Texas Intergrative Pain Institute Inc.

Welcome to our Practice

Today's Date:_____

PATIENT INFORMATION				
Last Name	**First**	**MI**	**Maiden Name**	**Gender** M / F
Date of Birth	**Social Security**	**Marital status** ○ Single ○ Married ○ Widowed ○ Divorced ○ Other		
Address	**City**		**State**	**Zip Code**
Primary Number ( )	**Alternate Number** ( )		**E-Mail**	
Ethnicity	**Race**	**Employer Name and Phone Number**		
Emergency Contact	**Phone Number**	**Preferred Language**		

INSURANCE INFORMATION		
Primary Insurance	**Policy Number**	**Group Number**
Subscriber's Name	**Social Security**	**Relationship to Patient**

Worker's Compensation, Motor Vehicle or Injury Claim Information

Is your pain the result of a Worker's Compensation Injury? ☐Yes ☐No

Worker's Comp Company _____ **Phone Number**

_____

Is your pain the result of a Motor Vehicle Accident or Personal Injury? ☐Yes ☐No
(A separate page will be given to you to describe details of your accident)

Date of Accident _____

Preferred Pharmacy

Pharmacy Name **Phone Number** _____

Address _____

(List cross streets if not sure the exact address)

Private and Group Accident and Health Insurance Assignment for Direct Payment to Doctor

I hereby instruct and direct my insurance company to pay by check made out and mailed directly to: ***Texas Intergrative Pain Institute Inc.***, for professional or medical expense benefits allowable, ad otherwise payable to me under my current insurance policy as payment toward the total charges for professional services rendered.

This Is Direct Assignment of My Rights and Benefits under This Policy

This payment will not exceed my indebtedness to the above-mentioned assignee, and I have agreed to pay any balance of said professional service charges over and above this insurance payment, except in instances where No-Fault or Workers' Compensation insurance fee schedules apply.

I also understand and agree that I am ultimately responsible for all fees including reasonable collection costs. This assignment of benefits does not release me from obligation to pay professional fees.

A Photo Copy of This Assignment Shall Be Considered As Effective and Valid As the Original

I authorize the release of any information pertinent to my case to any insurance company, adjuster or attorney involved in this case.

Appointment Policy

In effort to provide efficient treatment to all of our patients, it is the policy of this company that if you are unable to make your scheduled appointment, you must call to cancel the appointment no later than 24 hours before the scheduled time. If you fail to cancel your office appointment or fail to show up to your appointment, you will be charged a "NO SHOW" fee of $30.00 per occurrence. If you are scheduled for a procedure and fail to cancel the appointment no later than 24 hours before or no show to your procedure, you will be charged a fee of $100. For most insurance plans and Workers' Compensation carriers "NO SHOW" charges are a non-covered service. You will be solely responsible for payment of this charge. Repeated "NO SHOWS" and cancellations of your scheduled appointments may result in you being DISCHARGED from care at ***Texas Intergrative Pain Institute Inc***.
If you arrive **15 minutes late** after your scheduled appointment, your appointment will be rescheduled for the next available appointment. If you have any questions regarding our policy, please speak to our staff before signing.

Notice of Privacy Practices Acknowledgement

A **Notice of Privacy Practices (NPP)** is provided to all patients. This Notice of Privacy Practices identifies: 1) how medical information about you may be used or disclosed; 2) your rights to access your medical information, amend your medical information, request an accounting of disclosures of your medical information, and request additional restrictions on our uses and disclosures of that information; 3) your rights to complain if you believe your privacy rights have been violated; and 4) our responsibilities for maintaining the privacy of your medical information.

The undersigned certifies that he/she has read the foregoing, received a copy of the Notice of Privacy Practices and is the patient, or the patient's personal representative.

_____ _____

Patient Signature Date

I (we) the undersigned patient and/or responsible party hereby authorize this office to release medical, billing and appointment information to the following family members in lieu of myself:

1. Relationship:

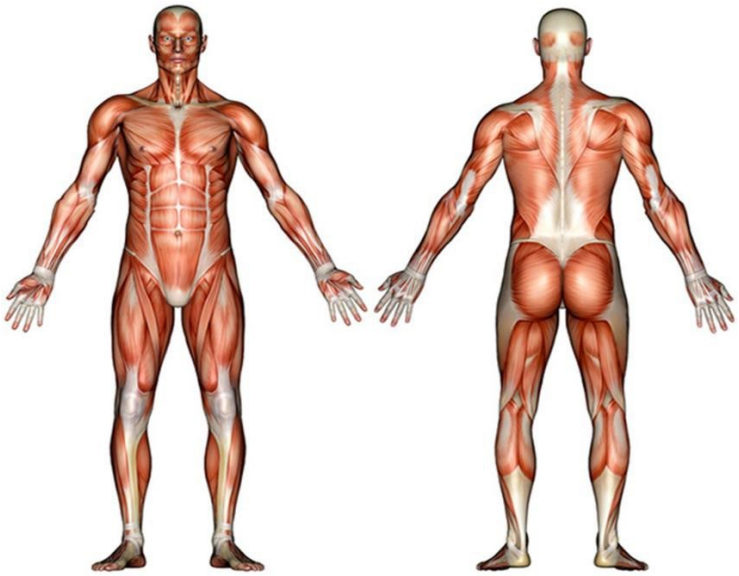
2. Relationship:

3. Relationship:

***Please understand that unless the name appears on this form, we CANNOT disclose any of the patient's information. ***

CONFIDENTIAL NEW PATIENT QUESTIONNAIRE

Mark on the picture where you are having pain. Also mark (X) for Numbness, (T) for Tingling, (B) for Burning.



Where is your pain? ☐ Neck ☐ Arm ☐ Lower Back ☐ Leg ☐ Other _____

How bad are your symptoms at their:

Best	0	1	2	3	4	5	6	7	8	9	10
Worst	0	1	2	3	4	5	6	7	8	9	10
Today	0	1	2	3	4	5	6	7	8	9	10

Duration of pain:

How/When did the pain begin?_____(Month/year)

☒ < 1 week 1-4 weeks 1-3 months Work Accident Following Surgery 6-12 months > 1 year Home Accident Unknown

☒ Auto Accident Other _____

How has your pain intensity changed since it began?

Constantly (6 hours +) Intermittent (2-4 hours /day) Frequently more than 2 days /week

Select one or more items below to describe the nature of your pain:

Throbbing Shooting Sharp Cramping Hot/Burning Aching Stabbing Tingling Numbing Dull Ache

How do the following factors affect your pain?

	Better	Worse	No Effect
Changes			
Cold Compresses			
Coughing			
Massage			
Lifting			
Alcohol			

	Better	Worse	No Effect
Heat Compresses			
Climate			
Lying Down			
Sitting			
Walking			
Sex			

Have you had imaging done in the past year (MRIs, CT scans, etc.)? If so, where? _____

Do you have any metal, pins, screws, foreign objects in your body? Yes ☐ No ☐ _____

CONFIDENTIAL NEW PATIENT QUESTIONNAIRE (cont.)

Which of the following are affected by your pain?

☐ Mood ☐Activities of Daily Living ☐Social Interaction ☐Household chores ☐Falling Sleep ☐Staying Asleep ☐ Work ☐Sexual Activity

Have you had any of the following treatments for your pain?

Treatment	Dates	Treatment	Dates
Acupuncture		Massage	
Exercise		Brace	
Facet Blocks		Psychotherapy	
Trigger Point		Epidurals	
Chiropractor		TENS unit	
Physical Therapy		Nerve Blocks	

Past Medical History

AIDS OR HIV Anemia Arthritis Asthma Bleeding Disorder Cancer Depression

Diabetes Type I or Type II Emphysema Fibromyalgia Gout Headaches/Migraines Heart Disease

Hepatitis (A, B, C) High Blood Pressure Thyroid Disease Insomnia Kidney Disease Kidney Stones

Liver Disease Lupus Pacemaker Panic Attacks Peripheral Vascular Disease Prostate Enlargement

Mental Disorder(s) Shingles Stroke Tuberculosis

Please tell us about any SURGERIES you have had, you may indicate the date/year if known:

Surgery	Date

Please tell us about your FAMILY HISTORY:

☐I HAVE NO SIGNIFICANT FAMILY MEDICAL HISTORY ☐I AM ADOPTED (Family History Unknown)

Mark with a X	Cancer	Diabetes	Heart Disease	Kidney Problems	Mental Disorders	Spine Problems	Stroke
Mother							
Father							
Brother(s)							
Sister(s)							
Other Conditions							

SOCIAL HISTORY

Occupation: _____

Do You Smoke? Yes No How Many Pack/Day? _____

_____ Years? _____

Did You Smoke in the Past but Quit? Yes No _____

When?

Drink Alcohol? Yes No If Yes, How Much?

Do You Use Any Other Drugs (Marijuana, Cocaine, Etc.?) Yes ☐ No ☐

If Yes, Please Name: _____

Marital Status Single Married Divorced Widowed Do You Live Alone? Yes N o If No, Who

Do You Live With? _____

FOR FEMALES ONLY:

Are you pregnant? ☐Yes ☐No ☐Not Sure Patient's Initials _____

Are y ou t

CURRENT MEDICATIONS

aking a p rescribed **blood t hinning** medication? Yes☐ No ☐ *If you're unsure ask the doctor Please list ALL medications you are currently taking. Attach an additional sheet, if you need more space.

Name of Medication	**Dosage** (i.e. milligram)	**How taken** (i.e. 1 tablet daily)

List any Pain Medications that you have tried in the past? _____

Are you **allergic** to any medications**?** _____

REVIEW OF SYSTEMS

Are you experiencing any of the following? Please circle

General Loss of appetite Recent Weight Change Fever/Chills Fatigue Night Sweats

Endocrine/Hematologic Heat / Cold Intolerance Easy Bruising Easy Bleeding Visual Changes

Cardiovascular Chest Pain Palpitations Leg Swelling

Respiratory Difficulty Breathing Cough Wheezing

Eyes Blurred Vision Double Vision Loss of Vision Eye Pain

Genitourinary Painful Urination Blood in Urine Frequent Urination

Skin Rash Itching Other Skin Changes

Gastrointestinal Nausea and/or Vomiting Heartburn Blood in Stool Constipation

Ear/Nose/Throat Hoarseness Hearing Loss Trouble Swallowing Ear Pain

Neurological Tremors Dizziness Tingling Seizures

Psychiatric Depression / Anxiety Suicidal Thoughts Drug/Alcohol Addiction Trouble Sleeping

OFFICE PROTOCOL AGREEMENT

The following protocols are necessary to provide appropriate care to all our patients. Please review, initial each entry and sign below indicating that you understand these office protocols and agree to abide by them. Lack of signature does not invalidate these protocols.

- I understand that refills are given at the time of the office visit. Refills are not done over the phone. _____ (Initial)
- I understand with controlled substance therapy (narcotics), it is expected that I may need to undergo random urine drug testing as part of my treatment plan._____(Initial)
- I understand that I am an active participant in my health care and agree to abide by the treatment plan given and reviewed with me at each visit. I understand that any changes in condition may need an office visit for reassessment. For acute changes in my condition, I may need to access care through the emergency room. _____(Initial)
- I understand that this practice utilizes mid-level providers such as Nurse Practitioners. They provide care in terms of assessing new patients, follow-ups, and any changes in conditions; while also educating the patient on their condition, medication and treatment options. (Initial)

  _____
- I understand that my access to care via telephone or on site will require my behavior to be in a manner that is not abusive to staff. I agree to refrain for behavior that reflects yelling, cursing, name-calling or **multiple calls in same day.** I understand that this behavior may terminate my relationship with this practice.

  _____(Initial)
- I agree to cancel my established appointments in advance to benefit other patients that are in need of earlier appointments. I understand that not showing up for an appointment without calling in advance, may be a factor in the continuation or discontinuation of my care with this group._(Initial)
- I understand that I am to arrive 15 minutes before my appointment time to check in for follow up appointments and 45 minutes before a new patient appointment. (Initial)

Patients Name: _____
(Print name)

Patients Signature: _____ Date: _____

CONTROLLED SUBSTANCE AGREEMENT

I_____am entering into contract with ***Texas Intergrative Pain Institute Inc.*** and their doctors – **Dr. Brett Warfield** regarding the prescription of chronic narcotics for my pain. I understand that if I break this agreement all narcotic therapy may be discontinued and my relationship with this practice will be terminated.

I agree to the following:

1. All controlled substances prescribed for the treatmentof chronic pain must come from the physician who is assigned to your care, or during his or her absence, by covering provider, unless specific authorization is obtained for an exception. You are **not** to receive **any** prescriptions for controlled substances or sedative drugs from any other provider.

2. The prescribing provider has permission to discuss all diagnostic and treatment detail with dispensing pharmacists or other professionals who provide your health care for purposes of maintaining accountability.

3. All controlled substances must be obtained at the same pharmacy, where possible. Should the need to arise to change pharmacies, our office must be informed. The pharmacy you have selected is:

   Pharmacy Name:_____Pharmacy #: _____

4. Random urine or serum toxicology screens will be requested, and your cooperation is REQUIRED. Presence of unauthorized substances may prompt termination of your opioid treatment and referral for assessment for addictive behavior, and termination from the practice.

5. Refills will occur on a monthly basis and **ONLY** after a visit and physical examination. **NO REFILLS WILL**

   BE MADE OVER THE TELEPHONE. NO REFILLS WILL BE GIVEN AFTER HOURS, ON WEEKENDS AND/OR HOLIDAYS. Renewals are contingent on keeping scheduled appointments. Please do not phone for prescriptions after hours or on weekends.

6. If refill requests are made after hours, you will be instructed if pain is too severe by the answering service to go to an emergency room of your choice.

7. You are expected to inform our office of any new medications, or medical conditions, and of any adverse effects you experienced from any medications that you take.

8. Prescriptions may be issued early if the physician or patient will be out of town when refill is due. These prescriptions will contain instructions to the pharmacist that they not be filled prior to the appropriate date.

There will be NO early refills or pre-dated prescriptions unless approved by the provider.
Any evidence of prescription, forged prescriptions, substance abuse, or aberrant behavior (including verbal abuse to our office staff) will result in termination of patient –physician relationship.

9. Medications will **not** be replaced if they are lost, stolen, destroyed, left on airplane, etc. It is YOUR responsibility to protect your medications.

10. An official prescription, written for a Schedule II controlled substance, must be filled within 21 days after the date the prescription was issued. If you hold on to the prescription longer than 21 days or forget to pick it up from the pharmacy, it will not be re-written until you are seen in an office visit. **No Exceptions!**

11. Prescriptions are to be used **ONLY** as written. Use of increased amount of medication without consultation with a physician will not be allowed.

12. You may **NOT** share, sell, or otherwise permit others to have access to these medications.

13. Since the drugs may be hazardous or lethal to a person who is not tolerant to their effects, especially a child, you must **keep them out of reach of children.**

14. Termination terms will include a written letter to you and fulfillment of your medical needs, one month after the date of termination.

15. **PLEASE ALLOW 48 – 72 HOURS FOR MEDICATION REFILLS.**

16. Due to overwhelming phone calls for prescription refills, if you call Texas Intergrative Pain Institute Inc. for medication refills you are allowed one phone call per day, **PLEASE LEAVE VOICEMAIL**, if you call multiple times a day, you will be charged a $5 fee per call.

Your pain is **YOUR** responsibility. Making appointments for medication refills is **YOUR** responsibility. Texas Intergrative Pain Institute Inc. will provide medical support in your quest to minimize your pain. You must make new efforts to improve sleep habits, nutrition, body weight, conditioning and psychological state. Medications are **not** the answer to chronic pain, but can be used to effectively to improve your pain.

_____ _____

Patient Signature Date

MEDICAL RECORD RELEASE FORM

THE PURPOSE OF THIS RELEASE IS AT THE REQUEST OF THE PATIENT.

Date: _____

Patient Name:_____DOB: _____

Patient Address:_____City/State/Zip: Patient Phone #_____Social _____

Security # _____

I hereby authorize:

_____

Address:_____

Phone:_ Fax:_____

To release my medical records to: **Texas Intergrative Pain Instiute Inc.**

Dr.Brett Warfield

Ph: 346.888.5237 **Fax:** 346.888.5864

The following is authorized for release:

- ☐ ALL medical records, Including Clinical, Progress, and Procedure Reports/Notes
- ☐ Demographics and Insurance Card
- ☐ Lab Results, Imaging Reports, Urine Toxicology Results

I understand that the information in my health record may include information related to sexually transmitted disease (AIDS/HIV). It may also include information about behavioral, or mental service, and treatment for alcohol and drug abuse.

_____ _____

Signature of Patient/ Legal Representative Date

_____

Print Name

URINE DRUG AND PREGNANCY SCREENING PROTOCOL

1. I hereby knowingly and voluntarily authorize and consent to the collection and testing of specimens of my urine by Texas Intergrative Pain Institute or its designated agent, for the purpose of drug testing and/or pregnancy testing.
2. I authorize Texas Intergrative Pain Institute to retain the results of my drug or pregnancy test to my patient file and I further authorize Texas Intergrative Pain Institute to regard the results as confidential.
3. I acknowledge that the drug and/or pregnancy test results will be utilized by Texas Intergrative Pain Institute to determine my eligibility for my medical treatment or continued treatment plan, therewith.
4. I acknowledge that at the time of collection, a refusal to authorize the collection and testing of my urine by Texas Intergrative Pain Institute or a refusal to authorize the above disclosure of the test results will be treated as a positive drug and/or pregnancy test and will be repercussions will be at the discretion of the practice. I further acknowledge that a positive drug and/or pregnancy test will impact my medical treatment plan up to and including refusal of treatment or termination of new/current treatment plans.
5. In addition, I hereby knowingly and voluntarily release Texas Intergrative Pain Institute and their respective officers, directors, employees and agents from any and all claims, damages, losses, liabilities, cost and expenses, including attorney fees, arising from or relating to such a collection and testing and any disclosure if any inaccurate or incomplete results, to the fullest extent permitted by law.
6. I understand that two failed drug test patient placed on non-opioid management only (Injections, NSAIDS) or termination. Unspecifed drugs are at the discretion of the provider to terminate the doctor-patient relationship based on past medical and social history
7. I further authorize Texas Intergrative Pain Institute to perform and agree to participate in random drug or pregnancy screenings for a period of time that I am an established patient with the practice.
8. I acknowledge that I have the right to receive a copy of this authorization.
9. I have read and understood the above Authorization and Consent in its entirety, and I agree that a copy of this document is as valid as the original.

_____ _____

Patient Signature Date

PRESCRIPTION REFILL POLICY

1. When it is time for a prescription refill, ask your pharmacy to call our office.
2. It is our policy that we do not fill early or lost prescriptions for any reason.
3. Patients should call 3 business days in advance for a refill to ensure that you do not run out of medications.
4. The Drug Enforcement Agency and the Texas Department of Public Safety carefully monitor triplicate medications.

Medications will be filled:

- By 3:00pm weekdays
- Medications will NOT be filled:Weekends and Holidays

*****It is important for you to take responsibility for keeping track of your medications.*****

Obtain controlled substance medications from only one doctor.

You can only use one pharmacy for prescribed medications.

_____ _____

Patient Signature Date

Oswestry Disability Index

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 normally but it is very painful.
□ I can look after myself normally but it is very painful.
□ 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 my personal care.
□ I need help every day in most aspects of self-care.
□ I do not get dressed, 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 from lifting heavy weights off the floor, but I can manage if they are conveniently positioned (i.e. on a table).
□ Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
□ I can lift only very light weights.
□ I cannot lift or carry anything at all.

Section 4 – Walking

□ Pain does not prevent me walking any distance.
□ Pain prevents me walking more than 1mile.
□ Pain prevents me walking more than ¼ of a mile.
□ Pain prevents me walking more than 100 yards.
□ I can only walk using a stick or crutches.
□ I am in bed most of the time and have to crawl to the toilet.

Section 5 – Sitting

□ I can sit in any chair as long as I like.
□ I can sit in my favorite chair as long as I like.
□ Pain prevents me from sitting for more than 1 hour.
□ Pain prevents me from sitting for more than ½ hour.
□ Pain prevents me from sitting for more than 10 minutes.
□ Pain prevents me from sitting at all.

Section 6 – Standing

□ I can stand as long as I want without extra pain.
□ I can stand as long as I want but it gives me extra pain.
□ Pain prevents me from standing more than 1 hour.
□ Pain prevents me from standing for more than ½ an hour.
□ Pain prevents me from standing for more than 10 minutes.
□ Pain prevents me from standing at all.

Section 7 – Sleeping

□ My sleep is never disturbed by pain.
□ My sleep is occasionally disturbed by pain.
□ Because of pain, I have less than 6 hours sleep.
□ Because of pain, I have less than 4 hours sleep.
□ Because of pain, I have less than 2 hours sleep.
□ Pain prevents me from sleeping at all.

Section 8 – Sex life (if applicable)

□ My sex life is normal and causes no extra pain.
□ My sex life is normal but causes some extra pain.
□ My sex life is nearly normal but is very painful.
□ My sex life is severely restricted by pain.
□ My sex life is nearly absent because of pain.
□ Pain prevents any sex life at all.

Section 9 – Social Life

□ My social life is normal and cause me no extra pain.
□ My social life is normal but increases the degree of pain.

- □ Pain has no significant effect on my social life apart from limitingmy more energetic interests, i.e. sports.
- □ Pain has restricted my social life and I do not go out as often.
- □ Pain has restricted social life to my home.
- □ I have no social life because of pain.

Section 10 – Traveling

□ I can travel anywhere without pain.

□ I can travel anywhere but it gives extra pain.

□ Pain is bad but I manage journeys of over two hours.

□ Pain restricts me to short necessary journeys under 30 minutes.

□ Pain prevents me from traveling except to receive treatment.

Section 11 - Previous Treatment

Over the past three months have you received treatment,

tablets or medicines of any kind for your back or leg pain?

Please check the appropriate box.

□ No

□ Yes (if yes, please state the type of treatment you have received)

□ I can do as much work as I want to.
□ I can 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.

Neck Disability Index

This questionnaire has been designed to give the doctor information as to how your neck pain has affected your ability to manage in everyday life. Please answer every section and mark in each section only the ONE box which applies to you. We realize you may consider that two of the statements in any one section relate to you, but please just mark the box which most closely describes your problem.

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 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 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.

Section 3 – Lifting
□ I can lift heavy weights without extra pain.
□ I can lift heavy weights but it gives extra pain.
□ Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned, for example on a table.
□ Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
□ I can lift very light weights.
□ I cannot lift 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 with moderate pain in my neck.
□ I cannot read as much as I want because of moderate pain in my neck.
□ I can hardly read at all because of severe pain in my neck.
□ I cannot read at all.

Section 5 – Headaches
□ I have no headaches at all.
□ I have slight headaches that 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 sligh
□ I have a fair degree of difficulty in concentrating to.
□ I have a lot of difficulty in concentrating when I
□ I have a great deal of difficulty in concentrating
□ I cannot concentrate at all.
□ I can concentrate fully when I want to with no difficulty. (0)

Section 7 – Work
□ I can drive my car without any neck pain.
□ I can drive my car as long as I want with slight p
□ I can drive my car as long as I want with modera neck.
□ I cannot drive my car as long as I want because o pain in my neck.
□ I can hardly drive at all because of severe pain in
□ I cannot drive my car at all.

Section 8 – Driving
□ I have no trouble sleeping.
□ My sleep is slightly disturbed (less than 1 hour s
□ My sleep is mildly disturbed (1-2 hours sleepless
□ My sleep is moderately disturbed (2-3 hours slee
□ My sleep is greatly disturbed (3-5 hours sleeples
□ My sleep is completely disturbed (5-7 hours slee

Section 9 – Sleeping
□ I am able to engage in all my recreation activitie neck pain at all.
□ I am able to engage in all my recreation activitie some pain in my neck.
□ I am able to engage in most, but not all, of my us recreation activities because of pain in my neck.
□ I am able to engage in a few of my usual recreati activities because of pain in my neck.
□ I can hardly do any recreation activities because my neck.
□ I cannot do any recreation activities at all.

Section 10 – Recreation

Functional Strength of the Cervical Spine

Starting Position	Action	Functional Test
Supine lying	Lift head keeping chin tucked in (neck flexion)	6 to 8 repetitions: functional 3 to 5 repetitions: functionally fair 1 to 2 repetitions: functionally poor 0 repetitions: nonfunctional
Prone lying	Lift head backward (neck extensions)	Hold 20 to 25 seconds: functional
Side lying (pillows under head so head is not side flexed)	Life head sideways away from pillow (neck side flexion) (must be repeated or other side)	
Supine lying	Lift head off bed and rotate to one side keeping head off bed or pillow (neck rotation) (must be repeated both ways)	
		Hold 10 to 19 seconds: functionally fair Hold 1 to 9 seconds: functionally poor Hold 0 seconds: nonfunctional
	Hold 20 to 25 seconds: functional Hold 10 to 19 seconds: functionally fair Hold 1 to 9 seconds: functionally poor Hold 0 seconds: nonfunctional	
	Hold 20 to 25 seconds: functional Hold 10 to 19 seconds: functionally fair Hold 1 to 9 seconds: functionally poor	
		Hold 0 seconds: nonfunction

ZURICH CLAUDICATION QUESTIONNAIRE

In the Last Month, How Would You Describe:

The pain you have had on average including pain in your back, buttocks and pain that goes down the legs?

1- None
2- Mild
3- Moderate
4- Severe
5- Very Severe

How often have you had back, buttock, or leg pain?

1- Less than once a week
2- At least once a week
3- Every day, for at least a few minutes
4- Every day, for most of the day
5- Every minute of the day The pain in your back or buttocks?

1- None
2- Mild
3- Moderate
4- Severe
5- Very Severe

The pain in your legs or feet?

1- None
2- Mild
3- Moderate
4- Severe
5- Very Severe

Numbness or tingling in your legs or feet?

1- None
2- Mild
3- Moderate
4- Severe
5- Very Severe

Weakness in your legs or feet?

1- None
2- Mild

3- Moderate
4- Severe
5- Very Severe

Problems with your balance?

1- No, I've had no problems with balance
3- Yes, sometimes I feel my balance is off, or that I am not sure-footed
5- Yes, often I feel my balance is off, or that I am not sure-footed

In the Last Month, on a Typical Day:

How far have you been able to walk?

1- Over 2 miles
2- Over 2 blocks, but less than 2 miles
3- Over 50 feet, but less than 2 blocks
4- Less than 50 feet

Have you taken walks outdoors or in malls for pleasure?

1- Yes, comfortably
2- Yes, but sometimes with pain
3- Yes, but always with pain
4- No

Have you been shopping for groceries or other items?

1- Yes, comfortably
2- Yes, but sometimes with pain
3- Yes, but always with pain
4- No

Have you walked around the different rooms in your house or apartment?

1- Yes, comfortably
2- Yes, but sometimes with pain
3- Yes, but always with pain
4- No

Have you walked from your bedroom to the bathroom?

1- Yes, comfortably
2- Yes, but sometimes with pain 3Yes, but always with pain
4- No

IF APPLICABLE, How Satisfied Are You With:

The overall result of back operation?

1- Very satisfied
2- Somewhat satisfied
3- Somewhat dissatisfied
4- Very dissatisfied

Relief of pain following the operation?

1- Very satisfied
2- Somewhat satisfied
3- Somewhat dissatisfied
4- Very dissatisfied

Your ability to walk following the operation 1-
Very satisfied
2- Somewhat satisfied
3- Somewhat dissatisfied
4- Very dissatisfied

Your ability to do housework, yard work, or job following the operation?

1- Very satisfied
2- Somewhat satisfied
3- Somewhat dissatisfied
4- Very dissatisfied

Your strength in the thighs, legs, and feet?

1- Very satisfied
2- Somewhat satisfied
3- Somewhat dissatisfied
4- Very dissatisfied

Your balance, or steadiness on your feet?

1- Very satisfied
2- Somewhat satisfied
3- Somewhat dissatisfied
4- Very dissatisfied