



**REACTIVATED PATIENT – INFORMATION UPDATE / VERIFICATION**

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

Name of Patient: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Social Security Number: \_\_\_\_\_

Current Mailing Address: \_\_\_\_\_

(City, State, Zip Code): \_\_\_\_\_

Home Phone Number: \_\_\_\_\_

Cell Phone Number: \_\_\_\_\_

Cell Phone Carrier: \_\_\_\_\_

May We Text Message Appointment Reminders? YES or NO

Chief Complaint for Visit: \_\_\_\_\_

\_\_\_\_\_

## Insurance Information

*We will make a copy of your insurance card/s; however, please complete the following information as well.*

Please check any and **all** insurance coverage that may be applicable in your case:

Major Medical       Worker's Compensation       Medicare       Medicaid  
 Auto Accident       Medical Savings Account & Flex Plans       Other

Name of Primary Insurance Company: \_\_\_\_\_  
\_\_\_\_\_

Policy Number: \_\_\_\_\_ Group Number: \_\_\_\_\_

Are you the policy holder? Yes / No    If not, who is the policy holder? Spouse    Parent    Employer    Other

Policy Holder's First Name: \_\_\_\_\_ MI \_\_\_\_\_ Last Name: \_\_\_\_\_

Policy Holder's Date of Birth: \_\_\_\_\_ Policy Holder's Social Security #: \_\_\_\_\_

Policy Holder's Employer: \_\_\_\_\_

Do you have secondary insurance coverage? Yes / No    If yes, please complete the following information:

Name of Secondary Insurance Company: \_\_\_\_\_  
\_\_\_\_\_

Policy Number: \_\_\_\_\_ Group Number: \_\_\_\_\_

Policy Holder's First Name: \_\_\_\_\_ MI \_\_\_\_\_ Last Name: \_\_\_\_\_

Policy Holder's Date of Birth: \_\_\_\_\_ Policy Holder's Social Security #: \_\_\_\_\_

Policy Holder's Employer: \_\_\_\_\_

**AUTHORIZATION AND RELEASE: I authorize payment of insurance benefits directly to the chiropractor or chiropractic office. I authorize the doctor to release all information necessary to communicate with personal physicians, other healthcare providers, and payors in order to secure, as a courtesy to me, the payment of benefits.**

**I understand and agree that health and accident insurance policies are an agreement between me and an insurance carrier. I clearly understand that I am responsible for all costs of chiropractic care, regardless of insurance coverage. I also understand that if I suspend or terminate my schedule of care and treatment as determined by my treating doctor, any fees or outstanding balances for services I have received will be immediately due and payable.**

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

Patient's Signature Authorizing Care: \_\_\_\_\_

Parent's / Guardian's Authorizing Signature: \_\_\_\_\_

## TO OUR VALUED PATIENTS

[Please Read!]

Continued issues and discrepancies in the information we are given by your insurance company regarding your chiropractic benefits have necessitated this notice to re/emphasize some things to you:

1. As a courtesy to you, we make every attempt, by utilizing online insurance websites as well as calling your insurance company, to verify as accurately as we can up front what your chiropractic benefits are and whether a preauthorization is required for care.
2. When we call your insurance company, however, we are immediately given a benefit disclaimer that the information they are about to tell us is “not a guarantee of coverage or payment either in part or in whole.”
3. In fact, we are routinely given inaccurate and misinformation by your insurance company as to what they will and will not cover as well as what your financial responsibility is and is not.
4. This misinformation by your insurance company means that despite our best efforts, we may not always accurately collect your financial responsibility at the time your services are rendered.
5. Consequently, we may end up owing you a refund or **you may have additional financial responsibility to pay.**
6. It is only when we receive payment/non-payment from your insurance company with the accompanying Explanation of Benefits – the same ones they send to you – that we truly find out what your coverage / financial responsibility is.
7. **Please keep in mind, and we say this most respectfully, it is not our fault what your insurance covers and does not cover or what your financial responsibility is. Your benefit plan with your insurance company is one that you have chosen and is an arrangement, agreement, and relationship between you and your insurance company. We cannot influence or change what your benefits are or what your financial responsibility is.**
8. **Therefore, please understand that regardless of your coverage or our initial understanding of your benefits, the cost of the valuable care you receive here is ultimately your responsibility.**
9. To minimize surprises, we ask that you do your part. Call your insurance company yourself to ask specifically about your chiropractic benefits. We can even give you a list of our commonly used codes/services about which to inquire directly. Your calls as a member are routed to a completely different call center than ours are as a provider, and you are often treated differently (meaning better) than we are when you call.

10. Whenever you call your insurance company, make sure you ask for and obtain a call reference number! This is the “proof” you’ll need of the information you were given on that particular call.
11. Be diligent about looking at your Explanation of Benefits (EOBs) when you receive them and bring to our attention immediately if you have any questions or see any discrepancies from the initial understanding of your coverage/responsibility. Being proactive about paying any additional financial responsibility would also be greatly appreciated.
12. You have come to us seeking relief from your body’s pain and dysfunctions – without the use of unhealthy drugs and invasive and expensive surgery – through safe, effective, and comparatively affordable chiropractic care. While Dr. Jay is loosely aware of our initial understanding of your benefits, he would be doing you a disservice if he let your benefits or lack thereof dictate his prescribed plan of treatment for you. **Our mission is TO GET YOU BETTER**, and Dr. Jay makes his professional, experienced, treatment decisions based on this goal – not on your insurance coverage.
13. Insurance companies are not doctors; they are profit-centered businesses whose CEOs make tens of MILLIONS of dollars a year. It has been our experience that they try to pay as little as possible and often make it as difficult as possible for you to use your benefits and for us to be fairly compensated for our services. As patient and provider, we must work together to hold insurance companies accountable.
14. Regardless of your benefits, it is imperative to us that you see the VALUE in the care that you receive here. Compared to all other alternatives for treatment – certainly compared to the even greater long-term cost (in time, money, and quality of life) of doing nothing about your current pain and dysfunction – chiropractic care offers the best value for most people. Your health is important to us, but you must likewise realize that you are worth the investment of time, energy, and money to improve your health and make it a priority. It is then that you will fully discover what chiropractic can do for you.
15. Lastly, all of us at Forever Young Chiropractic pride ourselves on exceeding your expectations of your chiropractic healthcare experience, and we TRULY appreciate you entrusting us with your spinal health.

**Please acknowledge that you have received this notice.**

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**Printed Name**

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**Signature**

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**Date**

## Consent to Care

A patient coming to the doctor gives him / her permission and authority to care for the patient in accordance with appropriate tests, diagnosis, and analysis. The clinical procedures performed are usually beneficial and seldom cause any problem. In rare cases, underlying physical defects, deformities, or pathologies may render the patient susceptible for injury. The doctor, of course, will not provide specific healthcare if he / she is aware that such care may be contraindicated. It is the responsibility of the patient to make it known or to learn through health care procedures from whatever he / she is suffering – latent pathological defects, illnesses, or deformities – which would otherwise not come to the attention of the physician.

I have read and understand the foregoing.

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

Print Name \_\_\_\_\_

Signature \_\_\_\_\_

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## X-Ray Questionnaire

(For WOMEN Only)

Our consultation and examination may indicate that x-rays are necessary to accurately diagnose and analyze your spinal condition. Should x-rays be necessary, we would like to confirm that you are NOT pregnant at this time.

Name: \_\_\_\_\_

- There is a possibility that I may be pregnant at this time.
  - Yes, I am definitely pregnant.
  - No, I am definitely NOT pregnant at this time.
  - I request that x-ray films not be taken because \_\_\_\_\_
- 

Date of last menstrual period: \_\_\_\_\_

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

Date \_\_\_\_\_

## Patient Health Information Consent Form

We at Forever Young Chiropractic want you to know how your Patient Health Information (PHI) is going to be used in this office and your rights concerning those records. Before we will begin any health care operations, we must require you to read and sign this consent form stating that you understand and agree with how your records will be used. If you would like a more detailed account of our policies and procedures concerning the privacy of your PHI, we encourage you to read the HIPAA NOTICE that is available to you at the billing office before signing this consent.

1. The patient understands and agrees to allow this chiropractic office to use his / her Patient Health Information (PHI) for the purpose of treatment, payment, healthcare operations, and coordination of care. As an example, the patient agrees to allow this chiropractic office to submit requested PHI to the Health Insurance Company / ies provided to us by the patient for the purpose of payment. Be assured that this office will limit the release of all PHI to the minimum needed for what the insurance company / ies require for payment.
2. The patient has the right to examine and obtain a copy of his / her health records at any time and request corrections. The patient may request to know what disclosures have been made and submit in writing any further restrictions on the use of his / her PHI. Our office is obligated to agree to those restrictions only to the extent they coincide with state and federal law.
3. A patient's written consent need only be obtained one time for all subsequent care given the patient in this office.
4. The patient may provide a written request to revoke consent at any time during care. This would not affect the use of those records for the care given prior to the written request to revoke consent but would apply to any care given after the request has been presented.
5. Our office may contact the patient periodically regarding appointments, treatments, products, services, or charitable work performed by our office. The patient may choose to opt-out of any marketing or fundraising communications at any time.
6. For the patient's security and right to privacy, all staff has been trained in the area of patient record privacy, and a privacy official has been designated to enforce those procedures in our office. We have taken all precautions that are known by this office to assure that patient records are not readily available to those who do not need them.
7. Patients have the right to file a formal complaint with our privacy official and the Secretary of Health and Human Services about any possible violation of these policies and procedures without retaliation by this office.
8. Our office reserves the right to make changes to this notice and to make the new notice provisions effective for all protected health information that it maintains. You will be provided with a new notice at your next visit following any change.
9. This notice is effective on the date stated below.
10. If the patient refuses to sign this consent for the purpose of treatment, payment, and health care operations, the chiropractic physician has the right to refuse to give care.

I have read and understand how my Patient Health Information will be used, and I agree to these policies and procedures.

I \_\_\_\_\_ give \_\_\_\_\_ do **not** give permission for appointment reminders to be sent electronically to my email or cellular phone account. My cell phone carrier is \_\_\_\_\_.

I \_\_\_\_\_ give \_\_\_\_\_ do **not** give permission for mail to be sent to my home address.

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

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

*For further information regarding this notice, please contact Dr. Wolford at (502)-538-0222.*

**Patient Acknowledgement and Receipt of Notice of Privacy Practices Pursuant to HIPAA  
and Consent for Use of Health Information**

\_\_\_\_\_  
Patient's Printed Name

\_\_\_\_\_  
Date

The undersigned does hereby acknowledge that he or she has received a copy of this office's Notice of Privacy Practices Pursuant to HIPAA and has been advised that a full copy of this office's HIPAA Compliance Manual is available upon request.

The undersigned does hereby consent to the use of his or her health information in a manner consistent with the Notice of Privacy Practices Pursuant to HIPAA, the HIPAA Compliance Manual, State Law, and Federal Law.

Dated this \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_

By \_\_\_\_\_

Patient's Legal Signature

If patient is a minor or under a guardianship order as defined by State law:

By \_\_\_\_\_

Legal Signature of Parent / Guardian (circle one)

## Physical Activity Readiness Questionnaire (PAR-Q)

Please read the following questions carefully and circle YES or NO next to the question.

- |     |    |   |
|-----|----|---|
| YES | NO | 1. Has your doctor ever told you that you have a heart of lung problem?   |
| YES | NO | 2. Have you ever had any heart-related problem?   |
| YES | NO | 3. Do you frequently feel chest discomfort or pain?   |
| YES | NO | 4. Do you often feel faint or have spells of severe dizziness?  |
| YES | NO | 5. Has your doctor ever told you that you have high blood pressure; have you ever had high blood pressure in the past; and / or are you currently taking any medication for blood pressure?                     |
| YES | NO | 6. Are you aware of any bone, joint, or muscle problems that may be aggravated by exercise?   |
| YES | NO | 7. Have you ever had an episode of asthma induced by exercise – that is, severe wheezing, coughing, or severe shortness of breath – or do you have customary shortness of breath at rest or with mild exertion? |
| YES | NO | 8. Do you ever have episodes of labored or difficult breathing during the night where you have to sit up to breathe?  |
| YES | NO | 9. Have you ever been told by a doctor that you have diabetes?  |
| YES | NO | 10. Are you over age 65 and not involved in a regular exercise program?   |
| YES | NO | 11. Is there a good reason no mentioned here why you should not engage in exercise?   |
| YES | NO | 12. Are you pregnant?   |
| YES | NO | 13. Have you had any surgeries in the last six months?  |

COMMENTS: \_\_\_\_\_

I hereby certify that the above information is correct.

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

Print Name \_\_\_\_\_

Signature \_\_\_\_\_

\*Any "YES" response concerning cardiovascular, pulmonary, or metabolic problems may not engage in any fitness test or exercise program until a medical clearance form is completed or signed by an appropriate physician.

I hereby certify that, to the best of my knowledge, this person examined has no contraindications to participation in an exercise profile, musculoskeletal rehabilitation, and / or fitness program.

List any limitations or precautions:

\_\_\_\_\_

Signature of Physician: \_\_\_\_\_

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



## Revised OSWESTRY Index – Neck Pain

Name: \_\_\_\_\_

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

File #: \_\_\_\_\_

This questionnaire helps us to understand how much your **neck pain** has affected your ability to perform every day activities. Please mark with an X the one box in each section that most clearly describes your problem now.

<p><b>Section 1 – Pain Intensity</b></p> <p><input type="checkbox"/> I have no pain at the moment.</p> <p><input type="checkbox"/> The pain is very mild at the moment.</p> <p><input type="checkbox"/> The pain is moderate at the moment.</p> <p><input type="checkbox"/> The pain is fairly severe at the moment.</p> <p><input type="checkbox"/> The pain is very severe at the moment.</p> <p><input type="checkbox"/> The pain is the worst imaginable at the moment.</p>	<p><b>Section 6 – Concentration</b></p> <p><input type="checkbox"/> I can concentrate fully when I want to with no difficulty.</p> <p><input type="checkbox"/> I can concentrate fully when I want to with slight difficulty.</p> <p><input type="checkbox"/> I have a fair degree of difficulty in concentrating when I want to.</p> <p><input type="checkbox"/> I have a lot of difficulty in concentrating when I want to.</p> <p><input type="checkbox"/> I have a great deal of difficulty in concentrating when I want to.</p> <p><input type="checkbox"/> I cannot concentrate at all.</p>
<p><b>Section 2 – Personal Care (washing, dressing, etc.)</b></p> <p><input type="checkbox"/> I can look after myself normally without causing extra pain.</p> <p><input type="checkbox"/> I can look after myself normally, but it causes extra pain.</p> <p><input type="checkbox"/> It is painful to look after myself, and I am slow and careful.</p> <p><input type="checkbox"/> I need some help but manage most of my personal care.</p> <p><input type="checkbox"/> I need help every day in most aspects of self-care.</p> <p><input type="checkbox"/> I do not get dressed; I wash with difficulty and stay in bed.</p>	<p><b>Section 7 – Work</b></p> <p><input type="checkbox"/> I can do as much work as I want to.</p> <p><input type="checkbox"/> I can only do my usual work but no more.</p> <p><input type="checkbox"/> I can do most of my usual work but no more.</p> <p><input type="checkbox"/> I cannot do my usual work.</p> <p><input type="checkbox"/> I can hardly do any work at all.</p> <p><input type="checkbox"/> I cannot do any work at all.</p>
<p><b>Section 3 – Lifting</b></p> <p><input type="checkbox"/> I can lift heavy weights without extra pain.</p> <p><input type="checkbox"/> I can lift heavy weights, but it gives extra pain.</p> <p><input type="checkbox"/> Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned (e.g., on a table).</p> <p><input type="checkbox"/> Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.</p> <p><input type="checkbox"/> I can only lift very light weights at the most.</p>	<p><b>Section 8 – Driving</b></p> <p><input type="checkbox"/> I can drive my car without any neck pain.</p> <p><input type="checkbox"/> I can drive my car as long as I want with slight pain in my neck.</p> <p><input type="checkbox"/> I can drive my car as long as I want with moderate pain in my neck.</p> <p><input type="checkbox"/> I can't drive my car as long as I want because of moderate pain in my neck.</p> <p><input type="checkbox"/> I can hardly drive at all because of severe pain in my neck.</p> <p><input type="checkbox"/> I can't drive my car at all.</p>
<p><b>Section 4 – Reading</b></p> <p><input type="checkbox"/> I can read as much as I want with no pain in my neck.</p> <p><input type="checkbox"/> I can read as much as I want with slight pain in my neck.</p> <p><input type="checkbox"/> I can read as much as I want with moderate pain in my neck.</p> <p><input type="checkbox"/> I can't read as much as I want because of moderate pain in my neck.</p> <p><input type="checkbox"/> I can hardly read at all because of severe pain in my neck.</p> <p><input type="checkbox"/> I cannot read at all due to pain.</p>	<p><b>Section 9 – Sleeping</b></p> <p><input type="checkbox"/> I have no trouble sleeping.</p> <p><input type="checkbox"/> My sleep is slightly disturbed (less than 1 hr. sleepless).</p> <p><input type="checkbox"/> My sleep is mildly disturbed (1-2 hrs. sleepless).</p> <p><input type="checkbox"/> My sleep is moderately disturbed (2-3 hrs. sleepless).</p> <p><input type="checkbox"/> My sleep is greatly disturbed (3-5 hrs. sleepless).</p> <p><input type="checkbox"/> My sleep is completely disturbed (5-7 hrs. sleepless).</p>
<p><b>Section 5 – Headaches</b></p> <p><input type="checkbox"/> I have no headaches at all.</p> <p><input type="checkbox"/> I have slight headaches that come infrequently.</p> <p><input type="checkbox"/> I have moderate headaches that come infrequently.</p> <p><input type="checkbox"/> I have moderate headaches that come frequently.</p> <p><input type="checkbox"/> I have severe headaches that come frequently.</p> <p><input type="checkbox"/> I have headaches almost all the time.</p>	<p><b>Section 10 – Recreation</b></p> <p><input type="checkbox"/> I am able to engage in all my recreation activities with no neck pain at all.</p> <p><input type="checkbox"/> I am able to engage in all my recreation activities with some pain in my neck.</p> <p><input type="checkbox"/> I am able to engage in most but not all of my usual recreation activities because of neck pain.</p> <p><input type="checkbox"/> I am able to engage in a few of my usual recreation activities because of pain in my neck.</p> <p><input type="checkbox"/> I can hardly do any recreation activities because of pain in my neck.</p> <p><input type="checkbox"/> I can't do any recreation activities at all.</p>

## Revised OSWESTRY Index – Low Back

Name: \_\_\_\_\_

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

File #: \_\_\_\_\_

This questionnaire helps us to understand how much your **low back** has affected your ability to perform every day activities. Please mark with an X the one box in each section that most clearly describes your problem now.

<p><b>Section 1 – Pain Intensity</b></p> <p><input type="checkbox"/> The pain comes and goes and is very mild.</p> <p><input type="checkbox"/> The pain is mild and does not vary much.</p> <p><input type="checkbox"/> The pain comes and goes and is moderately increasing.</p> <p><input type="checkbox"/> The pain is moderate and does not vary much.</p> <p><input type="checkbox"/> The pain comes and goes and is severe.</p> <p><input type="checkbox"/> The pain is severe and does not vary much.</p>	<p><b>Section 6 – Standing</b></p> <p><input type="checkbox"/> I can stand as long as I want without pain</p> <p><input type="checkbox"/> I have some pain standing, but it does not increase with time.</p> <p><input type="checkbox"/> I cannot stand for longer than 1 hour without increasing pain.</p> <p><input type="checkbox"/> I cannot stand for longer than ½ hour without increasing pain.</p> <p><input type="checkbox"/> I cannot stand for longer than 10 minutes without increasing pain.</p> <p><input type="checkbox"/> I avoid standing because it increases the pain immediately.</p>
<p><b>Section 2 – Personal Care (washing, dressing, etc.)</b></p> <p><input type="checkbox"/> I do not have to change my way or washing or dressing in order to avoid pain.</p> <p><input type="checkbox"/> I do not normally change my way of washing or dressing even though it causes some pain.</p> <p><input type="checkbox"/> Washing and dressing increase the pain, but I manage not to change my way of doing it.</p> <p><input type="checkbox"/> Washing and dressing increase the pain, and I find it necessary to change my way of doing it.</p> <p><input type="checkbox"/> Because of the pain, I am unable to do some washing and dressing without help.</p> <p><input type="checkbox"/> Because of the pain, I am unable to do any washing and dressing without help.</p>	<p><b>Section 7 – Sleeping</b></p> <p><input type="checkbox"/> I get no pain in bed.</p> <p><input type="checkbox"/> I get pain in bed, but it does not prevent me from sleeping well.</p> <p><input type="checkbox"/> Because of pain, my normal night's sleep is reduced by less than ¼.</p> <p><input type="checkbox"/> Because of pain, my normal night's sleep is reduced by less than ½.</p> <p><input type="checkbox"/> Because of pain, my normal night's sleep is reduced by less than ¾.</p> <p><input type="checkbox"/> Pain prevents me from sleeping at all.</p>
<p><b>Section 3 – Lifting</b></p> <p><input type="checkbox"/> I can lift heavy weights without extra pain.</p> <p><input type="checkbox"/> I can lift heavy weights, but it gives extra pain.</p> <p><input type="checkbox"/> Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned (e.g., on a table).</p> <p><input type="checkbox"/> Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.</p> <p><input type="checkbox"/> I can only lift very light weights at the most.</p>	<p><b>Section 8 – Social Life</b></p> <p><input type="checkbox"/> My social life is normal and gives me no pain.</p> <p><input type="checkbox"/> My social life is normal but increases the degree of pain.</p> <p><input type="checkbox"/> Pain has no significant effect on my social life apart from limiting my more energetic interests (e.g., dancing, etc.).</p> <p><input type="checkbox"/> Pain has restricted my social life, and I do not go much.</p> <p><input type="checkbox"/> Pain has restricted my social life to my home.</p> <p><input type="checkbox"/> I have hardly any social life because of my pain.</p>
<p><b>Section 4 – Walking</b></p> <p><input type="checkbox"/> I have no pain when walking.</p> <p><input type="checkbox"/> I have some pain when walking, but it does not increase with distance.</p> <p><input type="checkbox"/> I cannot walk more than 1 mile without increasing pain.</p> <p><input type="checkbox"/> I cannot walk more than ½ mile without increasing pain.</p> <p><input type="checkbox"/> I cannot walk more than ¼ mile without increasing pain.</p> <p><input type="checkbox"/> I cannot walk at all without increasing pain.</p>	<p><b>Section 9 – Traveling</b></p> <p><input type="checkbox"/> I get no pain while traveling.</p> <p><input type="checkbox"/> I get some pain while traveling, but none of my usual forms of travel make it worse.</p> <p><input type="checkbox"/> I get extra pain while traveling, but it does not compel me to seek alternative forms of travel.</p> <p><input type="checkbox"/> I get extra pain while traveling which compels me to seek alternative forms of travel.</p> <p><input type="checkbox"/> Pain prevents all forms of travel except when done lying down.</p> <p><input type="checkbox"/> Pain restricts all forms of travel.</p>
<p><b>Section 5 – Sitting</b></p> <p><input type="checkbox"/> I can sit in any chair as long as I like without pain.</p> <p><input type="checkbox"/> I can sit only in my favorite chair as long as I like.</p> <p><input type="checkbox"/> Pain prevents me from sitting more than 1 hour.</p> <p><input type="checkbox"/> Pain prevents me from sitting more than ½ hour.</p> <p><input type="checkbox"/> Pain prevents me from sitting more than 10 minutes.</p> <p><input type="checkbox"/> I avoid sitting because it increases pain immediately.</p>	<p><b>Section 10 – Changing Degrees of Pain</b></p> <p><input type="checkbox"/> My pain is rapidly getting better.</p> <p><input type="checkbox"/> My pain fluctuates, but overall, it is definitely getting better.</p> <p><input type="checkbox"/> My pain seems to be getting better, but slowly improves.</p> <p><input type="checkbox"/> My pain is neither getting better nor worse.</p> <p><input type="checkbox"/> My pain is gradually worsening.</p> <p><input type="checkbox"/> My pain is rapidly worsening.</p>

## Patient Specific Functional and Pain Scales (PSFS)

<b>Patient Last Name</b>	<b>Patient First Name</b>	<b>Patient ID</b>	<b>Date of Birth (MM/DD/YYYY)</b>
<b>Provider Name:</b> Dr. Jason R. Wolford, D.C.		<b>Provider Phone:</b> 502-538-0222	

**Clinician Instructions:** Complete after the patient's history and before his/her exam.

**Initial Assessment:** Please list and score below **at least three** primary activities in your life that you are unable to perform or are having the most difficulty performing as a result of your chief problem. These may be general daily activities such as lifting, walking or showering, or they may be activities more specific to your work or play such as sitting at the computer, playing golf, or gardening. We will use these activities to measure your progress during your care.

**Follow-Up Assessment:** When you were assessed on \_\_\_\_\_, you told us that you were unable to perform or had difficulty performing the following activities because of your chief problem. Please score these same activities according to how you feel most recently.

**Patient Specific Activity Scoring Scheme – Score ONE number for EACH activity for each new date.**

0 = UNABLE to perform activity	0 1 2 3 4 5 6 7 8 9 10	10 = ABLE to perform activity at same level as before injury or problem
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Activity	Date:	Date:	Date:	Date	Date:
<b>1.</b>	<u>Score (0-10)</u>	<u>Score (0-10)</u>	<u>Score (0-10)</u>	<u>Score (0-10)</u>	<u>Score (0-10)</u>
<b>2.</b>	<u>Score (0-10)</u>	<u>Score (0-10)</u>	<u>Score (0-10)</u>	<u>Score (0-10)</u>	<u>Score (0-10)</u>
<b>3.</b>	<u>Score (0-10)</u>	<u>Score (0-10)</u>	<u>Score (0-10)</u>	<u>Score (0-10)</u>	<u>Score (0-10)</u>
<b>4.</b>	<u>Score (0-10)</u>	<u>Score (0-10)</u>	<u>Score (0-10)</u>	<u>Score (0-10)</u>	<u>Score (0-10)</u>
<b>5.</b>	<u>Score (0-10)</u>	<u>Score (0-10)</u>	<u>Score (0-10)</u>	<u>Score (0-10)</u>	<u>Score (0-10)</u>
<b>Totals:</b>					

I understand that the information I have provided above is current, complete, and accurate to the best of my knowledge.

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