

APPLICATION FOR TREATMENT

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

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

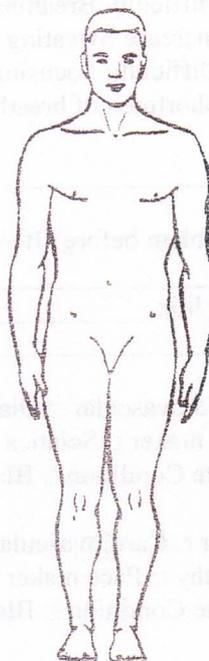
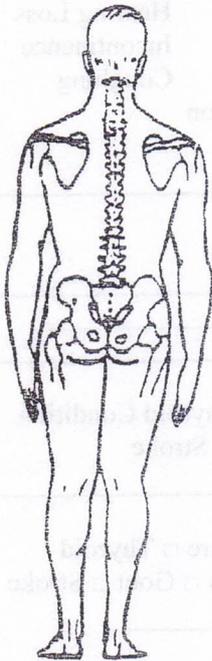
Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home #: \_\_\_\_\_ Cell#: \_\_\_\_\_ Text Alert : Y\_\_ N\_\_ E-mail: \_\_\_\_\_

Check if you are:  Single  Married  Divorced  Widowed  Separated

Name of Spouse: \_\_\_\_\_ Referred to our office by: \_\_\_\_\_

Payment will be made via:  Health Ins  Auto Ins  Worker's Comp  Cash  Credit  Check  
Please mark the exact location of your pain on the diagram below. Please write the type of pain: Dull, Sharp, Ache, Burning, Stabbing, Throbbing. Mark the area in which you experience Numbness, Tingling or Weakness. Indicate number on pain scale ranging from 0-10; 0 =No pain - 10 = Excruciating pain. Indicate frequency of pain i.e., Constant or Intermittent (comes and goes)



What is your chief complaint? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

When did this develop? Days: \_\_\_\_\_ Weeks: \_\_\_\_\_ Months: \_\_\_\_\_ Years: \_\_\_\_\_

How did this develop? Fall: \_\_\_\_\_ Accident: \_\_\_\_\_ Trauma: \_\_\_\_\_ Lifting: \_\_\_\_\_ Other: \_\_\_\_\_

Arms or legs weakness?  No  Yes; Where \_\_\_\_\_

Anything makes it better? \_\_\_\_\_ Anything makes it worse? \_\_\_\_\_

What Limitation are you experiencing (circle)? Standing, Driving, Walking, Lifting, Sitting, Sleeping, Bathing, Dressing, Washing, Focusing, Reading, Exercising

Received any treatments?  No  Yes, If yes, circle: MD/DO  Chiropractor  Physical Therapy  Massage

Their Name: \_\_\_\_\_ Seen other Specialist: Ortho \_\_\_\_\_ Neuro \_\_\_\_\_ Pain manag \_\_\_\_\_

Name of the Specialist: \_\_\_\_\_ Date Consulted: \_\_\_\_\_

X-rays?  Neck  Mid back  Low back  Shoulder  Other \_\_\_\_\_ When \_\_\_\_\_ Where \_\_\_\_\_

MRI's?  Neck  Mid back  Low back  Shoulder  Other \_\_\_\_\_

When \_\_\_\_\_ Where \_\_\_\_\_

Do you have a herniated disc?  No  Yes, Where \_\_\_\_\_

Is your condition getting better, worse, or staying the same? \_\_\_\_\_

Please check any other symptoms that you are experiencing:

- |  |  |  |   |  |
|--|--|--|---|--|
| <input type="checkbox"/> Headache        | <input type="checkbox"/> Dizziness     | <input type="checkbox"/> Loss of Consciousness | <input type="checkbox"/> Loss of Balance        | <input type="checkbox"/> Loss of Smell |
| <input type="checkbox"/> Loss of Taste   | <input type="checkbox"/> Memory Loss   | <input type="checkbox"/> Loss of Coordination  | <input type="checkbox"/> Sensory Loss           | <input type="checkbox"/> Tremors       |
| <input type="checkbox"/> Nausea          | <input type="checkbox"/> Vomiting      | <input type="checkbox"/> Difficulty Speaking   | <input type="checkbox"/> Depressed              | <input type="checkbox"/> Irritability  |
| <input type="checkbox"/> Seizures        | <input type="checkbox"/> Blurry Vision | <input type="checkbox"/> Difficulty Swallowing | <input type="checkbox"/> Anxiety                | <input type="checkbox"/> Bipolar       |
| <input type="checkbox"/> Ringing in ears | <input type="checkbox"/> Double Vision | <input type="checkbox"/> Difficulty Breathing  | <input type="checkbox"/> Chest Pain             | <input type="checkbox"/> Hearing Loss  |
| <input type="checkbox"/> Apnea           | <input type="checkbox"/> Sleep Loss    | <input type="checkbox"/> Increase Sweating     | <input type="checkbox"/> Palpitation            | <input type="checkbox"/> Incontinence  |
| <input type="checkbox"/> Loss of Bowel   | <input type="checkbox"/> Swelling      | <input type="checkbox"/> Difficulty Focusing   | <input type="checkbox"/> Fever                  | <input type="checkbox"/> Coughing      |
| <input type="checkbox"/> Constipation    | <input type="checkbox"/> Falling down  | <input type="checkbox"/> Shortness of breath   | <input type="checkbox"/> Burning upon urination |  |

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

Have you ever had this problem or similar problem before? If yes, please explain \_\_\_\_\_

has this condition affected your life? 1. Home life: \_\_\_\_\_

2. Occupational life: \_\_\_\_\_ 3. Recreational life: \_\_\_\_\_

Check if you have history of:  Cancer  Cardiovascular  Diabetes  High Blood Pressure  Thyroid Condition  
 M.S.  Parkinson  Polyneuropathy  Pace maker  Sciatica  Rheumatoid Arthritis  Gout  Stroke  
 High Cholesterol  Kidney Stones  Prostate Condition  Bladder Infection  Other: \_\_\_\_\_

Check if you have family history of:  Cancer  Cardiovascular  Diabetes  High Blood Pressure  Thyroid Condition  
 M.S.  Parkinson  Polyneuropathy  Pace maker  Sciatica  Rheumatoid Arthritis  Gout  Stroke  
 High Cholesterol  Kidney Stones  Prostate Condition  Bladder Infection  Other: \_\_\_\_\_

History of falls, trauma or accidents? \_\_\_\_\_

List all Surgeries: \_\_\_\_\_

List all Medications you are taking: \_\_\_\_\_

Any chiropractor consulted in past? Name: \_\_\_\_\_ When: \_\_\_\_\_ Where: \_\_\_\_\_

For what problem: \_\_\_\_\_

Do you play sports or exercise? \_\_\_\_\_ Smoke:  Yes  No \* Alcohol:  Yes  No

Are you pregnant?  Yes  No  N/A

Your Goals/ expectation from treatment: \_\_\_\_\_

Patient's Signature: \_\_\_\_\_ Social Security #: \_\_\_\_\_ Date: \_\_\_\_\_

**FIRST MERRITT CHIROPRACTIC/ACUPUNCTURE, P.A.**

**Informed Consent to Care**

Informed Consent to Care You are the decision maker for your health care. Part of our role is to provide you with information to assist you in making informed choices. This process is often referred to as "informed consent" and involves your understanding and agreement regarding the care we recommend, the benefits and risks associated with the care, alternatives, and the potential effect on your health if you choose not to receive the care. We may conduct some diagnostic or examination procedures if indicated. Any examinations or tests conducted will be carefully performed but may be uncomfortable. Chiropractic care centrally involves what is known as a chiropractic adjustment. There may be additional supportive procedures or recommendations as well. When providing an adjustment, we use our hands or an instrument to reposition anatomical structures, such as vertebrae. Potential benefits of an adjustment include restoring normal joint motion, reducing swelling and inflammation in a joint, reducing pain in the joint, and improving neurological functioning and overall well-being. It is important that you understand, as with all health care approaches, results are not guaranteed, and there is no promise to cure. As with all types of health care interventions, there are some risks to care, including, but not limited to: muscle spasms, aggravating and/or temporary increase in symptoms, lack of improvement of symptoms, burns and/or scarring from electrical stimulation and from hot or cold therapies, including but not limited to hot packs and ice, fractures (broken bones), disc injuries, strokes, dislocations, strains, and sprains. With respect to strokes, there is a rare but serious condition known as an "arterial dissection" that typically is caused by a tear in the inner layer of the artery that may cause the development of a thrombus (clot) with the potential to lead to a stroke. The best available scientific evidence supports the understanding that chiropractic adjustment does not cause a dissection in a normal, healthy artery. Disease processes, genetic disorders, medications, and vessel abnormalities may cause an artery to be more susceptible to dissection. Strokes caused by arterial dissections have been associated with over 72 everyday activities such as sneezing, driving, and playing tennis. Arterial dissections occur in 3-4 of every 100,000 people whether they are receiving health care or not. Patients who experience this condition often, but not always, present to their medical doctor or chiropractor with neck pain and headache. Unfortunately, a percentage of these patients will experience a stroke. The reported association between chiropractic visits and stroke is exceedingly rare and is estimated to be related in one in one million to one in two million cervical adjustments. For comparison, the incidence of hospital admission attributed to aspirin use from major GI events of the entire (upper and lower) GI tract was 1219 events/ per one million persons/year and risk of death has been estimated as 104 per one million users. It is also important that you understand there are treatment options available for your condition other than chiropractic procedures. Likely, you have tried many of these approaches already. These options may include, but are not limited to: self-administered care, over-the-counter pain relievers, physical measures and rest, medical care with prescription drugs, physical therapy, bracing, injections, and surgery. Lastly, you have the right to a second opinion and to secure other opinions about your circumstances and health care as you see fit. I have read, or have had read to me, the above consent. I appreciate that it is not possible to consider every possible complication to care. I have also had an opportunity to ask questions about its content, and by signing below, I agree with the current or future recommendation to receive chiropractic care as is deemed appropriate for my circumstance. I intend this consent to cover the entire course of care from all providers in this office for my present condition and for any future condition(s) for which I seek chiropractic care from this office.

Patient Name: \_\_\_\_\_ Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
Parent or Guardian: \_\_\_\_\_ Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
Witness Name: \_\_\_\_\_ Signature: \_\_\_\_\_ Date: \_\_\_\_\_



**FIRST MERRITT CHIROPRACTIC/ACUPUNCTURE, P.A.**

*Amit Patel, DC, DACNB, FIAMA*

*Diplomate of American Chiropractic Neurology Board*

*Fellow of International Academy of Medical Acupuncture*

**80 Fortenberry Road**

**Merritt Island, FL 32952**

**(O) 321-453-1345 · (F) 321-453-3131**

Dear Patients,

We value your time and support. In order to better assist you as our patient, please notify us at least 24 hours in advance of any cancellation. Cancellations with less than 24 hour notice are subject to a fee of \$35.

We understand that circumstances may occasionally arise that may prevent you from notifying us within 24 hours. We will take consideration for this on a case by case basis.

Thank you,

First Merritt Chiropractic/Acupuncture

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Print Name

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Date

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Signature

**FIRST MERRITT CHIROPRACTIC/ACUPUNCTURE., P.A.**

**80 Fortenberry Road  
Merritt Island, FL 32952  
(321) 453-1345 · Fax (321) 453-3131**

**AUTHORIZATIONS AND RELEASES**

**CONSENT FOR EXAMINATION & TREATMENT**

I, the undersigned, hereby authorize Amit Patel, D.C. and whomever he may designate as his assistant(s) to perform, examination and diagnostic tests, including but not limited to radiographs, and to administer treatment as is necessary. I also certify that no guarantee or assurance has been made to the results that may be obtained. The clinical procedure 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 know or to learn through health care procedures from whatever he/she is suffering from: latent pathological defects, illness, or deformities which would otherwise not come to the attention of the physician. I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that this office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to this office will be credited to my account upon receipt. I permit this office to endorse remittances for the conveyance of credit to my account upon receipt. I permit this office to endorse remittances for the conveyance of credit to my account. However, I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment.

Patient's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**CONSENT FOR EXAMINATION & TREATMENT OF MINOR**

I hereby authorize Amit Patel, D.C. and whomever he may designate as his assistant(s) to perform examination and diagnostic tests, including but not limited to radiographs, and to administer treatment as he deems necessary to my (child's name) \_\_\_\_\_. I also certify that no guarantee or assurance has been made to the results that may be obtained. I also certify that no guarantee or assurance has been made to the results that may be obtained. The clinical procedure 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 know or to learn through health care procedures from whatever he/she is suffering from: latent pathological defects, illness, or deformities which would otherwise not come to the attention of the physician. I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that this office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to this office will be credited to my account upon receipt. I permit this office to endorse remittances for the conveyance of credit to my account upon receipt. I permit this office to endorse remittances for the conveyance of credit to my account. However, I clearly understand and agree that all services rendered to my child are charged directly to me and that I am personally responsible for payment.

Parent or Guardian's name : \_\_\_\_\_ Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**AUTHORIZATION TO RELEASE MEDICAL INFORMATION**

I authorize the release of any medical information necessary to process my insurance claim(s) and also certify that all insurance information given to this clinic is correct and complete.

Patient's (Parent's/Guardian's) Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**DIRECT PAYMENT AUTHORIZATION WITHOUT ASSIGNMENT OF BENEFITS**

By way of original or copy hereof, I hereby direct my applicable personal injury protection and/or medical payments insurance carrier to make payment directly to Amit Patel, D.C. for services and/or supplies rendered to me by said provider which were necessitated by a 0work-related injury, motor vehicle accident, or other accident occurring on \_\_\_\_\_.

Additionally, I hereby authorize and direct my applicable personal protection and/or medical payments insurance carrier to make any and all checks out to Amit Patel, D.C. only and to forward same to this provider's place of business.

This authorization for direct payment should not be deemed as assignment of benefits in that I, the patient, retain all rights to enforce my applicable insurance contract. Furthermore, this Direct Payment Authorization without Assignment of Benefits transfers no rights, title or interest in said contract other than the right to receive direct payment as specified herein above.

Patient's (Parent's/Guardian's) Signature: \_\_\_\_\_ Date: \_\_\_\_\_

## Maintenance Therapy

Under the **Medicare program and with most Insurance Carriers**, Chiropractic maintenance therapy is not considered to be medically reasonable or necessary, and is therefore not payable.

Maintenance therapy is defined as a treatment plan that seeks to prevent disease, promote health, and prolong and enhance the quality of life; or therapy that is performed to maintain or prevent deterioration of a chronic condition. When further clinical improvement cannot reasonably be expected from continuous ongoing care, and the chiropractic treatment becomes supportive rather than corrective in nature, the treatment is then considered maintenance therapy.

**Reference: Department Of Health And Human Services/MC Manual: 240.1-Coverage of Chiropractic Services Chiropractor's Services (Rev.23, Issued: 10-08-04, Effective:10-01-04, Implementation:10-04-04)B3 2020.26**

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Print

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Date

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Signature

First Merritt Chiropractic And Acupuncture, PA  
HIPAA OMNIBUS RULE

**Patient Acknowledgement of Receipt of Notice of Privacy Practices**

Print Patient Name: \_\_\_\_\_

I acknowledge that I have been provided a copy of the currently effective Notice of Privacy. A copy of this signed, dated document shall be as effective as the original.

DATE: \_\_\_\_\_

\_\_\_\_\_  
Signature of Patient or Personal Representative

\_\_\_\_\_  
Signature of Witness / Office Representative

You may refuse to sign the acknowledgement & authorization. In refusing, this practice will not be allowed to process your insurance claims.

I acknowledge that I declined the Notice of Privacy Practices provided:

DATE: \_\_\_\_\_

\_\_\_\_\_  
Signature of Patient or Personal Representative

\_\_\_\_\_  
Signature of Witness / Office Representative

\*\*\*\*\*

**Office Use Only:** I attempted to obtain written authorization of receipt of Notice of Privacy Practices, but acknowledgement could not be obtained because: \_\_\_ Individual refused to sign \_\_\_ Communication barrier \_\_\_  
Emergency situation occurred with patient \_\_\_ Other (explain): \_\_\_\_\_

\_\_\_\_\_  
Signature of Office Representative

# Neck Index

Form N1-100

rev 3/27/2003

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

Date \_\_\_\_\_

*This questionnaire will give your provider information about how your neck condition affects your everyday life. Please answer every section by marking the one statement that applies to you. If two or more statements in one section apply, please mark the one statement that most closely describes your problem.*

## Pain Intensity

- Ⓐ I have no pain at the moment.
- Ⓛ The pain is very mild at the moment.
- Ⓒ The pain comes and goes and is moderate.
- Ⓜ 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.

## Personal Care

- Ⓐ I can look after myself normally 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 I manage most of my personal care.
- Ⓢ I need help every day in most aspects of self care.
- Ⓟ I do not get dressed, I wash with difficulty and stay in bed.

## Sleeping

- Ⓐ I have no trouble sleeping.
- Ⓛ My sleep is slightly disturbed (less than 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).

## Lifting

- Ⓐ I can lift heavy weights without extra pain.
- Ⓛ I can lift heavy weights but it causes extra pain.
- Ⓒ Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned (e.g., on a table).
- Ⓜ Pain prevents me from lifting heavy weights off the floor, but I can manage light to medium weights if they are conveniently positioned.
- Ⓢ I can only lift very light weights.
- Ⓟ I cannot lift or carry anything at all.

## Reading

- Ⓐ I can read as much as I want with no neck pain.
- Ⓛ I can read as much as I want with slight neck pain.
- Ⓒ I can read as much as I want with moderate neck pain.
- Ⓜ I cannot read as much as I want because of moderate neck pain.
- Ⓢ I can hardly read at all because of severe neck pain.
- Ⓟ I cannot read at all because of neck pain.

## Driving

- Ⓐ I can drive my car without any neck pain.
- Ⓛ I can drive my car as long as I want with slight neck pain.
- Ⓒ I can drive my car as long as I want with moderate neck pain.
- Ⓜ I cannot drive my car as long as I want because of moderate neck pain.
- Ⓢ I can hardly drive at all because of severe neck pain.
- Ⓟ I cannot drive my car at all because of neck pain.

## Concentration

- Ⓐ I can concentrate fully when I want with no difficulty.
- Ⓛ I can concentrate fully when I want with slight difficulty.
- Ⓒ I have a fair degree of difficulty concentrating when I want.
- Ⓜ I have a lot of difficulty concentrating when I want.
- Ⓢ I have a great deal of difficulty concentrating when I want.
- Ⓟ I cannot concentrate at all.

## Recreation

- Ⓐ I am able to engage in all my recreation activities without neck pain.
- Ⓛ I am able to engage in all my usual recreation activities with some neck pain.
- Ⓒ I am able to engage in most but not all my usual recreation activities because of neck pain.
- Ⓜ I am only able to engage in a few of my usual recreation activities because of neck pain.
- Ⓢ I can hardly do any recreation activities because of neck pain.
- Ⓟ I cannot do any recreation activities at all.

## Work

- Ⓐ I can do as much work as I want.
- Ⓛ I can only do my usual work but no more.
- Ⓒ I can only 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.

## 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.

Index Score = [Sum of all statements selected / (# of sections with a statement selected x 5)] x 100

Neck  
Index  
Score

# Back Index

Form BI100

rev 3/27/2003

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

Date \_\_\_\_\_

*This questionnaire will give your provider information about how your back condition affects your everyday life. Please answer every section by marking the one statement that applies to you. If two or more statements in one section apply, please mark the one statement that most closely describes your problem.*

## Pain Intensity

- ⓪ The pain comes and goes and is very mild.
- ① The pain is mild and does not vary much.
- ② The pain comes and goes and is moderate.
- ③ The pain is moderate and does not vary much.
- ④ The pain comes and goes and is very severe.
- ⑤ The pain is very severe and does not vary much.

## Sleeping

- ⓪ I get no pain in bed.
- ① I get pain in bed but it does not prevent me from sleeping well.
- ② Because of pain my normal sleep is reduced by less than 25%.
- ③ Because of pain my normal sleep is reduced by less than 50%.
- ④ Because of pain my normal sleep is reduced by less than 75%.
- ⑤ Pain prevents me from sleeping at all.

## Sitting

- ⓪ I can sit in any chair as long as I like.
- ① I can only sit in my favorite chair as long as I like.
- ② Pain prevents me from sitting more than 1 hour.
- ③ Pain prevents me from sitting more than 1/2 hour.
- ④ Pain prevents me from sitting more than 10 minutes.
- ⑤ I avoid sitting because it increases pain immediately.

## Standing

- ⓪ I can stand as long as I want without pain.
- ① I have some pain while standing but it does not increase with time.
- ② I cannot stand for longer than 1 hour without increasing pain.
- ③ I cannot stand for longer than 1/2 hour without increasing pain.
- ④ I cannot stand for longer than 10 minutes without increasing pain.
- ⑤ I avoid standing because it increases pain immediately.

## Walking

- ⓪ I have no pain while walking.
- ① I have some pain while walking but it doesn't increase with distance.
- ② I cannot walk more than 1 mile without increasing pain.
- ③ I cannot walk more than 1/2 mile without increasing pain.
- ④ I cannot walk more than 1/4 mile without increasing pain.
- ⑤ I cannot walk at all without increasing pain.

## Personal Care

- ⓪ I do not have to change my way of washing or dressing in order to avoid pain.
- ① I do not normally change my way of washing or dressing even though it causes some pain.
- ② Washing and dressing increases the pain but I manage not to change my way of doing it.
- ③ Washing and dressing increases the pain and I find it necessary to change my way of doing it.
- ④ Because of the pain I am unable to do some washing and dressing without help.
- ⑤ Because of the pain I am unable to do any washing and dressing without help.

## Lifting

- ⓪ I can lift heavy weights without extra pain.
- ① I can lift heavy weights but it causes extra pain.
- ② Pain prevents me from lifting heavy weights off the floor.
- ③ Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned (e.g., on a table).
- ④ Pain prevents me from lifting heavy weights off the floor, but I can manage light to medium weights if they are conveniently positioned.
- ⑤ I can only lift very light weights.

## Traveling

- ⓪ I get no pain while traveling.
- ① I get some pain while traveling but none of my usual forms of travel make it worse.
- ② I get extra pain while traveling but it does not cause me to seek alternate forms of travel.
- ③ I get extra pain while traveling which causes me to seek alternate forms of travel.
- ④ Pain restricts all forms of travel except that done while lying down.
- ⑤ Pain restricts all forms of travel.

## Social Life

- ⓪ My social life is normal and gives me no extra pain.
- ① My social life is normal but increases the degree of pain.
- ② Pain has no significant affect on my social life apart from limiting my more energetic interests (e.g., dancing, etc).
- ③ Pain has restricted my social life and I do not go out very often.
- ④ Pain has restricted my social life to my home.
- ⑤ I have hardly any social life because of the pain.

## Changing degree of pain

- ⓪ My pain is rapidly getting better.
- ① My pain fluctuates but overall is definitely getting better.
- ② My pain seems to be getting better but improvement is slow.
- ③ My pain is neither getting better or worse.
- ④ My pain is gradually worsening.
- ⑤ My pain is rapidly worsening.

Index Score = [Sum of all statements selected / (# of sections with a statement selected x 5)] x 100

Back  
Index  
Score