:_____
- ☐ Did not have photo ID and has been rescheduled to:_____
- ☐ Did not have Insurance card and has been rescheduled to:_____
- ☐ Did not show up for his/her initial appointment, we have destroyed their information and patient **will not** be rescheduled.
- ☐ Other:_____

_____

If you have any questions or if we can be of assistance please feel free to call our office.

Sincerely,

Rivers Edge Pain Relief Staff

ROLAND F CHALIFOUX JR., D.O., PLLC
1001 W. BALTIMORE STREET
MCMECHEN,WV 26040
www.riversedgepainrelief.com
PHONE: 304-242-4004
FAX: 304-242-8004

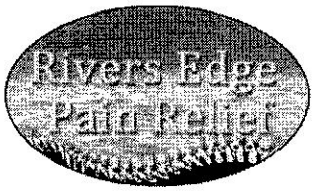
1001 W. Baltimore Street
McMechen, WV 26040

Located on WV Route 2

Take 12th Street McMechen Exit on river side

Cross the train tracks and make right

Our office is right next to Dollar General Store



ROLAND F CHALIFOUX JR., D.O., PLLC
1001 W. BALTIMORE STREET
MCMECHEN,WV 26040
www.riversedgepainrelief.com
PHONE: 304-242-4004
FAX: 304-242-8004

Receipt of Notice of Privacy Practice
Written Acknowledgement Form

I am a patient of Dr. Chalifoux. I hereby acknowledge receipt of Chalifoux's Notice of Privacy Practices.

Name (Please Print) _____

Signature _____

Date _____

RIVERS EDGE PAIN RELIEF

Roland F. Chalifoux Jr., D.O., PLLC

NECK PAIN AND DISABILITY INDEX (Vernon Mior)

NAME:_____ DATE: _____ SCORE: _____

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

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 very mild 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

☐ 0 I can look after myself normally without causing pain.
☐ 1 I can look after myself normally but it causes extra pain.
☐ 2 It is painful to look after myself and 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 I stay in bed.

SECTION 3- LIFTING

☐ 0 I can lift weights without extra pain.
☐ 1 I can lift heavy weights but it gives 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 contently positioned.
☐ 4 I can lift very light weights.
☐ 5 I cannot lift or carry anything at all.

SECTION 4- READING

☐ 0 I can read as much as I want with no pain in my neck.
☐ 1 I can read as much as I want with slight pain in my neck.
☐ 2 I can read as much as I want with moderate pain in my neck.
☐ 3 I can't read as much as I want to because of moderate pain in my neck.
☐ 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 which come frequently.
☐ 2 I have moderate headaches which come infrequently.
☐ 3 I have moderate headaches which come frequently.
☐ 4 I have severe headaches which come frequently.
☐ 5 I have headaches almost all of the time.

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.
☐ 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 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 cannot 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 cannot 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 cannot drive my car at all.

SECTION 9- SLEEPING

☐ 0 I have no trouble sleeping.
☐ 1 My sleep is slightly disturbed (less than one hour sleepless).
☐ 2 My sleep is mildly disturbed (1-2 hrs. sleepless).
☐ 3 My sleep is moderately disturbed (2-3 hrs. sleepless).
☐ 4 My sleep is greatly disturbed (3-5 hrs. sleepless).
☐ 5 My sleep is completely disturbed (5-7 hrs. 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 usual recreation activities because of pain in my neck.
☐ 4 I hardly do any recreation activities because of pain in my neck.
☐ 5 I cannot do recreation activities at all.

RIVERS EDGE PAIN RELIEF

Roland F. Chalifoux Jr., D.O., PLLC

LOW BACK

MODIFIED OSWESTRY DISABILITY QUESTIONNAIRE

NAME:_____ DATE: _____ SCORE:_____

The purpose of this questionnaire is to measure your perceived disability from your condition. The selections you choose will give your doctor information about how your pain has affected your ability to manage everyday life.

INSTRUCTIONS: PLEASE MARK WITH AN "X" ONLY ONE BOX WHICH BEST APPLIES TO YOU.
PLEASE ANSWER EVERY SECTION:

PAIN INTENSITY
- ☐ 0 I have no pain.
- ☐ 1 Pain comes and goes and is very mild.
- ☐ 2 Pain is constant and very mild.
- ☐ 3 Pain comes and goes and is moderate.
- ☐ 4 Pain is constant and is moderate.
- ☐ 5 Pain is constant and is severe.

PERSONAL CARE (WASHING AND DRESSING)
- ☐ 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 and 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, wash with difficulty, and stay in bed.

LIFTING
- ☐ 0 I can lift heavy weights without extra pain.
- ☐ 1 I can lift heavy weights but it gives m extra pain.
- ☐ 2 Pain prevents me from lifting heavy weights but I can manage if they are conveniently positioned.
- ☐ 3 Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are contently positioned.
- ☐ 4 I can lift very light weights.
- ☐ 5 I cannot lift or carry anything at all.

WALKING
- ☐ 0 Pain does not prevent me from walking any distance.
- ☐ 1 Pain prevents me from walking more than one mile.
- ☐ 2 Pain prevents me from walking more than ½ mile.
- ☐ 3 Pain prevents me from walking more than ¼ mile.
- ☐ 4 I can only walk using a cane or crutches.
- ☐ 5 I am in bed most of the time and have to crawl to the toilet.

SITTING
- ☐ 0 I can sit in any chair as long as I like.
- ☐ 1 I can only sit in my favorite chair as long as I like.
- ☐ 2 Pain prevents me from sitting for more than 1 hour.
- ☐ 3 Pain prevents me from sitting more than ½ hour.
- ☐ 4 Pain prevents me from sitting for more than 10 minutes.
- ☐ 5 I avoid sitting since it increases my pain right away.

STANDING
- ☐ 0 I can stand as long as I want without extra pain.
- ☐ 1 I can stand as long as I want but it gives me extra pain.
- ☐ 2 Pain prevents me from standing for more than 1 hour.
- ☐ 3 Pain prevents me from standing for more than ½ hour.
- ☐ 4 Pain prevents me from standing for more than 10 minutes.
- ☐ 5 Pain prevents me from standing at all.

SLEEPING
- ☐ 0 I have no trouble sleeping.
- ☐ 1 I can only sleep well by taking medications.
- ☐ 2 I get less than six hours of sleep before the pain wakes me up.
- ☐ 3 I get less than four hours of sleep before the pain wakes me up.
- ☐ 4 I get less than two hours of sleep before the pain wakes me up.
- ☐ 5 Pain prevents me from sleeping at all.

CHANGING DEGREE OF PAIN
- ☐ 0 My pain is rapidly decreasing and I am getting better.
- ☐ 1 My pain fluctuates but I am gradually getting better.
- ☐ 2 My pain is decreasing and my improvement is slow.
- ☐ 3 My pain is not changing- I am not getting better or worse.
- ☐ 4 My pain is increasing and I am gradually getting worse.
- ☐ 5 My pain is rapidly increasing- I am getting worse.

SOCIAL LIFE
- ☐ 0 My social like is normal an gives me no extra pain..
- ☐ 1 My social life is normal but 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 by social life, I don't go out as often.
- ☐ 4 Pain has restricted my social life to my home.
- ☐ 5 I have no social life because of the pain.

TRAVELING
- ☐ 0 I can travel anywhere without extra pain.
- ☐ 1 I can travel anywhere but it gives me extra pain.
- ☐ 2 Pain is bad but I manage journeys of less than one hour.
- ☐ 3 Pain restricts me to journeys of less than one hour.
- ☐ 4 Pain restricts me to short, necessary journeys under ½ hour.
- ☐ 5 Pain prevents me from traveling except to my doctor.