



610 N. Alma School Rd Ste 50  
Chandler, AZ 85224  
(480) 857-1991

New Patient Registration and Accident Questionnaire

Name: \_\_\_\_\_ Age: \_\_\_\_\_ Date of birth: \_\_\_\_\_ Date: \_\_\_\_\_  
LAST FIRST MIDDLE

Address: \_\_\_\_\_ Social Security #: \_\_\_\_\_ ☐ Male ☐ Female

City, State, Zip: \_\_\_\_\_ Marital Status: ☐ M ☐ S ☐ W ☐ D # of Children \_\_\_\_\_

Home Phone (\_\_\_\_\_) \_\_\_\_\_ Work Phone (\_\_\_\_\_) \_\_\_\_\_

Cell Phone (\_\_\_\_\_) \_\_\_\_\_ Email address: \_\_\_\_\_

Employer: \_\_\_\_\_ Spouse's Name: \_\_\_\_\_

Occupation: \_\_\_\_\_ Spouse's Employer: \_\_\_\_\_

**In case of emergency, notify \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone (\_\_\_\_\_) \_\_\_\_\_**

Current Symptoms: 1. \_\_\_\_\_ 2. \_\_\_\_\_ 3. \_\_\_\_\_ 4. \_\_\_\_\_

5. \_\_\_\_\_ 6. \_\_\_\_\_ 7. \_\_\_\_\_ 8. \_\_\_\_\_

When did your symptoms begin? \_\_\_\_\_

In general what makes your symptoms better? \_\_\_\_\_

In general what makes your symptoms worse? \_\_\_\_\_

In general how would you describe your pain? (ache, burn, dull, sharp, throbbing): \_\_\_\_\_

Are your symptoms local or do they travel to another area? (If they travel, to where?) \_\_\_\_\_

Are symptoms; ☐ Constant >76% ☐ Frequent 51-75% ☐ Occasional 26-50% ☐ Intermittent <25% **of your waking hours**

**Where there any symptoms which you had after the crash that have now resolved? (please list)**

**Please list all medications and dosage:**

**Frequency**

**For What Illness?**

List any allergies to medications, foods or other: \_\_\_\_\_

**Are you pregnant?** ☐ Yes ☐ No First day of last menstrual cycle: \_\_\_\_\_

Do you smoke? ☐ Yes ☐ No; How much? \_\_\_\_\_ Do you drink alcohol? ☐ Yes ☐ No; How much? \_\_\_\_\_

**Please list all serious illness and serious accidents:**

**Month and Year**

**City, State**

Patient's Name: \_\_\_\_\_ Date: \_\_\_\_\_

**Please list any recent x-rays, lab or other tests:** **Date** **Facility/Doctor**

Date of Crash: \_\_\_\_\_ Hour: \_\_\_\_\_ AM \_\_\_\_\_ PM \_\_\_\_\_

Specific Location of Crash: \_\_\_\_\_

**Describe in detail, in your own words, how the crash/accident happened:** \_\_\_\_\_

**AUTOMOBILE/MOTORCYCLE ONLY**

In the crash: Were you the ☐ Driver ☐ Passenger ☐ Pedestrian ☐ Other? \_\_\_\_\_

Did your vehicle strike the other vehicle? ☐ Yes ☐ No Did the other vehicle strike your car? ☐ Yes ☐ No

Were you struck from? ☐ Behind ☐ Front ☐ Driver Side ☐ Passenger Side **Motorcycle Only:** ☐ Left Side ☐ Right Side

Were traffic citations issued to? ☐ You ☐ Driver of Your Vehicle ☐ Driver of the Other Vehicle ☐ No Citations Given

Was your vehicle heading? ☐ North ☐ South ☐ East ☐ West on \_\_\_\_\_ (Street/Highway)

Was the other heading? ☐ North ☐ South ☐ East ☐ West on \_\_\_\_\_ (Street/Highway)

**CHECK ANY OF THE FOLLOWING SYMPTOMS YOU HAVE NOTICED SINCE THE CRASH/ACCIDENT:**

- |  |  |   |   |
|--|--|---|---|
| <input type="checkbox"/> Headache          | <input type="checkbox"/> Middle Back Pain      | <input type="checkbox"/> Lower Back Pain      | <input type="checkbox"/> <i>Ears Ring</i>       |
| <input type="checkbox"/> Neck Pain         | <input type="checkbox"/> Chest Pain            | <input type="checkbox"/> Lower Back Stiffness | <input type="checkbox"/> <i>Buzzing in Ears</i> |
| <input type="checkbox"/> Neck Stiffness    | <input type="checkbox"/> Bruised Chest         | <input type="checkbox"/> Radiating Pain       | <input type="checkbox"/> <i>Dizziness</i>       |
| <input type="checkbox"/> Sleeping Problems | <input type="checkbox"/> Bruising Anywhere     | <input type="checkbox"/> Tingling in Legs     | <input type="checkbox"/> Loss of Smell          |
| <input type="checkbox"/> <i>Depression</i> | <input type="checkbox"/> <i>Blurred Vision</i> | <input type="checkbox"/> Tingling in Arms     | <input type="checkbox"/> Loss of Taste          |
| <input type="checkbox"/> <i>Anxiety</i>    | <input type="checkbox"/> Sensitivity to Light  | <input type="checkbox"/> Jaw Pain             | <input type="checkbox"/> <i>Any Burns</i>       |
| <input type="checkbox"/> <i>Fainting</i>   | <input type="checkbox"/> Upper Arm Pain        | <input type="checkbox"/> Upper Leg Pain       | <input type="checkbox"/> <i>Any Stitches</i>    |
| <input type="checkbox"/> Muscle Spasms     | <input type="checkbox"/> Lower Arm Pain        | <input type="checkbox"/> Lower Leg Pain       | <input type="checkbox"/> <i>Any Cuts</i>        |

☐ Other Symptoms: \_\_\_\_\_

**Have you lost time from work?** ☐ Yes ☐ No: If Yes, Dates: \_\_\_\_\_ to \_\_\_\_\_

**Where did you go after the crash?** ☐ Hospital ☐ Urgent Care ☐ Home ☐ Work ☐ Other \_\_\_\_\_

**Were you taken by ambulance?** ☐ Yes ☐ No **To which hospital?** \_\_\_\_\_

Address: \_\_\_\_\_ Date of Hospitalization: \_\_\_\_\_

Attending E.R. Doctor: \_\_\_\_\_ Treatment Given? \_\_\_\_\_

**Have you done any of the following since the crash:**

- |  |  |                                      |
|--|--|--------------------------------------|
| <input type="checkbox"/> Ice             | <input type="checkbox"/> Medication (name) _____ | <input type="checkbox"/> Rest        |
| <input type="checkbox"/> Heat (any kind) | <input type="checkbox"/> Exercise                | <input type="checkbox"/> Other _____ |



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Patient's Name: \_\_\_\_\_ Date: \_\_\_\_\_

**DO YOU HAVE A HISTORY OF ANY OF THE FOLLOWING DISEASES?:**

Tuberculosis <input type="checkbox"/> Yes	Lung Disease <input type="checkbox"/> Yes	Gout <input type="checkbox"/> Yes	Diabetes <input type="checkbox"/> Yes
Kidney Disease <input type="checkbox"/> Yes	Stomach/Ulcer <input type="checkbox"/> Yes	Heart Disease <input type="checkbox"/> Yes	Hepatitis <input type="checkbox"/> Yes
Sciatica <input type="checkbox"/> Yes	Blood Pressure <input type="checkbox"/> Yes	Transfusion <input type="checkbox"/> Yes	Polio / MS <input type="checkbox"/> Yes
Colon Disease <input type="checkbox"/> Yes	Stroke <input type="checkbox"/> Yes	Cancer <input type="checkbox"/> Yes	Bleeding <input type="checkbox"/> Yes
Paralysis <input type="checkbox"/> Yes	Seizures <input type="checkbox"/> Yes	Arthritis <input type="checkbox"/> Yes	Asthma <input type="checkbox"/> Yes
Anemia <input type="checkbox"/> Yes	Thyroid Disease <input type="checkbox"/> Yes	Drug Dependence <input type="checkbox"/> Yes	AIDS <input type="checkbox"/> Yes

**PLEASE PROVIDE US WITH THE APPROPRIATE INSURANCE INFORMATION:**

**1) YOUR AUTOMOBILE INSURANCE CARRIER:** \_\_\_\_\_

Address: \_\_\_\_\_ Telephone: (\_\_\_\_) \_\_\_\_\_ Insured: \_\_\_\_\_

Claim #: \_\_\_\_\_ Policy #: \_\_\_\_\_

Claim Representative: \_\_\_\_\_

Telephone: (\_\_\_\_) \_\_\_\_\_ Fax: (\_\_\_\_) \_\_\_\_\_

Med-Pay Benefits: \_\_\_\_\_ Uninsured (UM) Benefits: \_\_\_\_\_ Underinsured (UIM) Benefits: \_\_\_\_\_

Have you signed a selection waiver of benefits? ☐ Yes ☐ No ☐ Unsure

Are you a full time Student? ☐ Yes ☐ No Do you reside with a relative? ☐ Yes ☐ No

**2) YOUR HEALTH INSURANCE COMPANY:** \_\_\_\_\_

Address: \_\_\_\_\_ Insured: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Policy #: \_\_\_\_\_ SS#: \_\_\_\_\_

Telephone: (\_\_\_\_) \_\_\_\_\_ Fax: (\_\_\_\_) \_\_\_\_\_

**3) ADVERSE OR THIRD PARTY AUTOMOBILE INSURANCE CARRIER:** \_\_\_\_\_

Address: \_\_\_\_\_ Claims Rep: \_\_\_\_\_

Claim #: \_\_\_\_\_ Policy #: \_\_\_\_\_ Insured: \_\_\_\_\_

Telephone: (\_\_\_\_) \_\_\_\_\_ Fax: (\_\_\_\_) \_\_\_\_\_

**4) ATTORNEY:** \_\_\_\_\_ Legal Assistant: \_\_\_\_\_

Address: \_\_\_\_\_

Telephone: (\_\_\_\_) \_\_\_\_\_ Fax: (\_\_\_\_) \_\_\_\_\_

**HIPAA Compliance**

Our office is required by law to maintain the HIPAA Notice of Privacy Practices. This notice explains our legal duties and privacy practices with respect to your protected health information. Signature below acknowledges that I have read this Notice of our Privacy Practices. A copy will be provided to me upon request.

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Witness: \_\_\_\_\_ Date: \_\_\_\_\_

Staff Initials: \_\_\_\_\_

Patient's Name: \_\_\_\_\_

Today's Date: \_\_\_\_\_

## Auto Accident Mechanism of Injury Form

Date of Collision: \_\_\_\_\_ Hour of Accident: \_\_\_\_\_ AM / PM

Please describe how the collision happened: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

What was your position in the car? (Circle) **Driver / Front Passenger / Left Rear / Right Rear**

If "Driver", were your hands on the steering wheel? **Both / Left / Right**

Did the airbags deploy? **Yes / No**

Did you strike another vehicle? **Yes / No** Did another vehicle strike your vehicle? **Yes / No**

Angle of Impact: **Front / Back / Left / Right / Other:** \_\_\_\_\_

If Second Collision – Angle of 2<sup>nd</sup> impact: **Front / Back / Left / Right / Other:** \_\_\_\_\_

1) In relation to the back of your head, was your headrest set: **Low / Middle / High**

2) Were you surprised by the impact? **Yes / No**

If "NO", how did you brace? **With Hands / With Feet**

3a) Where was your head facing at the time of impact? **Straight Ahead / Left / Right / Behind**

3b) Were you leaning forward at the time of impact? **Yes / No**

4) What type and year of vehicle were you in? \_\_\_\_\_

4a) What was the approximate speed of your vehicle when the accident occurred? \_\_\_\_\_ mph

5) What type and year of vehicle struck yours? \_\_\_\_\_

5b) What was the approximate speed of the other vehicle when the accident occurred? \_\_\_\_\_ mph

6) Were you wearing a seatbelt? **Yes / No** What type: **Lap Belt / Shoulder Belt / Both**

7) Did you feel pain immediately after the accident? **Yes / No**

Were you rendered unconscious as a result of the accident? **Yes / No**

Did you strike anything in the vehicle at the time of impact? **Yes / No** If "YES", specify what part of your body struck what: (i.e. head, chest, chin, shoulder, knee, etc.)

<input type="checkbox"/> Steering Wheel	<input type="checkbox"/> Windshield
<input type="checkbox"/> Dashboard	<input type="checkbox"/> Roof
<input type="checkbox"/> Left Side Door	<input type="checkbox"/> Right Side Door
<input type="checkbox"/> Left Window	<input type="checkbox"/> Right Window
<input type="checkbox"/> Other	



Ryan Hicks DC.

Patient's Name: \_\_\_\_\_

Today's Date: \_\_\_\_\_

Did your seat break or bend? **Yes / No**

Immediately following the accident, how did you feel? (Circle all that apply) **Dizzy / Dazed / Weak / Upset / Disoriented / Nervous / Nauseous / Other:** \_\_\_\_\_

### **Police and Ambulance:**

Was the accident reported to the police? **Yes / No**

Were traffic citations issued? **Yes / No** If "YES", to whom? \_\_\_\_\_

Did you go to the hospital? **Yes / No** If "YES", when? \_\_\_\_\_

If "YES", how did you get there? **Ambulance / Police Car / Private Transportation**

Were you admitted? **Yes / No** If "YES", how long? \_\_\_\_\_

Name of Hospital? \_\_\_\_\_ Attended by Dr. \_\_\_\_\_

What treatment given? (Circle all that apply) **None / X-rays / Pain Medication / Stitches /**

**Muscle Relaxants / Bandaged / Cervical Collar / Physical Therapy / Instructed Regarding**

**Concussion / Instructed Regarding Sprains & Strains / Instructed to Call an Orthopedist /**

**Instructed to Call a Private Physician / Referred to This Office / Other:** \_\_\_\_\_

What other doctor have you seen as a result of this injury? \_\_\_\_\_

Do you have difficulty in excessive: **Standing / Walking / Riding / Bending / Twisting**

Do you have difficulty in excessive lifting: **Light / Moderate / Heavy / Repetitive**

Symptoms other than above: \_\_\_\_\_

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date



Patient's Name: \_\_\_\_\_

Ryan Hicks DC.

Date: \_\_\_\_\_

### **Duties Under Duress Summary**

Complete the following summary as it relates to your living and work duties and how the injury(s) are affecting your performance. List the day to day living duties which are painful or difficult for you to perform as a result of the injuries you sustained in the motor vehicle collision. Include those duties/responsibilities which require that you reduce the time you are capable of performing them. Include all instances where you have received lifting, stretching, bending, sitting, standing, walking or other restrictions which affect your performance.

<b>Work</b>	<b>Reason for the difficulty</b>	<b>Duration</b>
-------------	----------------------------------	-----------------

Job Description: \_\_\_\_\_

Lifting	Increased Pain	_____
Bending	Increased Pain	_____
Sitting	Increased Pain	_____
Walking	Increased Pain	_____
Computer Duties	Increased Pain	_____
Other: _____	Increased Pain	_____

<b>Studies/School</b>	<b>Reason for the difficulty</b>	<b>Duration</b>
-----------------------	----------------------------------	-----------------

Lifting	Increased Pain	_____
Bending	Increased Pain	_____
Sitting	Increased Pain	_____
Walking	Increased Pain	_____
Computer Duties	Increased Pain	_____
Studying	Increased Pain	_____
Other: _____	Increased Pain	_____

<b>Domestic Duties</b>	<b>Reason for the difficulty</b>	<b>Duration</b>
------------------------	----------------------------------	-----------------

Vacuuming	Increased Pain	_____
Taking Care of Kids	Increased Anxiety	_____
Cleaning	Increased Pain	_____
Preparing Meals	Increased Pain	_____
Other: _____	Increased Pain	_____

<b>Household Duties</b>	<b>Reason for the difficulty</b>	<b>Duration</b>
-------------------------	----------------------------------	-----------------

Yardwork	Increased Pain	_____
Transportation	Increased Anxiety	_____
Shopping	Increased Pain	_____
Taking Out Trash	Increased Pain	_____
Other: _____	Increased Pain	_____



Patient's Name: \_\_\_\_\_

Ryan Hicks DC.  
Date: \_\_\_\_\_

### **Loss of Enjoyment Summary**

Complete the following summary as it relates to your lifestyle, work environment and activities which you normally would be enjoying, but are currently not enjoying, as a result of the motor vehicle collision. Include all areas which you have had to reduce the time you are capable of experiencing them. Include all instances where you have received lifting, stretching, bending, sitting, standing, walking or other restrictions which affect your participation in any of the following areas:

<b>Work</b>	<b>Reason for the difficulty</b>	<b>Duration</b>
-------------	----------------------------------	-----------------

Job Description: \_\_\_\_\_

Lifting	Increased Pain	_____
Bending	Increased Pain	_____
Sitting	Increased Pain	_____
Walking	Increased Pain	_____
Computer Duties	Increased Pain	_____
Other: _____	Increased Pain	_____

<b>Studies/School</b>	<b>Reason for the difficulty</b>	<b>Duration</b>
-----------------------	----------------------------------	-----------------

Lifting	Increased Pain	_____
Bending	Increased Pain	_____
Sitting	Increased Pain	_____
Walking	Increased Pain	_____
Computer Duties	Increased Pain	_____
Studying	Increased Pain	_____
Other: _____	Increased Pain	_____



Patient's Name: \_\_\_\_\_

Ryan Hicks DC.

Date: \_\_\_\_\_

### Loss of Enjoyment

Domestic Duties	Reason for the difficulty	Duration
Vacuuming	Increased Pain	_____
Taking Care of Kids	Increased Anxiety	_____
Cleaning	Increased Pain	_____
Preparing Meals	Increased Pain	_____
Other: _____	Increased Pain	_____

Household Duties	Reason for the difficulty	Duration
Yardwork	Increased Pain	_____
Transportation	Increased Anxiety	_____
Shopping	Increased Pain	_____
Taking Out Trash	Increased Pain	_____
Other: _____	Increased Pain	_____

Sports	Reason for the difficulty	Duration
Social	_____	_____
Competitive	_____	_____
Regional	_____	_____
Other:	_____	_____



## QUADRUPLE VISUAL ANALOGUE SCALE

Patient Name \_\_\_\_\_

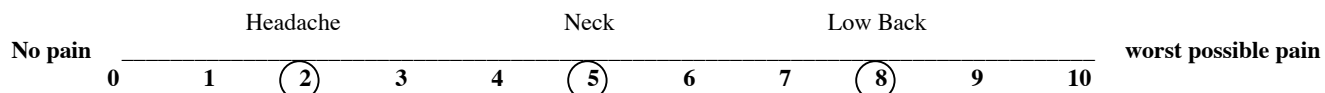
Date \_\_\_\_\_

**Please read carefully:**

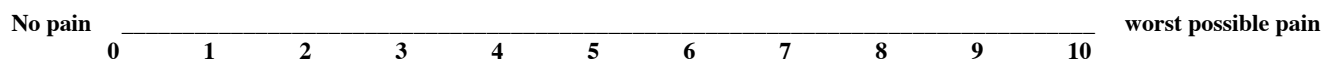
**Instructions:** Please circle the number that best describes the question being asked.

**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.

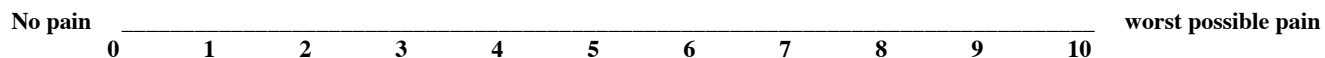
**Example:**



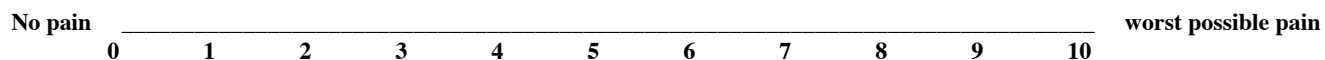
**1 – What is your pain RIGHT NOW?**



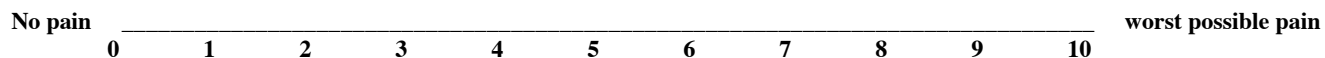
**2 – What is your TYPICAL or AVERAGE pain?**



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



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



**OTHER COMMENTS:**

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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.

## REVISED OSWESTRY BACK PAIN DISABILITY QUESTIONNAIRE

Name \_\_\_\_\_

Date \_\_\_\_\_

### Please read carefully:

*This questionnaire has been designed to enable us to understand how your back pain has affected your ability to manage everyday life. Please answer every section, and mark in each section only **ONE CHOICE** which applies to you. We realize that you may consider that two of the statements in any one section relate to you, but please just **mark the one box which most closely describes your problem right now.***

### SECTION 1 – Pain Intensity

- A. The pain comes and goes and is very mild.
- B. The pain is mild and does not vary much.
- C. The pain comes and goes and is moderate.
- D. The pain is moderate and does not vary much.
- E. The pain comes and goes and is severe.
- F. The pain is severe and does not vary much.

### SECTION 2 – Personal Care

- A. I would not have to change my way of washing or dressing in order to avoid pain.
- B. I do not normally change my way of washing or dressing even though it causes some pain.
- C. Washing and dressing increases the pain, but I manage not to change my way of doing it.
- D. Washing and dressing increases the pain and I find it necessary to change my way of doing it.
- E. Because of the pain, I am unable to do some washing and dressing without help.
- F. Because of the pain, I am unable to do any washing or dressing without help.

### SECTION 3 – Lifting

- A. I can lift heavy weights without extra pain.
- B. I can lift heavy weights but it gives me extra pain.
- C. Pain prevents me from lifting heavy weights off the floor.
- D. Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned-eg, on a table
- E. Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
- F. I can only lift very light weights, at the most.

### SECTION 4 – Walking

- A. Pain does not prevent me from walking any distance.
- B. Pain prevents me from walking more than 1 mile.
- C. Pain prevents me from walking more than ½ mile.
- D. Pain prevents me from walking more than ¼ mile.
- E. I can only walk using a stick or crutches.
- F. I am in bed most of the time and have to crawl to the toilet.

### SECTION 5 – Sitting

- A. I can sit in any chair as long as I like without pain.
- B. I can only sit in my favorite chair as long as I like.
- C. Pain prevents me sitting more than 1 hour.
- D. Pain prevents me sitting more than ½ hour.
- E. Pain prevents me sitting more than 10 minutes.
- F. Pain prevents me from sitting at all.

### OTHER COMMENTS:

\_\_\_\_\_  
\_\_\_\_\_

### SECTION 6 – Standing

- A. I can stand as long as I want without pain.
- B. I have some pain while standing, but it does not increase with time.
- C. I cannot stand for longer than 1 hour without increasing pain.
- D. I cannot stand for longer than ½ hour without increasing pain.
- E. I cannot stand for longer than 10 minutes without increasing pain.
- F. Pain prevents me from standing at all.

### SECTION 7 – Sleeping

- A. I get no pain in bed.
- B. I get pain in bed, but it does not prevent me from sleeping well.
- C. Because of pain, my normal night's sleep is reduced by less than one-quarter.
- D. Because of pain, my normal night's sleep is reduced by less than one-half.
- E. Because of pain, my normal night's sleep is reduced by less than three-quarters.
- F. Pain prevents me from sleeping at all.

### SECTION 8 – Social Life

- A. My social life is normal and gives me no pain.
- B. My social life is normal, but increases the degree of my pain.
- C. Pain has no significant effect on my social life apart from limiting my more energetic interests, eg, dancing, etc.
- D. Pain has restricted my social life and I do not go out very often.
- E. Pain has restricted my social life to my home.
- F. I have hardly any social life because of the pain.

### SECTION 9 – Traveling

- A. I get no pain while traveling.
- B. I get some pain while traveling but none of my usual forms of travel make it any worse.
- C. I get extra pain while traveling but it does not compel me to seek alternative forms of travel.
- D. I get extra pain while traveling which compels me to seek alternative forms of travel.
- E. Pain restricts all forms of travel.
- F. Pain prevents all forms of travel except that done lying down.

### SECTION 10 – Changing Degree of Pain

- A. My pain is rapidly getting better.
- B. My pain fluctuates, but overall is definitely getting better.
- C. My pain seems to be getting better, but improvement is slow at present.
- D. My pain is neither getting better nor worse.
- E. My pain is gradually worsening.
- F. My pain is rapidly worsening.

\_\_\_\_\_  
Examiner

## 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:** \_\_\_\_\_