INTEGRATIVE CHIROPRACTIC

HEALTH & WELLNESS

PATIENT APPLICATION FORM

WELCOME TO OUR CLINIC. We specialize in assisting our patients to achieve their highest level of health through our spinal and postural corrective programs. Our approach is very unique and advanced from other rehabilitative programs. This allows our patients to achieve far superior results compared to most other systems.

Please fill out the following information thoroughly

This will allow the doctor to determine if you are a case we can accept. Please feel free to ask any questions if you need assistance. We look forward to serving you.

Patient Signature: _____Date:_____

PATIENT APPLICATION SURVEY

Name: _____ (Age) _____ Gender: M F

Home Address: _____ Home Phone: (___)_____

City, State, Zip: _____ Work Phone: (___)_____

Email Address: _____Cell Phone: (___)_____

Birth Date: _____ /_____ / _____ Social Security #: _____ - _____ -_____

Marital Status: S M D W Height: _____ Ft. _____in Weight: _____

Occupation: _____Employer Name: _____

Spouse's Name: _____ Work Phone: (___)_____ Cell Phone: (___)_____

Spouse's Employer: _____ Occupation: _____

PURPOSE OF THIS VISIT

***What is the Primary reason for your visit today (Primary symptom/Condition) _____

1. Is this condition due to a motor vehicle accident or work injury? Yes / No
   If yes, When? _____
2. When did this condition begin? _____/_____/_____ What caused it?_____
3. How often do you experience this condition?
   Constantly (76%-100% of the time)
   Frequently (51-75% of the time)
   Occasionally (26-50% of the time)
   or Intermittently (1-25% of the time)

4. How would you describe the pain? Sharp Dull Diffuse Achy Burning Shooting Stiff Numb Tingly Sharp with motion Shooting with motion Stabbing with motion Electric with motion Other:
   _____

5. Using a scale of 0-10 (10 being the worst pain possible) how would you rate your problem?
   0 1 2 3 4 5 6 7 8 9 10

6. Have you experienced this condition before? If yes, please explain and who you have seen for this problem. _____
7. How much has the problem interfered with your work/social life? Not at all A little bit Moderately
   Quite a bit Extremely

***What is the second reason for your visit today (Secondary symptom/Condition) _____

8. When did this condition begin? _____/_____/_____ What caused it?_____
9. How often do you experience this condition? Constantly (76%-100% of the time) Frequently (51-75% of the time) Occasionally (26-50% of the time) or Intermittently (1-25% of the time)
10. How would you describe the pain? Sharp Dull Diffuse Achy Burning Shooting Stiff Numb Tingly Sharp with motion Shooting with motion Stabbing with motion Electric with motion Other:
    _____

11. Using a scale of 0-10 (10 being the worst pain possible) how would you rate your problem?

0 1 2 3 4 5 6 7 8 9 10

12. Have you experienced this condition before? If yes, please explain and who you have seen for this problem. _____
13. How much has the problem interfered with your work/social life? Not at all A little bit Moderately Quite a bit Extremely

***What is the third reason for your visit today (3rd symptom/Condition) _____

14. How often do you experience this condition? Constantly (76%-100% of the time) Frequently (51-75% of the time) Occasionally (26-50% of the time) or Intermittently (1-25% of the time)

15. How would you describe the pain? Sharp Dull Diffuse Achy Burning Shooting Stiff Numb Tingly Sharp with motion Shooting with motion Stabbing with motion Electric with motion Other:
_____
16. Using a scale of 0-10 (10 being the worst pain possible) how would you rate your problem?

0 1 2 3 4 5 6 7 8 9 10

17. Have you experienced this condition before? If yes, please explain and who you have seen for this problem. _____
18. How much has the problem interfered with your work/social life? Not at all A little bit Moderately Quite a bit Extremely

EXPERIENCE WITH CHIROPRACTIC

Have you seen a Chiropractor before? Yes / No
who? _____
When? _____
Reason for visits: _____
How did you respond? _____
Did your previous chiropractor take **before** and **after** x-rays? Yes No
Did you know posture determines your health? Yes No
Are you aware of any of your poor posture habits? Yes No Explain: _____
Are you aware of any poor posture habits in your spouse or children? Yes No
Explain: _____

The most common postural weakness is Forward Head Syndrome (head and neck starting to bend forward and progressively moving downward weakening your whole body). Even less severe forms of this posture can cause many adverse affects on your overall health. Have you ever been told or felt like you carry your head forward, noticed a rounding of your shoulders or a developing “hump” at the base of your neck? **Yes No**

HEALTH LIFESTYLE

1. Do you exercise? Yes No how often? 1X 2X 3X 4X 5X per week other:
2. What activities? Running Jogging Weight Training Cycling Yoga Pilates Swimming
3. Do you smoke? Yes No How much? _____
4. Do you drink alcohol? Yes No How much / week? _____
5. Do you drink coffee? Yes No How many cups / day? _____

6. Do you take any supplements (i.e. vitamins, minerals, herbs)? _____
7. What activities do you do outside of work? _____
8. Have you ever been hospitalized? Yes No If yes, why:_____
9. Have you had significant past trauma? Yes No When? _____
10. **Anything else pertinent to your visit today?** _____

Health History: (Check all that you currently have or have had in the past)

Joint Pain/Stiffness	Arthritis	Rheumatoid
Cancer	Tumor	High Blood Pressure
Stroke	Kidney Stones	Kidney Disorders
Prostate Problems	Abnormal weight changes	Loss of Appetite
Ulcer	Hepatitis	Liver/ Gall Bladder
Muscular Incoordination	Diabetes	Excessive Thirst
Depression	Systemic Lupus	Epilepsy
HIV/AIDS	Birth Control Pills	Hormonal Replacement
Pregnancy		

Please list any health conditions not mentioned:

_____

Please list any surgeries: _____

Please list any allergies: _____

PLEASE LIST ALL MEDICATIONS YOU ARE CURRENTLY TAKING (PRESCRIPTION AND OVER THE COUNTER)

MEDICATION: REASON: HOW OFTEN:

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_____ _____ _____

PATIENT/CLIENT NAME PATIENTS SIGNATURE
TODAY'S DATE

Abnormal postural habits or distortions are the result of trauma or stress to the body that have misaligned the vertebrae in your spine. When these vertebrae are twisted from their normal position, they will cause stress to the spinal cord and the delicate nerves that pass between the vertebrae. These misalignments are called subluxations (sub-lux-a-shuns). It has been extensively documented that subluxations, causing stress to your nerves, will weaken and distort the overall structure of your spine. This results in a weakened and distorted POSTURE. Postural distortions have many serious and adverse affects on your overall health. The most common and detrimental postural distortion is called Forward Head Syndrome (a "hunched forward" posture starting in the neck and progressively moving down your spine weakening the entire body).

Please Underline any health condition you may be experiencing, NOW or in the PAST.

CERVICAL SPINE (NECK):

Postural distortions from subluxations, (causing Forward Head Syndrome), in your neck will weaken the nerves into your arms, hands and head affecting these parts of your body. Do you experience…?

Neck Pain	Headaches	Sinusitis
Pain into your shoulders/arms/hands	Dizziness	Allergies/Hay fever
Numbness/tingling in arms/hands	Visual disturbances	Recurrent colds/Flu
Hearing disturbances	Coldness in hands	Low Energy/Fatigue
Weakness in grip	Thyroid conditions	TMJ/Pain/Clicking
Wrist Pain		

THORACIC SPINE (UPPER BACK):

Postural distortions from subluxations (resulting from Forward Head Syndrome) in the upper back will weaken the nerves to the heart and lungs and affect these parts of your body. Do you experience…?

Heart Palpitations	Heart Murmurs	Recurrent Lung Infections/Bronchitis
Asthma/Wheezing	Tachycardia	Shortness of Breath
Heart Attacks/Angina	Upper Back Pain	Pain on Deep Inspiration/Expiration

THORACIC SPINE (MID BACK):

Postural distortions from subluxations (resulting from Forward Head Syndrome) in the mid back will weaken the nerves into your ribs/chest and upper digestive tract, and affect these parts of your body. Do you experience…?

Mid Back Pain	Nausea	Pain Into Your Ribs/Chest
Ulcers/Gastritis	Indigestion/Heartburn	Hypoglycemia
Reflux	Tired/Irritable after eating or when you haven't eaten for a while	

LUMBAR SPINE (LOW BACK):

Postural distortions from subluxations in the low back (resulting from Forward Head Syndrome) will weaken the nerves into your legs/feet and pelvic organs and affect these parts of your body. Do you experience…?

Pain into your hips/legs/feet	Constipation/Diarrhea	Low back pain
Numbness/tingling in your legs/feet	Recurrent bladder infections	Coldness legs/feet
Frequent/difficulty urinating	Muscle cramps in your legs/feet	Sexual dysfunction
Weakness/injuries in your hips/knees/ankles	Menstrual irregularities/cramping	

FAMILY HEALTH HISTORY

Have any of your **family members** ever been diagnosed with the following:

[ ] Diabetes	[ ] Varicose veins	[ ] Neurological problems	[ ] Lung Disease
[ ] Rheumatic fever	[ ] Circulatory problems	[ ] Stroke	[ ] Heart murmur
[ ] High blood pressure	[ ] Heart Disease	[ ] Cancer	[ ] Osteoporosis
[ ] Kidney disease	[ ] Epilepsy/seizures	[ ] Migraine Headaches	[ ] Arthritis
[ ] Liver disease	[ ] Metal Implants	[ ] Infectious disease	[ ] Gall bladder
[ ] Broken bones/fractures	[ ] Appendectomy	[ ] Tonsillectomy	[ ] Hernia
[ ] Pneumonia	[ ] Polio	[ ] Tuberculosis	[ ] Anemia
[ ] Whooping Cough	[ ] Chicken Pox	[ ] Mumps	[ ] Measles
[ ] Thyroid	[ ] Small Pox	[ ] Influenza	[ ] Pleurisy
[ ] Lumbago	[ ] Eczema	[ ] ALS	[ ] Lupus
[ ] Rheumatoid Arthritis	[ ] Other:		

_____

AUTHORIZATION CARE

I authorize and agree to allow the doctor and/or assistant to work with my spine through the use spinal adjustments and rehabilitative exercises for the sole purpose of postural and structural restoration of normal biomechanical and neurological function.

I understand that I am responsible for all fees incurred for the services provided, and agree to ensure full payment of all charges.

The Doctor and/or assistant will not be held responsible for any health conditions or diagnoses which are pre-existing, given by another health care practitioner, or are not related to the spinal structural conditions diagnosed at this clinic.

I also clearly understand that if I do not follow the doctors and/or assistant's specific recommendations at this clinic that I will not receive the full benefit from these programs, and that if I terminate my care prematurely that all fees incurred will be due and payable at that time. I authorize the assignment of all insurance benefits be directed to the doctor and/or assistant for all services rendered.

_____ _____ _____

Patient's Name Printed Date Patient's Signature

_____ _____

Minors Name Guardian/Spouse's Signature of Authorizing care for minor

IN CASE OF EMERGENCY

Name_____

Relationship_____

Work Phone_____

Home Phone_____

Cell Phone_____

MASTER ASSIGNMENT, LIEN, AND AUTHORIZATION OF INSURANCE /ATTORNEY PAYMENTS

To Whom It May Concern:

I, _____, hereby authorize and direct you, my insurance company, and/or my attorney to pay directly to **Integrative Chiropractic Health & Wellness**

such sums as may be due and owed to **Integrative Chiropractic Health & Wellness** for services rendered to me, both by reason of an accident or illness, and by reason of any other bills that are due to **Integrative Chiropractic Health & Wellness**, and to withhold such sums from any disability benefits, medical payment benefits, No-Fault benefits, health and accident benefits, worker's compensation benefits, or any other insurance benefits obligated to reimburse me, or from any settlement, judgment or verdict on my behalf as may be necessary to adequately protect **Integrative Chiropractic Health & Wellness**. I hereby further give a lien to **Integrative Chiropractic Health & Wellness** against any and all insurance benefits name herein, and any and all proceeds of settlement, judgment or verdict which may be paid to me as a result of the injuries or illness for which I have been treated **by Integrative Chiropractic Health & Wellness** This is to act as an assignment of my rights and benefits to the extent **of Integrative Chiropractic Health & Wellness's** services rendered.

In the event my insurance company is obligated to make payments to me upon the charges made by **Integrative Chiropractic Health & Wellness** for their services, refuses to make such payments, upon demand by me or **Integrative Chiropractic Health & Wellness**, I hereby assign and transfer **to Integrative Chiropractic Health & Wellness** any and all causes of action that I might have or that might exist in my favor against such company, and authorize **Integrative Chiropractic Health & Wellness** to prosecute said cause of action either in my name or in the **Integrative Chiropractic Health & Wellness's** name, and further I authorize **Integrative Chiropractic Health & Wellness** to compromise, settle, or otherwise resolve said claim or cause of action as they see fit.

I understand that I remain personally responsible for the total amounts due to Integrative Chiropractic Health & Wellness for their services rendered. I further understand and agree that this Master Assignment, Lien, and Authorization does not constitute any consideration for **Integrative Chiropractic Health & Wellness** to await payments and may demand payments from me immediately upon rendering services at their option.
I authorize **Integrative Chiropractic Health & Wellness** to release any information pertinent to my case to any insurance company, adjuster or attorney to facilitate collection under this Master Assignment, Lien and Authorization.
I hereby state and agree that a photocopy of this document we be as valid and binding on all parties involved as the original copy.

Date:_____ Signed:_____

Integrative Chiropractic Health & Wellness
1580 Montgomery Hwy Suite 14
Hoover, AL 35216

(YOUR COPY)
FORMS OF PAYMENT

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and me. I clearly understand and agree that all services rendered

after my insurance's contracted annual agreement, are charged directly to me and that I am personally responsible for payments.

I understand that I am responsible for my contracted payment at the time of service. I also understand that if I suspend or terminate my care and treatment any fees for professional services rendered me will be immediately due and payable. I will be responsible for any costs of collection, attorney's fee or court costs required to collect my bill.

We accept cash, personal checks, VISA, MasterCard, American Express, and DISCOVER. Any bounced checks and fees will be my responsibility and will be paid in full. Any credit arrangements must be authorized in advance.

Other options are available if your care is covered by Workers Compensation, Medicare, Personal Injury, or the result of an automobile accident. We will not become involved in disputes with your insurance company or attorney regarding deductible, co-payments, covered charges, secondary insurance, "usual and customary" charges, "medical necessity", etc. other than to supply factual information.

HIPAAGUIDELINES

We are very concerned with protecting your privacy. While the law requires us to give you this disclosure, please understand that we have, and always will respect the privacy of your health information. There are several circumstances in which we may have to use or disclose your health care information. We may have to disclose your PHI to another healthcare provider or hospital if it is necessary to refer you to them for the diagnosis, assessment, or treatment. We may have to disclose you health information and billing records to another party if they are potentially responsible for the payment of your services.

We may need to use your health information within our own practice for quality control or other operational purposes. We may need to use your PHI to remind you of appointments, send you a birthday card, send you a thank you, acknowledge your referral, send you a welcome to the office letter, invite you to participate in office workshops, or send promotional information. We have a more complete notice that provides a detailed description of how your PHI may be used or disclosed. You have the right to revise that notice before you sign this consent form. We reserve the right to change our privacy practices as described in that notice.

YOUR RIGHTS

You have the right to request that we do not disclose your PHI to specific individuals, companies, or organizations. If you would like to place any restrictions on the use or disclosure of your PHI please let us know in writing. We are not required to agree with your restrictions. However, if we agree with your restrictions, the restriction in binding upon us. You may revoke your consent to us at any time; however, your revocation must be in writing. We will not be able to honor you revocation request if we have already released your PHI before we receive your request. If you were required to give your authorization as a condition of obtaining insurance, they may have the right to your PHI if they decide to contest any of your claims. I have read your consent policy and agree to its terms. I am also acknowledging that I have received a copy this notice if requested.

(YOUR COPY)
HEALTHCARE AUTHORIZATION FORM

THE FOLLOWING AUTHORIZES INTEGRATIVE CHIROPRACTIC HEALTH & WELLNESS TO USE AND/OR DISCLOSE PROTECTED HEALTHCARE INFORMATION IN ACCORDANCE WITH THE FOLLOWING SPECIFIC AUTHORIZATIONS:

I give permission to Integrative Chiropractic Health & Wellness to use my name, address, phone numbers and clinical records to contact them with birthday cards, holiday related cards, health related e-mails messages and information about treatment alternatives or other health related information as well as any advertisements, newsletters or patient of the week/month postings. I also give Integrative Chiropractic Health & Wellness permission to use pre/post posture pictures and x-rays for awareness and office teaching.

I give permission to Integrative Chiropractic Health & Wellness to treat me in an open room where other patients are also being treated. I am aware that other persons in the office may overhear some of their protective health care information during the course of my treatment. Should I need to speak with a doctor or physical therapist in private, the doctor or therapist will provide a private room for these conversations.

By signing the following you are giving Integrative Chiropractic Health & Wellness permission to use and disclose their protected health information in accordance with the directives listed above

FORMS OF PAYMENT

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and me**. I clearly understand and agree that all services rendered after my insurance's contracted annual agreement, are charged directly to me and that I am personally responsible for payments.**

I understand that I am responsible for my contracted payment at the time of service. I also understand that if I suspend or terminate my care and treatment any fees for professional services rendered me will be immediately due and payable. I will be responsible for any costs of collection, attorney's fee or court costs required to collect my bill.

We accept cash, personal checks, VISA, MasterCard, American Express, and DISCOVER. Any bounced checks and fees will be my responsibility and will be paid in full. Any credit arrangements must be authorized in advance.

Other options are available if your care is covered by Workers Compensation, Medicare, Personal Injury, or the result of an automobile accident. We will not become involved in disputes with your insurance company or attorney regarding deductible, co-payments, covered charges, secondary insurance, "usual and customary" charges, "medical necessity", etc. other than to supply factual information.

_____Initial

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We may need to use your health information within our own practice for quality control or other operational purposes. We may need to use your PHI to remind you of appointments, send you a birthday card, send you a thank you, acknowledge your referral, send you a welcome to the office letter, and invite you to participate in office workshops, or send promotional information. We have a more complete notice that provides a detailed description of how your PHI may be used or disclosed. You have the right to revise that notice before you sign this consent form. We reserve the right to change our privacy practices as described in that notice.

_____Initial

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You have the right to request that we do not disclose your PHI to specific individuals, companies, or organizations. If you would like to place any restrictions on the use or disclosure of your PHI please let us know in writing. We are not required to agree with your restrictions. However, if we agree with your restrictions, the restriction is binding upon us. You may revoke your consent to us at any time; however, your revocation must be in writing. We will not be able to honor you revocation request if we have already released your PHI before we receive your request. If you were required to give your authorization as a condition of obtaining insurance, they may have the right to your PHI if they decide to contest any of your claims. I have read your consent policy and agree to its terms. I am also acknowledging that I have received a copy this notice if requested.

_____ _____

Sign Name Date Provider Representative

HEALTH CARE AUTHORIZATION FORM

THE FOLLOWING AUTHORIZES INTEGRATIVE CHIROPRACTIC HEALTH & WELLNESS TO USE AND/OR DISCLOSE PROTECTED HEALTHCARE INFORMATION IN ACCORDANCE WITH THE FOLLOWING SPECIFIC AUTHORIZATIONS:

I give permission to Integrative Chiropractic Health & Wellness to use my name, address, phone numbers and clinical records to contact me with birthday cards, holiday related cards, health related e-mails messages and information about treatment alternatives or other health related information as well as any advertisements, newsletters or patient of the week/month postings. I also give Integrative Chiropractic Health & Wellness permission to use pre/post posture pictures and x-rays for awareness and office teaching.

I give permission to Integrative Chiropractic Health & Wellness to treat me in an open room where other patients are also being treated. I am aware that other persons in the office may overhear some of my protective health care information during the course of my treatment. Should I need to speak with a doctor or physical therapist in private, the doctor or therapist will provide a private room for these conversations.

By signing the following you are giving Integrative Chiropractic Health & Wellness permission to use and disclose your protected health information in accordance with the directives listed above

ACKNOWLEDGEMENT OF RECEIPT & NOTICE OF PRIVACY PRACTICES

I, _____ understand and have been provided with a notice of
(print name) information practices that provides me a more complete description of information uses and disclosures, I understand that I have the following rights and privileges:

* The right to review the notice prior to signing this consent
* The right to object to the use of my health care information for directory purpose
* The right to request restrictions as to how my health care information may be
Used or disclosed in this office to carry out treatment, payment, or health care
Operations

INSURANCE INFORMATION

I clearly understand that all insurance coverage, whether accident, work related, or general coverage is an arrangement between my insurance carrier and myself. If this office chooses to bill any services to my insurance carrier that they are performing these services are strictly as a convenience to me. The Doctor's office will provide any necessary reports or required information to aid in insurance reimbursement of services, but **I understand that insurance**

carriers may deny my claims and that I am ultimately responsible for any unpaid balances. Any monies received will be credited to my account.

I understand there could be some services that my insurance company does not cover, if this is the case are you willing to pay for these services [ ] YES [ ] NO

Patients Signature_____ **Date**_____

Guardian or Spouse's Signature Authorizing Care_____ Date_____
I hereby authorize Integrative Chiropractic Health & Wellness to administer care as deemed necessary to my child, a minor under the age of 18 years old.

Name of Insurance Co. _____Contract/Policy#_____
Insured's Name_____ **Insured's SS#**_____
Relationship to Insured _____ **Insured's Birthdate**___/____/_____

Who should receive charges on your account?
Patient Spouse Parent/Guardian Workers Comp Auto Insurance
Medicare Personal Health Insurance Attorney (_____)

RADIOGRAPH CONSENT (X-Ray)

I, _____ do hereby give my consent to allow Integrative Chiropractic Health & Wellness and its representatives, as deemed by the examining physician to take radiographs of my spine and/or extremities.

Signature of Patient/or Guardian of Minor _____ Date _____

FOR FEMALES ONLY

I also hereby declare that to my knowledge that I am not pregnant _____

WORK HISTORY

Name: _____Today's Date: _____
Current Employer: _____ Current Occupation:_____
What limitations have you experienced as a result of your pain/condition? (Choose all that apply)

cannot use left arm cannot use right arm cannot use left leg cannot use Right leg cannot drive Increased fatigue Lifting makes it worse Pain limits amount of movement cannot sit cannot walk

UNABLE TO LIFT:

0-10lbs 11-15lbs 16-20lbs 21-25lbs 26-50lbs NO RESTRICTIONS

YOUR PRESENT JOB INVOLVES:

STANDING FOR _____ MIN/HOURS

DRIVING FOR _____ MIN/HOURS

WALKING FOR _____ MIN/HOURS

SITTING FOR _____ MIN/HOURS

LIFTING FOR _____ MIN/HOURS

REPETITIVE MOTION Yes or No

HAVE YOU MISSED ANY WORK AS A RESULT OF YOUR CONDITION?

YES, HOW MANY DAYS DID YOU MISS? _____ DAYS

NO, LAST FULL DAY OF WORK WAS ON _____

I UNDERSTAND THAT THE INFORMATION I HAVE PROVIDED IS CURRENT AND COMPLETE TO THE BEST OF MY KNOWLEDGE.

PATIENT SIGNATURE: _____

ROLAND-MORRIS LOW BACK PAIN INDEX

NAME: _____ DATE: _____

This list contains some sentences that people have used to describe themselves when they have **BACK PAIN.** When you read them, you may find that some stand out because they

describe you. As you read the list, think of yourself **TODAY.** Fill in the box next to any sentence that describes you today.

- ❑ **I stay at home most of the time because of my back**
- ❑ **I change positions frequently to try and get my back comfortable**
- ❑ **I walk more slowly than usual because of my back**
- ❑ **Because of my back, I am not doing any of the jobs that I usually do around the house**
- ❑ **Because of my back, I use a handrail to get upstairs**
- ❑ **Because of my back, I lie down to rest more often**
- ❑ **Because of my back, I have to hold on to something to get out of a chair**
- ❑ **Because of my back, I try to get other people to do things for me**
- ❑ **I get dressed more slowly than usual because of my back**
- ❑ **I only stand up for short periods of time because of my back**
- ❑ **Because of my back, I try not to bend or kneel down**
- ❑ **My back is painful almost all of the time**
- ❑ **I find it difficult to turn over in bed because of my back**
- ❑ **My appetite is not very good because of my back pain**
- ❑ **I have trouble putting on socks/stockings because of the pain in my back**
- ❑ **I only walk for short distances because of my back pain**
- ❑ **I sleep less well because of my back**
- ❑ **Because of my back pain I get dressed with the help of someone else**
- ❑ **I avoid heavy jobs around the house because of my back**
- ❑ **Because of my back pain, I am more irritable and bad tempered**
- ❑ **Because of my back pain, I go upstairs more slowly than usual**
- ❑ **I stay in bed most of the time because of my back**

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

Signature: _____