

**NAME:** \_\_\_\_\_ Mr Mrs Ms Miss Dr Rev  
Last name First name Initial (please circle one of the above)

**DATE OF BIRTH:** Year \_\_\_\_\_ Month \_\_\_\_\_ Day \_\_\_\_\_ Ht \_\_\_\_\_ Wt. \_\_\_\_\_ Shoe Sz. \_\_\_\_\_

**HOME ADDRESS:** \_\_\_\_\_  
Street City Province Postal Code

**PHONE NUMBER:** Home: \_\_\_\_\_ Cell: \_\_\_\_\_ Work: \_\_\_\_\_

**EMAIL ADDRESS:** \_\_\_\_\_

**OCCUPATION:** \_\_\_\_\_ **EMPLOYER:** \_\_\_\_\_

**MEDICAL DOCTOR:** \_\_\_\_\_ **HEALTH CARD#** \_\_\_\_\_

**How did you hear about our office?** \_\_\_\_\_

**Who should we contact in case of emergency?** \_\_\_\_\_ Phone # \_\_\_\_\_

**What is your major complaint today?** \_\_\_\_\_

**How long have you had this condition?** \_\_\_\_\_

**Describe the onset of this condition?** \_\_\_\_\_

**Is the condition getting:** (circle) Worse Same Better Consistent Recurring

**How would you describe the pain?** (circle) Aching Throbbing Tingling Numbness Burning  
Shooting Intermittent Constant

**Do you experience Numbness or Tingling to the arms or legs?** YES NO

**Is there a particular time of day when your complaint is worse?** (circle)

Morning Afternoon Evening Night After activities

**What activities are you unable to perform due to pain or functional impairment?** (ie. golf)  
\_\_\_\_\_

**Have you had this condition before?** YES NO

**Were XRAYs or other imaging performed?** YES NO

**What aggravates your condition?** \_\_\_\_\_

**What relieves your condition?** \_\_\_\_\_

**What types of treatment have you had for this condition?** \_\_\_\_\_

**Have you had previous chiropractic care?** YES NO

If "yes" how long has it been since you were last treated? \_\_\_\_\_

**DO YOU SUFFER –AT PRESENT- FROM ANY OF THE FOLLOWING**

- ( ) Fainting/ Spells/ Dizziness
- ( ) Difficulty Sleeping
- ( ) Pain that awakens you at night
- ( ) General Tiredness/ Fatigue
- ( ) Fever
- ( ) Chills
- ( ) Night sweats
- ( ) Unexplained or unintentional Weight Loss

Current medications (including birth control)

List any surgeries/hospitalizations you've had & date

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Supplements: \_\_\_\_\_

Have you suffered any fractures/dislocations?

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**HEALTH HABITS**

**Smoking:** YES NO if "yes" how many years? \_\_\_\_\_ packs/day \_\_\_\_\_

**Exercise:** YES NO **Drinking Alcohol:** YES NO **Caffeine:** YES NO

**PLEASE CHECK IF YOU HAVE HAD ANY OF THE FOLLOWING**

***Neuromusculoskeletal***

- ( ) Convulsions
- ( ) Headaches
- ( ) Backache
- ( ) Stiff neck
- ( ) Pain between shoulders
- ( ) Spinal curvature
- ( ) Swollen joints
- ( ) Weakness
- ( ) Twitching
- ( ) Numbness
- ( ) Tremors

***Skin or Allergies***

- ( ) Allergy
- ( ) Bruise Easily
- ( ) Dryness
- ( ) Eczema
- ( ) Sensitive Skin
- ( ) Shingles

***Other***

- ( ) Diabetes
- ( ) Cancer
- ( ) Depression/Anxiety

***Cardiovascular***

- ( ) Heart disease
  - ( ) High blood pressure
  - ( ) Low blood pressure
  - ( ) Stroke
  - ( ) Varicose Veins
  - ( ) Irregular heart beat
- Gastrointestinal***
- ( ) Poor digestion
  - ( ) Nausea/Vomiting
  - ( ) Belging/Bloating/Gas
  - ( ) Irritable bowel
  - ( ) Hemorrhoids

***Ear/Nose/Throat***

- ( ) Earaches
- ( ) Frequent colds
- ( ) Sinusitis
- ( ) Hayfever

- ( ) Alcoholism
- ( ) HIV positive
- ( ) Thyroid trouble

***Respiratory***

- ( ) Chest Pain
- ( ) Chronic cough
- ( ) Difficulty breathing
- ( ) Wheezing

***Genitourinary***

- ( ) Bed wetting
- ( ) Frequent urination
- ( ) Painful urination
- ( ) Prostate trouble
- ( ) Inability to control urine

***Women Only***

- ( ) Pregnant
- ( ) Cramping /backache
- ( ) Miscarriage
- ( ) Irregular Cycle
- ( ) Hot flashes/menopausal

Mark the areas on your body where you feel the following sensations:

Ache

Numbness

Pins &  
Needles

Burning

Stabbing

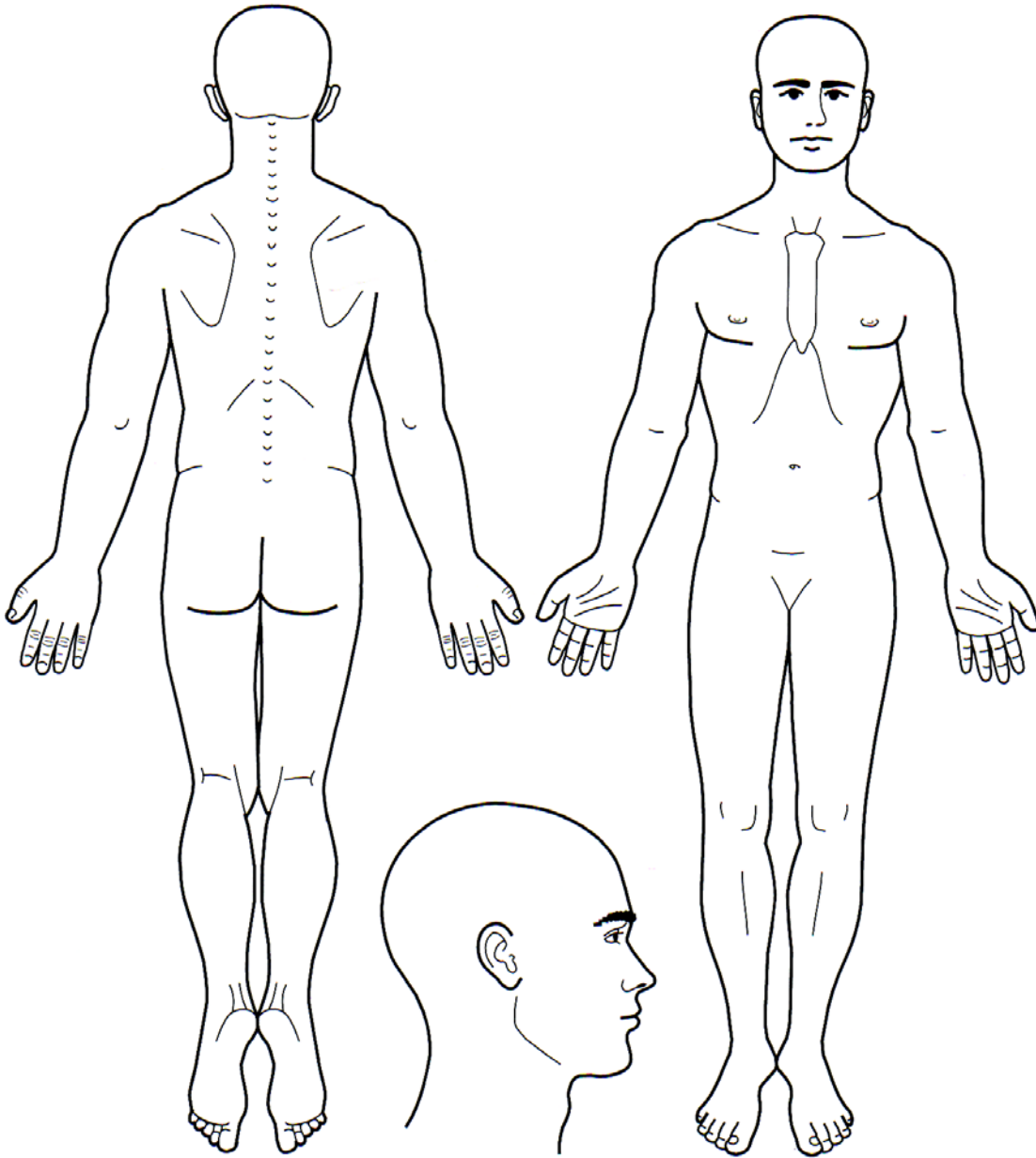
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NAME \_\_\_\_\_

DATE \_\_\_\_\_

# MODIFIED OSWESTRY LOW BACK PAIN DISABILITY QUESTIONNAIRE<sup>1</sup>

## **Section 1: To be completed by patient**

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

Age: \_\_\_\_\_

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

Occupation: \_\_\_\_\_

Number of days of back pain: \_\_\_\_\_ (this episode)

## **Section 2: To be completed by patient**

This questionnaire has been designed to give your therapist information as to how your back pain has affected your ability to manage in every day life. Please answer every question by placing a mark on the line that best describes your condition today. We realize you may feel that two of the statements may describe your condition, but **please mark only the line which most closely describes your current condition.**

### **Pain Intensity**

- \_\_\_\_\_ The pain is mild and comes and goes.
- \_\_\_\_\_ The pain is mild and does not vary much.
- \_\_\_\_\_ The pain is moderate and comes and goes.
- \_\_\_\_\_ The pain is moderate and does not vary much.
- \_\_\_\_\_ The pain is severe and comes and goes.
- \_\_\_\_\_ The pain is severe and does not vary much.

### **Personal Care (Washing, Dressing, etc.)**

- \_\_\_\_\_ I do not have to change the way I wash and dress myself to avoid pain.
- \_\_\_\_\_ I do not normally change the way I wash or dress myself even though it causes some pain.
- \_\_\_\_\_ Washing and dressing increases my pain, but I can do it without changing my way of doing it.
- \_\_\_\_\_ Washing and dressing increases my pain, and I find it necessary to change the way I do it.
- \_\_\_\_\_ Because of my pain I am partially unable to wash and dress without help.
- \_\_\_\_\_ Because of my pain I am completely unable to wash or dress without help.

### **Lifting**

- \_\_\_\_\_ I can lift heavy weights without increased pain.
- \_\_\_\_\_ I can lift heavy weights but it causes increased pain
- \_\_\_\_\_ Pain prevents me from lifting heavy weights off of the floor, but I can manage if they are conveniently positioned (ex. on a table, etc.).
- \_\_\_\_\_ Pain prevents me from lifting heavy weights off of the floor, but I can manage light to medium weights if they are conveniently positioned.
- \_\_\_\_\_ I can lift only very light weights.
- \_\_\_\_\_ I can not lift or carry anything at all.

### **Walking**

- \_\_\_\_\_ I have no pain when walking.
- \_\_\_\_\_ I have pain when walking, but I can still walk my required normal distances.
- \_\_\_\_\_ Pain prevents me from walking long distances.
- \_\_\_\_\_ Pain prevents me from walking intermediate distances.
- \_\_\_\_\_ Pain prevents me from walking even short distances.
- \_\_\_\_\_ Pain prevents me from walking at all.

### **Sitting**

- \_\_\_\_\_ Sitting does not cause me any pain.
- \_\_\_\_\_ I can only sit as long as I like providing that I have my choice of seating surfaces.
- \_\_\_\_\_ Pain prevents me from sitting for more than 1 hour.
- \_\_\_\_\_ Pain prevents me from sitting for more than 1/2 hour.
- \_\_\_\_\_ Pain prevents me from sitting for more than 10 minutes.
- \_\_\_\_\_ Pain prevents me from sitting at all.

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### **Section 2 (con't): To be completed by patient**

#### **Standing**

- I can stand as long as I want without increased pain.
- I can stand as long as I want but my pain increases with time.
- Pain prevents me from standing more than 1 hour.
- Pain prevents me from standing more than 1/2 hour.
- Pain prevents me from standing more than 10 minutes.
- I avoid standing because it increases my pain right away.

#### **Sleeping**

- I get no pain when I am in bed.
- I get pain in bed, but it does not prevent me from sleeping well.
- Because of my pain, my sleep is only 3/4 of my normal amount.
- Because of my pain, my sleep is only 1/2 of my normal amount.
- Because of my pain, my sleep is only 1/4 of my normal amount.
- Pain prevents me from sleeping at all.

#### **Social Life**

- My social life is normal and does not increase my pain.
- My social life is normal, but it increases my level of pain.
- Pain prevents me from participating in more energetic activities (ex. sports, dancing, etc.)
- Pain prevents me from going out very often.
- Pain has restricted my social life to my home.
- I have hardly any social life because of my pain.

#### **Traveling**

- I get no increased pain when traveling.
- I get some pain while traveling, but none of my usual forms of travel make it any worse.
- I get increased pain while traveling, but it does not cause me to seek alternative forms of travel.
- I get increased pain while traveling which causes me to seek alternative forms of travel.
- My pain restricts all forms of travel except that which is done while I am lying down.
- My pain restricts all forms of travel.

#### **Employment/Homemaking**

- My normal job/homemaking activities do not cause pain.
- My normal job/homemaking activities increase my pain, but I can still perform all that is required of me.
- I can perform most of my job/homemaking duties, but pain prevents me from performing more physically stressful activities (ex. lifting, vacuuming)
- Pain prevents me from doing anything but light duties.
- Pain prevents me from doing even light duties.
- Pain prevents me from performing any job or homemaking chores.

### **Section 3: To be completed by physical therapist/provider**

**SCORE: Initial**\_\_\_\_%    **Subsequent**\_\_\_\_%    **Subsequent**\_\_\_\_%    **Discharge**\_\_\_\_%

**Number of treatment sessions:**\_\_\_\_\_

**Diagnosis/ICD-9 Code:**\_\_\_\_\_

**KINETESIS SPORTS INJURY & PERFORMANCE CLINIC  
FEE SCHEDULE**

**Chiropractic Services**

Initial Consultation	\$100.00
Gait / Orthotic Assessment	\$75.00
Regular Office Visit	\$60.00

We direct bill Blue Cross for chiropractic services. All fees are due at the time services are rendered.