Chiropractic Offices of Gonstead, Stangl & Arkowski, LLCs

☐ Dr. MJ Gonstead ☐ Dr. Melissa Stangl ☐ Dr. Lisa Arkowski ☐ Dr. Jennifer Gonstead

503 E. Clairemont Avenue ◆ Eau Claire, WI 54701 ◆ 715-832-2223

Date:

NEW PATIENT INTAKE			
Name (first) (M) (Last)			
Address	**City**	**State**	**Zip**
Phone (Home) (Cell) (Work)			
Date of Birth	**Age**	**Gender** ☐ Male ☐ Female	
Email Address			
Race ☐ Caucasian/White ☐ African American/Black ☐ Asian ☐ Native American ☐ Other			
Ethnicity ☐ Hispanic/Latino ☐ NOT Hispanic/Latino			
Marital Status ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐Widowed			
Spouse's Name			
Children ☐ YES ☐ NO name(s)			
Employer	**Occupation**		
Emergency Contact	**Phone**	**Relationship**	
How did you hear about our office? ☐ insurance ☐ medical provider ☐ website ☐ Facebook ☐ ad/event ☐ family/friend:			

SOCIAL HISTORY
Smoking Status ☐ Never Smoker ☐ Daily Smoker ☐ Occasional Smoker ☐ Former Smoker – quit date:
Do you use non-smoking tobacco products? ☐ NO ☐ YES
Alcohol Status ☐ None ☐ Casual ☐ Moderate ☐ Heavy ☐ Beer ☐ Wine ☐ Liquor
Caffeine Status ☐ None ☐ less than 3 drinks/day ☐ 3-6 drinks/day ☐ more than 6 drinks/day
Exercise ☐ Never ☐ Daily ☐ Weekly ☐ Walks ☐ Runs ☐ Swims ☐ Weights ☐ Other:

FAMILY HISTORY - ☑ where applicable					
CONDITION	**SELF**	**FATHER**	**MOTHER**	**SIBLING**	**GRANDPARENT**
Aneurysm					
Cancer/Tumor					
Diabetes					
Epilepsy/Seizure					
Heart Disease					
High Cholesterol					
Hypertension					
Multiple Sclerosis					
Osteopenia/porosis					
Stroke					

PATIENT HISTORY				
DATE	**SURGERY - HOSPITALIZATIONS**		**DATE**	**ACCIDENT - ILLNESS - INJURY**

Patient Initials _____

PATIENT NAME	DATE

Previous Chiropractic Care ☐ NO ☐ YES Approximate Last Appointment:
Previous Doctor of Chiropractic Name/Location:

Current Health Care Provider(s)	Location(s)
Do you grant permission to contact these providers? ☐ NO ☐ YES Please initial here →	

Have you had radiology imaging within the past 2 years? ☐ NO ☐ YES		
☐ X-RAY	Region:	Date/Location:
☐ MRI ☐ CT	Region:	Date/Location:
☐ OTHER	Region:	Date/Location:

CURRENT MEDICATIONS (Rx or OTC), VITAMINS, HERBS AND SUPPLEMENTS					
STARTED	NAME	DOSE	FREQUENCY	REASON FOR TAKING	PRESCRIBED BY

ALLERGIES AND SENSITIVITIES	REACTION

REVIEW OF SYSTEMS – Please circle C = current P = Past

GENERAL			**CARDIOVASCULAR**			**GASTROINTESTINAL**			**ENT**		
C	P	Weight Gain	C	P	Chest Pain	C	P	Abdominal Pain	C	P	Cold/Congested
C	P	Weight Loss	C	P	Heart Murmur	C	P	Abnormal Stool	C	P	Dizzy/Vertigo
SKIN/BREAST			C	P	Hypertension	C	P	Appetite ⇧⇩	C	P	Headache/Migraine
C	P	Breast lump/tender	C	P	Palpations	C	P	Change in bowel	C	P	Nosebleeds
C	P	Dry Skin/Texture	C	P	Sleep Apnea	C	P	Constipation	C	P	Throat tender/mass
C	P	Nail Changes	C	P	Shortness of breath	C	P	Diarrhea	C	P	Vision changes
C	P	Mole Changes	C	P	Syncope (fainting)	C	P	Heartburn	**PSYCHIATRIC**		
C	P	Rash/Itching	C	P	Varicosities	C	P	Hemorrhoids	C	P	ADD/ADHD
NEUROLOGIC			**RESPIRATORY**			C	P	Indigestion	C	P	Anxiety
C	P	Convulsions	C	P	Asthma	C	P	Nausea/Vomit	C	P	Depression
C	P	Incoordination	C	P	Cough	**GENITOURINARY**			C	P	Bipolar
C	P	Memory	C	P	COPD	C	P	Bed Wetting	**IMMUNE/LYMPH/ENDOCRINE**		
C	P	Neuropathy	C	P	Fever/night sweats	C	P	Bleeding/Discharge	C	P	Anemia
C	P	Numbness	C	P	Infections	C	P	Cycle Irregularities	C	P	Bleeding Issues
C	P	Paralysis	C	P	Pain/Wheezing	C	P	Difficulty urinating	C	P	Lymph node large/tender
C	P	Speech	C	P	Shortness of breath	C	P	Libido	C	P	Frequent thirst/hunger
C	P	Tingling	C	P	Pneumonia	C	P	Pain on Urination	C	P	Heat/cold intolerant
C	P	Tremors				C	P	Unusual color/smell Urine	C	P	Thyroid Issues
						C	P	Urgency/Frequency			

FEMALES	Are you currently pregnant ☐ NO ☐ YES Due Date:	History of previous miscarriage? ☐ NO ☐ YES
Menopause ☐NO ☐YES	Current PAP ☐NO ☐YES	Current Mammogram ☐NO ☐YES Regular self-breast exams ☐ NO ☐ YES

Patient Initials _____

PATIENT NAME	DATE

HISTORY OF PRESENT COMPLAINT
Are your present complaints due to any of the following: ☐ Auto Accident ☐ Work Injury ☐ Personal Injury ☐ No
Have you had any recent accidents, falls, or injuries? ☐ No ☐ Yes approximate date:
Have you had any recent hospitalizations or new diagnoses? ☐ No ☐ Yes
Have you had any recent major life events? ☐ No ☐ Yes

NECK ☐ No Current Complaint	
Describe Current Complaint	
Date of Onset:	☐ Acute ☐ Chronic ☐ Recurrent ☐ Sudden ☐ Gradual
Provocation (what caused/contributed):	
Quality: ☐Ache ☐ Burn ☐ Dull ☐ Pinch/Stab ☐ Sharp ☐ Sore ☐ Spasm ☐ Stiff ☐ Throb ☐ Tight ☐ Other	
Radiation: ☐ Stay Localized ☐ Pain Travels/Shoots ☐ Pain Extends elsewhere ☐Numbness ☐ Tingling	
Severity: ☐ Minimal (no impairment) ☐ Slight (some impairment) ☐ Moderate (ADLs difficult) ☐ Marked (preclude activity)	
Pain Level: (no pain) 0 ----- 1 ----- 2 ----- 3 ----- 4 ----- 5 ----- 6 ----- 7 ----- 8 ----- 9 ----- 10 (worst pain ever, nothing else matters)	
Timing: ☐ Intermittent (0-25%) ☐ Occasional (25-50%) ☐ Frequent (50-75%) ☐ Constant (75-100%)	
What Makes it better?	
What Makes it worse?	

HEADACHE/MIGRAINE ☐ No Current Complaint	
Date of Onset:	☐ Acute ☐ Chronic ☐ Recurrent ☐ Sudden ☐ Gradual
Describe location AND quality of symptoms:	
Severity: ☐ Minimal (no impairment) ☐ Slight (some impairment) ☐ Moderate (ADLs difficult) ☐ Marked (preclude activity)	
Pain Level: (no pain) 0 ----- 1 ----- 2 ----- 3 ----- 4 ----- 5 ----- 6 ----- 7 ----- 8 ----- 9 ----- 10 (worst pain ever, nothing else matters)	
Timing: ☐ Daily ☐ Weekly ☐ Monthly ☐ Constant (75-100%)	

MIDBACK ☐ No Current Complaint	
Describe Current Complaint	
Date of Onset:	☐ Acute ☐ Chronic ☐ Recurrent ☐ Sudden ☐ Gradual
Provocation (what caused/contributed):	
Quality: ☐Ache ☐ Burn ☐ Dull ☐ Pinch/Stab ☐ Sharp ☐ Sore ☐ Spasm ☐ Stiff ☐ Throb ☐ Tight ☐ Other	
Radiation: ☐ Stay Localized ☐ Pain Travels/Shoots ☐ Pain Extends elsewhere ☐Numbness ☐ Tingling	
Severity: ☐ Minimal (no impairment) ☐ Slight (some impairment) ☐ Moderate (ADLs difficult) ☐ Marked (preclude activity)	
Pain Level: (no pain) 0 ----- 1 ----- 2 ----- 3 ----- 4 ----- 5 ----- 6 ----- 7 ----- 8 ----- 9 ----- 10 (worst pain ever, nothing else matters)	
Timing: ☐ Intermittent (0-25%) ☐ Occasional (25-50%) ☐ Frequent (50-75%) ☐ Constant (75-100%)	
What Makes it better?	
What Makes it worse?	

LOW BACK/HIP/PELVIS ☐ No Current Complaint	
Describe Current Complaint	
Date of Onset:	☐ Acute ☐ Chronic ☐ Recurrent ☐ Sudden ☐ Gradual
Provocation (what caused/contributed):	
Quality: ☐Ache ☐ Burn ☐ Dull ☐ Pinch/Stab ☐ Sharp ☐ Sore ☐ Spasm ☐ Stiff ☐ Throb ☐ Tight ☐ Other	
Radiation: ☐ Stay Localized ☐ Pain Travels/Shoots ☐ Pain Extends elsewhere ☐Numbness ☐ Tingling	
Severity: ☐ Minimal (no impairment) ☐ Slight (some impairment) ☐ Moderate (ADLs difficult) ☐ Marked (preclude activity)	
Pain Level: (no pain) 0 ----- 1 ----- 2 ----- 3 ----- 4 ----- 5 ----- 6 ----- 7 ----- 8 ----- 9 ----- 10 (worst pain ever, nothing else matters)	
Timing: ☐ Intermittent (0-25%) ☐ Occasional (25-50%) ☐ Frequent (50-75%) ☐ Constant (75-100%)	
What Makes it better?	
What Makes it worse?	
Check if you experience ☐ Upper extremity complaints ☐ Lower Extremity complaints ☐ Other Complaints:	

Patient Signature _____ Date _____

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503 E. Clairemont Ave ♦ Eau Claire, WI 54701 ♦ (715) 832-2223

INSURANCE INFORMATION

A ☐ Check this box if you are NOT billing insurance for your chiropractic services (Proceed to Section B)

Patient Name		Date of Birth
Patient Address		Patient Phone Number
City	State	Zip Code
Patient's Employer		Employer Phone
Insurance Company		Are you the primary Insurance Holder? Y N
If you're not the primary insurance holder, who is? (Check below)		
☐ Spouse ☐ Mother ☐ Father ☐ Other		
Policy #		Group #

Please fill out the information below if you are not the primary insurance holder		
Name of Primary		Primary's DOB
Primary's Address		Primary's Phone #
City	State	Zip Code
Primary's Employer		Employer's Phone #

Do you have secondary insurance? ☐ Yes ☐ No	
Policy #	Group #

PAYMENT AGREEMENT

I understand that there is no guarantee that my insurance companies or pre-paid health plan will cover or pay for all of my charges. Notwithstanding denial, reduction of benefits for any reason, I understand that I am responsible for all remaining charges.

Patient Signature _____ Date _____

B By signing below, I do hereby give my consent to the performance of conservative, noninvasive treatment to the joints and soft tissues. I understand that the procedures my consist of manipulations/ adjustments involving movement of the joints and soft tissues. Physical therapy exercises may also be used.

Although spinal manipulation/adjustment is considered to be one of the safest, most effective forms of therapy for musculoskeletal problems, I am aware that there are possible risks and complications associated with these procedures as follows: Soreness, Dizziness, Fractures/joint injury, Stroke, and physical therapy burns.

I understand the probability of any of these risks occuring is rare and that tests will be performed on me to minimize the risk of any complication from treatment, and I freely assume these risks. I am aware that reasonable alternatives to chiropractic procedures are available to me including rest, home application of therapy, prescription and over the counter medications, exercises, and possibly surgery. I also understand that there are beneficial effects associated with chiropractic treatment procedures including decreased pain, improved mocbility and function, and reduced muscle spasm. However, I appreciate there is no certainty that I will achieve these benefits. I agree to the performance of these procedures by my doctor and such other person(s) of the doctor's choosing. **I have read or have had read to me the above explanations of chiropractic treatment. Any question I have regarding these procedures have been answered to my satisfaction PRIOR TO MY SIGNING THIS CONSENT FORM. I have made my decisions voluntarily and freely.**

Patient Signature _____ Date_____

Office staff use only: Copy of Patient's insurance card is on file ☐ Staff Initials

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O Dr. MJ Gonstead O Dr. Melissa Stangl O Dr. Lisa Arkowski O Dr. Jennifer Gonstead
503 E. Clairemont Ave • Eau Claire, WI 54701 • P: (715) 832-222

CONSENT FOR USE OR DISCLOSURE OF HEALTH INFORMATION

Our Privacy Pledge

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 (PHI). There are several circumstances in which we may have to disclose your health care information.

• We may have to disclose your health information to another health care provider or a hospital if it is necessary to refer you to them for the diagnosis, assessment, or treatment of your health condition.

• We may have to disclose your 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 practice for quality control or other operational purposes.

• We may need to use your personal health information such as name, address, email or phone number to contact you with appointment reminders.

We have a more complete notice that provides a detailed description of how your health information may be used or disclosed. You have the right to review that notice before you sign this consent form (164.520). We reserve the right to change our privacy practices as described in that notice. If we make a change to our privacy practices, we will notify you in writing when you come in for treatment or by mail. Please feel free to call us any time for a copy of our privacy notices.

Your right to limit uses or disclosures

You have the right to request that we do not disclose your health information to specific individuals, companies, or organizations. If you would like to place any restrictions on the use or disclosure of your health information, please let us know in writing. We are not required to agree to your restrictions. However, if we agree with your restrictions, the restriction is binding on us.

Your right to revoke your authorization

You may revoke your consent to us at any time; however, your revocations must be in writing. We will not be able to honor your revocation request if we have already released your health information before we receive your request to revoke your authorization. If you were required to give your authorization as a condition of obtaining insurance, the insurance company may have a right to your health information 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 of this notice, if I request it.

_____ _____

Print Patient Name Authorized Staff Representative

_____ _____

Patient or Parent's Signature Date

I WOULD LIKE A COPY OF THIS HIPAA POLICY? YES NO (CIRCLE ONE) *PAPER COPY EMAIL* (CIRCLE ONE)

Patient Summary Form

PSF-750 (Rev: 7/1/2015)

Instructions
Please complete this form within the specified timeframe. All PSF submissions should be completed online at www.myoptumhealthphysicalhealth.com unless otherwise instructed.

Please review the Plan Summary for more information.

Complete this section

Patient Information

Patient name: Last | First | MI

○ Female ○ Male

Patient date of birth

Patient address | City | State | Zip code

Patient Insurance ID# | Health plan | Group number

Referring physician (if applicable) | Date referral issued (if applicable) | Referral number (if applicable)

Provider Information

1. Name of the billing provider or facility (as it will appear on the claim form)

2. Federal tax ID(TIN) of entity in box #1

3. Name and credentials of the individual performing the service(s)

1 MD/DO 2 DC 3 PT 4 OT 5 Both PT and OT 6 Home Care 7 ATC 8 MT 9 Other ____

4. Alternate name (if any) of entity in box #1

5. NPI of entity in box #1

6. Phone number: (715) 832-2223

7. Address of the billing provider or facility indicated in box #1: 503 E. Clairemont Avenue

8. City: Eau Claire

9. State: WI

10. Zip code: 54701

Provider Completes This Section:

Date you want *THIS* submission to begin:

Patient Type

1. New to your office
2. Est'd, new injury
3. Est'd, new episode
4. Est'd, continuing care

Cause of Current Episode

1. Traumatic
2. Unspecified
3. Repetitive
4. Post-surgical →
5. Work related
6. Motor vehicle

Date of Surgery

Type of Surgery

1. ACL Reconstruction
2. Rotator Cuff/Labral Repair
3. Tendon Repair
4. Spinal Fusion
5. Joint Replacement
6. Other _____

Diagnosis (ICD codes)
Please ensure all digits are entered accurately

1° 2° 3° 4°

Nature of Condition

1. Initial onset (within last 3 months)
2. Recurrent (multiple episodes of < 3 months)
3. Chronic (continuous duration > 3 months)

DC ONLY
Anticipated CMT Level

○ 98940 ○ 98942 ○ 98941 ○ 98943

Current Functional Measure Score

Neck Index | DASH | (other FOM)

Back Index | LEFS

Complete this section

Patient Completes This Section:

(Please fill in selections completely)

Symptoms began on:

1. Briefly describe your symptoms:

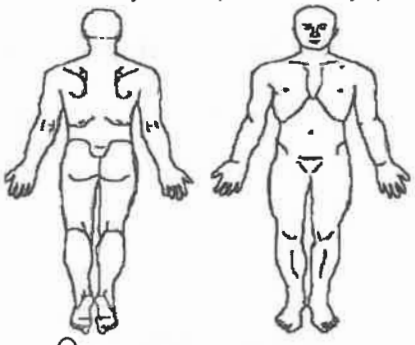
2. How did your symptoms start?

3. Average pain intensity:

Last 24 hours: **no pain** 0 1 2 3 4 5 6 7 8 9 10 **worst pain**

Past week: **no pain** 0 1 2 3 4 5 6 7 8 9 10 **worst pain**

Indicate where you have pain or other symptoms:



4. How often do you experience your symptoms?

1. Constantly (76%-100% of the time)
2. Frequently (51%-75% of the time)
3. Occasionally (26% - 50% of the time)
4. Intermittently (0%-25% of the time)

5. How much have your symptoms interfered with your usual daily activities? (including both work outside the home and housework)

1. Not at all
2. A little bit
3. Moderately
4. Quite a bit
5. Extremely

6. How is your condition changing, since care began at *this* facility?

0. **N/A — This is the initial visit**
1. Much worse
2. Worse
3. A little worse
4. No change
5. A little better
6. Better
7. Much better

7. In general, would you say your overall health right now is...

1. Excellent
2. Very good
3. Good
4. Fair
5. Poor

Patient Signature: X _____ **Date:** _____

OPTUM®
MN010-W120, PO Box 1459 | Minneapolis, MN 55440-1459 | Toll Free: (800) 873-4575 | Telephone: (763)595-3200 | Fax (763) 595-3333

The Keele STarT Back Screening Tool

Patient name: _____ Date: _____

Thinking about the **last 2 weeks** tick your response to the following questions:

		No 0	Yes 1
1	Has your back pain spread down your leg(s) at some time in the last 2 weeks?	☐	☐
2	Have you had pain in the shoulder or neck at some time in the last 2 weeks?	☐	☐
3	Have you only walked short distances because of your back pain?	☐	☐
4	In the last 2 weeks, have you dressed more slowly than usual because of back pain?	☐	☐
5	Do you think it's not really safe for a person with a condition like yours to be physically active?	☐	☐
6	Have worrying thoughts been going through your mind a lot of the time?	☐	☐
7	Do you feel that your back pain is terrible and it's never going to get any better?	☐	☐
8	In general have you stopped enjoying all the things you usually enjoy?	☐	☐

9. Overall, how **bothersome** has your back pain been in the last 2 weeks?

Not at all	Slightly	Moderately	Very much	Extremely
☐	☐	☐	☐	☐
0	0	0	1	1

Total score (all 9): _____ **Sub Score (Q5-9):**_____

Funded by Arthritis Research UK

Neck Pain Disability Index Questionnaire

Score: _____

Name: _____ Date: _____

This questionnaire is designed to enable your chiropractor to understand how much your neck pain has affected your ability to manage your everyday life. Please answer each section by marking in each section **ONE BOX** that best describes your condition today. We realize that you may feel that more than one statement may relate to you, but please **just mark the box that most closely describes your condition as you are feeling today.**

Section 1 – Pain Intensity

☐ I have no pain at the moment.
☐ The pain is very mild at the moment.
☐ The pain is moderate at the moment.
☐ The pain is fairly severe at the moment.
☐ The pain is very severe at the moment.
☐ The pain is the worst imaginable at the moment.

Section 2 – Personal Care (Washing, Dressing, etc.)

☐ I can look after myself without causing extra pain.
☐ I can look after myself normally but it causes extra pain.
☐ It is painful to look after myself and I am slow and careful.
☐ I need some help but manage most of my personal care.
☐ I need help every day in most aspects of self-care.
☐ I do not get dress, I wash with difficulty and stay in bed.

Section 3 – Lifting

☐ I can lift heavy weights without extra pain.
☐ I can lift heavy weights but it gives extra pain.
☐ Pain prevents me lifting heavy weights off the floor, but I can manage if they are conveniently positioned, (e.g. on a table).
☐ Pain prevents me lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
☐ I can lift very light weights.
☐ I cannot list or carry anything at all.

Section 4 – Reading

☐ I can read as much as I want to with no pain in my neck.
☐ I can read as much as I want to with slight pain in my neck.
☐ I can read as much as I want to with moderate pain in my neck.
☐ I cannot read as much as I want because of moderate pain in my neck.
☐ I cannot read as much as I want because of severe pain in my neck.
☐ I cannot read at all because of pain in my neck.

Section 5 - Headaches

☐ I have no headaches at all.
☐ I have slight headaches which come infrequently.
☐ I have moderate headaches which come infrequently.
☐ I have moderate headaches which come frequently.
☐ I have severe headaches which come frequently.
☐ I have headaches almost all the time.

Section 6 - Concentration

☐ I can concentrate fully when I want to with no difficulty.
☐ I can concentrate fully when I want to with slight difficulty.
☐ I have a fair degree of difficulty in concentrating when I want to.
☐ I have a lot of difficulty in concentrating when I want to.
☐ I have a great deal of difficulty in concentrating when I want to.
☐ I cannot concentrate at all.

Section 7 – Work

☐ I can do as much as I want to.
☐ I can only do my usual work, but no more.
☐I can do most of my usual work, but no more.
☐ I cannot do my usual work.
☐ I can hardly do any work at all.
☐ I cannot do any work at all.

Section 8 - Driving

☐ I can drive without any neck pain.
☐I can drive my car as long as I want with slight pain in my neck.
☐ I can drive my car as long as I want with moderate pain in my neck.
☐ I cannot drive my car as long as I want because of moderate pain in my neck.
☐ I can hardly drive at all because of severe pain in my neck.
☐ I cannot drive my car at all because of neck pain.

Section 9 - Sleeping

☐ I have no trouble sleeping.
☐ My sleep is slightly disturbed (less that 1 hour sleepless).
☐ My sleep is mildly disturbed (1-2 hours sleepless).
☐ My sleep is moderately disturbed (2-3 hours sleepless).
☐ My sleep is greatly disturbed (3-5 hours sleepless).
☐ My sleep is completely disturbed (5-7 hours sleepless).

Section 10 - Recreation

☐I am able to engage in all of my recreational activities with no neck pain at all.
☐ I am able to engage in all of my recreational activities with some pain in my neck.
☐ I am able to engage in most, but not all of my recreational activities because of neck pain.
☐ I am able to engage in a few of my recreational activities because of pain in my neck.
☐ I can hardly do any recreational activities because of pain in my neck.
☐ I cannot do any of my recreational activities at all.

The Neck Disability Index: A study of reliability and validity. J Manipulative Physiol Ther 1991;14:409-415

Quadruple Numerical Rating Scale

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

NOTE: Please answer the following questions in regard to your **NECK PAIN**

1. What is your pain **RIGHT NOW**?

No pain 0 1 2 3 4 5 6 7 8 9 10 worst possible pain

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

No pain 0 1 2 3 4 5 6 7 8 9 10 worst possible pain

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

No pain 0 1 2 3 4 5 6 7 8 9 10 worst possible pain

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

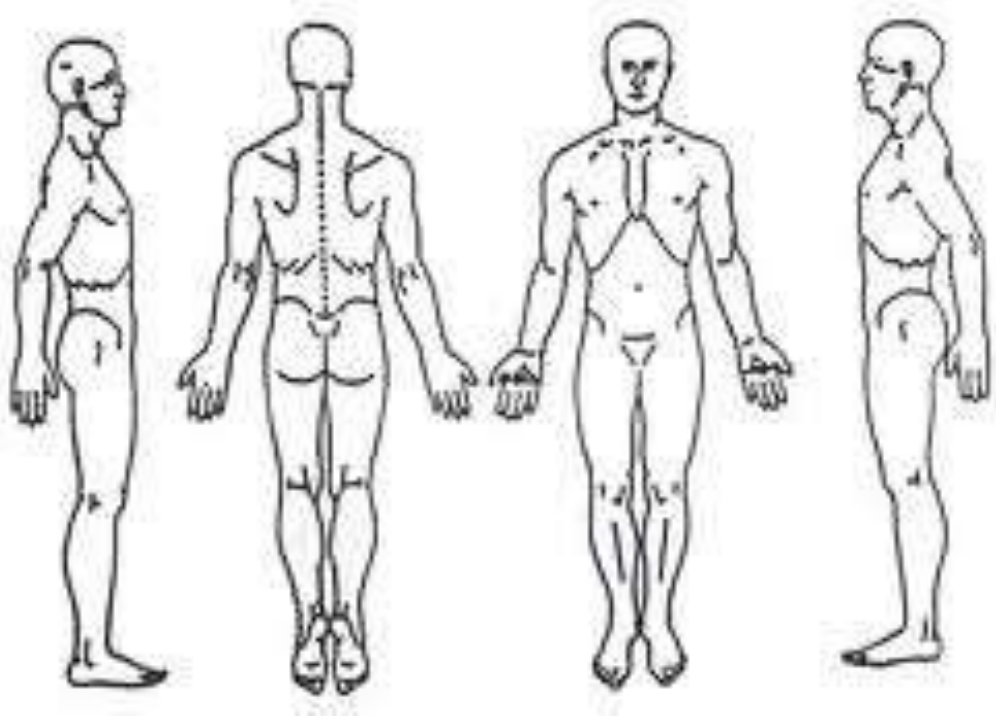
No pain 0 1 2 3 4 5 6 7 8 9 10 worst possible pain

OTHER COMMENTS:

_____

_____

INSTRUCTIONS: Please mark the diagram below to indicate where you are experiencing pain/symptoms



Oswestry Low Back Pain Questionnaire Score: _____

Name: _____ Date: _____

This questionnaire is designed to enable your chiropractor to understand how much your low back pain has affected your ability to manage your everyday life. Please answer each section by marking in each section **ONE BOX** that best describes your condition today. We realize that you may feel that more than one statement may relate to you, but please **just mark the box that most closely describes your condition as you are feeling today.**

Section 1 – Pain Intensity

☐ The pain comes and goes and is very mild.
☐ The pain is mild and does not vary much.
☐ The pain comes and goes and is moderate.
☐ The pain is moderate and does not vary much.
☐ The pain comes and goes and is severe.
☐ The pain is severe and does not vary much.

Section 2 – Personal Care

☐ I do not have to change my way of washing or dressing to avoid pain.
☐ I do not change my way of washing or dressing even though it causes me pain.
☐ I sometimes change my way of washing or dressing because it increases pain.
☐ I find it necessary to change my way of washing or dressing because it increases pain.
☐ Because of the pain I am unable to do some washing and dressing without help.
☐ Because of the pain I am unable to do any washing and dressing without help.

Section 3 – Lifting (skip if you have not attempted lifting since the onset of your low back pain)

☐ I can lift heavy weights without extra low back pain.
☐ I can lift heavy weights but it causes extra pain.
☐ Pain prevents me lifting heavy weights off the floor.
☐ Pain prevents me lifting heavy weights off the floor, but I can manage if they are conveniently positioned, (e.g. on a table).
☐ Pain prevents me lifting heavy weights but I can manage light to medium weights if they are conveniently positioned.
☐ I can only lift light weights at the most due to low back pain.

Section 4 – Walking

☐ I have no pain walking.
☐ I have some pain on walking, but I can still walk my required to normal distances.
☐ I cannot walk more than 1 mile without increasing pain.
☐ I cannot walk more than ½ mile without increasing pain.
☐ I cannot walk more than ¼ mile without increasing pain
☐ I cannot walk at all without increasing pain.

Section 5 - Sitting

☐ Sitting does not cause me any pain.
☐ I can sit as long as I need provided I have my choice of sitting surfaces.
☐ Pain prevents me from sitting more than 1 hour.
☐ Pain prevents me from sitting more than ½ hour.
☐ Pain prevents me from sitting more than 10 minutes.
☐ Pain prevents me from sitting at all.

Section 6 - Standing

☐ I can stand as long as I want without pain.
☐ I have some pain with standing. It does not increase with time.
☐ I cannot stand for longer than 1 hour without increasing pain.
☐ I cannot stand for longer than ½ hour without increasing pain.
☐ I cannot stand for longer than 10 mins without increasing pain.
☐ I avoid standing because it increases the pain immediately.

Section 7 - Sleeping

☐ I have no pain while in bed.
☐ I have pain in bed, but it does not prevent me from sleeping.
☐ Because of pain I sleep only ¾ of normal time.
☐ Because of pain I sleep only ½ of normal time.
☐ Because of pain I sleep only ¼ of normal time.
☐ Pain prevents me from sleeping at all.

Section 8 - Social Life

☐ My social life is normal and gives me no pain.
☐ My social life is normal, but increases the degree of pain.
☐ Pain prevents me from participating in more energetic activities (e.g. sports, dancing).
☐ Pain prevents me from going out very often.
☐ Pain has restricted my social life to my home.
☐ I hardly have any social life because of pain.

Section 9 - Traveling

☐ I get no pain while traveling.
☐ I get some pain while traveling, but none of my usual forms of travel make it any worse.
☐ I get some pain while traveling, but it does not compel me to seek alternative forms of travel.
☐ I get extra pain while traveling that requires me to seek alternative forms of travel.
☐ Pain restricts all forms of travel.
☐ Pain prevents all forms of travel except that done lying down.

Section 10 - Employment/Homemaking

☐ My normal job/homemaking duties do not cause pain.
☐ My normal job/home duties cause me extra pain, but I can still perform all that's required of me.
☐ I can perform most of my job/homemaking duties, but pain prevents me from performing more physically stressful activities e.g. lifting, vacuuming, etc.
☐ Pain prevents me from doing anything but light duties.
☐ Pain prevents me from even light duties.
☐ Pain prevents me from performing any job/household chore.

Reference: The Oswestry Disability Index. Spine 25:2940-2953. 2000.

Quadruple Numerical Rating Scale

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

NOTE: Please answer the following questions in regard to your **BACK PAIN**

1. What is your pain **RIGHT NOW**?

No pain _____ worst possible pain
0 1 2 3 4 5 6 7 8 9 10

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

No pain _____ worst possible pain
0 1 2 3 4 5 6 7 8 9 10

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

No pain _____ worst possible pain
0 1 2 3 4 5 6 7 8 9 10

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

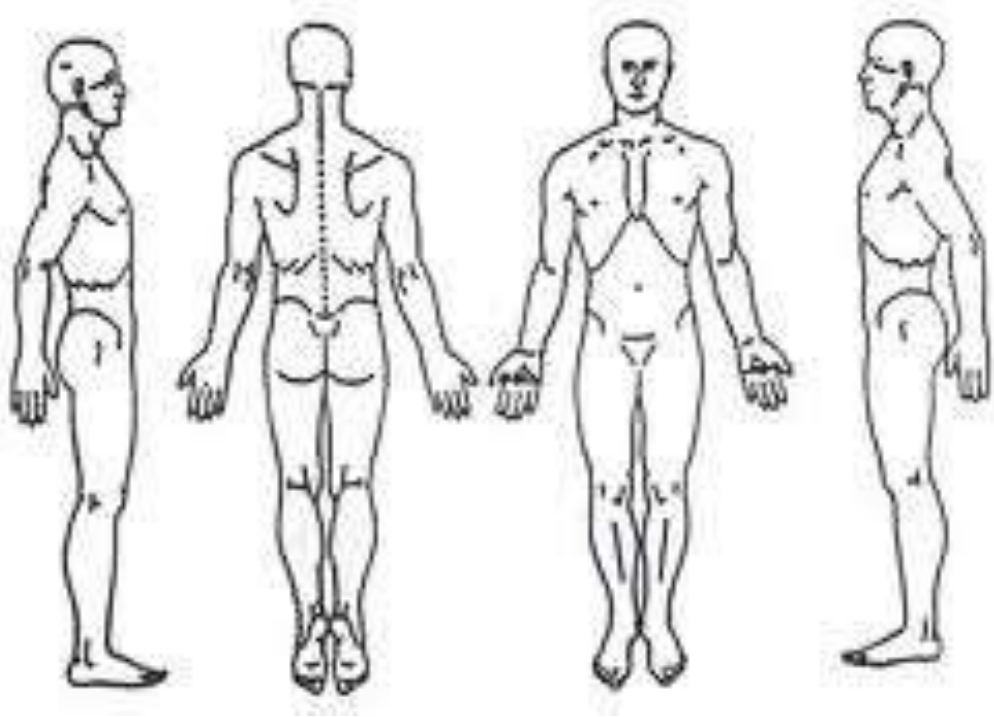
No pain _____ worst possible pain
0 1 2 3 4 5 6 7 8 9 10

OTHER COMMENTS:

_____

_____

INSTRUCTIONS: Please mark the diagram below to indicate where you are experiencing pain/symptoms



503 E CLAIREMONT AVENUE * EAU CLAIRE, WI 54701 * PHONE: 715-832-2223 * FAX: 715-832-7416

Patient name: _____ DOB: _____

AUTHORIZATION FOR VERBAL COMMUNICATION

👉**Whom may we speak to on your behalf about scheduling and/or billing**

(List First and Last Names of Person(s) To Whom Your Information May Be Disclosed, Such as Parents, Spouse, Etc).

I authorize communication between :_____

_____

And the doctor(s)/staff of:

O MJ Gonstead LLC
O Arkowski Chiropractic LLC
O Stangl Chiropractic & Massage Therapy LLC
O Jennifer Gonstead Chiropractic LLC

AUTHORIZATION TO LEAVE VOICEMAIL/TEXT MESSAGES

👉**May we leave a voicemail or text about scheduling and/or billing**

O Leave Voicemail/Text at the Following Number(s)_____

Cell Phone provider: O Verizon O T-Mobile O AT&T O _____ (Other)

I authorize to leave messages with:

O Anyone O Names of authorized individuals listed above

👉This authorization will expire **one year** from date signed, unless otherwise indicated:

O Indefinite O Other end date: _____ (MM/DD/YYYY)

In accordance with the conditions listed above, I authorize the use and/or disclosure of my medical information pertaining to appointments and billing at this office. This does not authorize the release of copies of medical records.

Signature of Patient/Representative: _____

Date: _____

If signed by persons other than the patient, please print name and state relationship to patient.

Print Name: _____*Relationship:* _____