Rushmore Family
CHIROPRACTIC

NAME: _____ DATE: _____/_____/_____

Automobile Accident Questionnaire

AUTOMOBILE ACCIDENT QUESTIONNAIRE

Today's Date: _____

Name: _____ Marital Status_____ DOB ___/____/_____ Home #: (_____) _____-_____

Address: _____ City: _____ State: _____ Zip: _____

Occupation: _____ Business #: (_____) _____-_____ Company Name: _____

SSN: _____-_____-_____ Who referred you to our office? _____

Date of accident: _____/_____/_____ Time of accident: _____

City of accident: _____Street of accident: _____

Road conditions at time of accident: WET DRY ICY OTHER _____

Please give your best description of what happened during this accident: _____

_____

_____

_____

_____

You were heading _____NORTH _____SOUTH _____EAST _____WEST on _____

Other vehicle was heading _____NORTH _____SOUTH _____EAST _____WEST on _____

Did the police come to the accident scene? ____YES ____NO. Is there a police report? ____YES ____NO.

You were: ____ driver ____passenger ____ front seat ____back seat ____using seat belt

Did you go to the hospital? _____

If yes, give name and city of hospital: _____

How did you get to hospital: _____

What parts of your body were x-rayed at hospital: _____

Treatment provided at the hospital: _____

How long did you stay at hospital: _____

What bleeding cuts did you sustain during this accident: _____

What bruises did you sustain during this accident: _____

Were you aware of the approaching collision prior to impact, or did impact catch you by surprise?

AWARE_____ SURPRISE_____

Did you lose consciousness (black out) upon impact? ____YES ____NO How long _____

Do you remember the actual collision? ____YES ____NO

Did you experience a flash of light or explosion in your head? ____YES ____NO

Did you become: CONFUSED____ DISORIENTED____ LIGHT HEADED____ DIZZY____ NAUSEATED____ BLURRED VISION____ RING/BUZZ IN EARS____

If you still have any of those symptoms, which ones: _____

Are you currently suffering from any of the following (please circle):

Restlessness	Irritability	Difficulty concentrating	Difficulty memory
Sleeplessness	Forgetfulness	Reduced tolerance to heat	Reduced tolerance to alcohol

Doctor Signature: _____

Patient Signature: _____

Rushmore Family
CHIROPRACTIC

NAME: _____ DATE: _____/_____/_____

Automobile Accident Questionnaire

What is the approximate distance between the back of your head and your vehicle's headrest? _____inches

Did your head go back over the top of your vehicle's headrest? ____YES ____NO

Were you wearing a seatbelt? ____YES ____NO

If yes, was it a lap seatbelt_____ OR shoulder-lap seatbelt_____

Does your vehicle have airbags? ____YES ____NO

Did the airbags deploy in this accident? ____YES ____NO

Did you receive an injury from the airbag? ____YES ____NO

Please describe _____

Was your car stopped at the time of impact? ____YES ____NO

If yes, was the driver's foot also on the brake? ____YES ____NO

If no, then estimate the speed of the vehicle you were in _____mph

On what part of the automobile did the following body parts hit?

Head hit _____ Chest hit _____

Right/left shoulder hit _____ Right/left arm hit _____

Right/ left hip hit _____ Right/ left leg hit _____

Right/ left knee hit _____ Other _____

Did you receive any injury or bruises from the seatbelt (i.e. breast or abdomen)? ____YES ____NO

If yes, then describe _____

Was the trunk of your body pointed straight forward at the time of the collision? ____YES ____NO

If no, how was it turned? _____

Was your head pointed straight forward? ____YES ____NO

If no, what direction was it turned and by how much? _____

Have you ever had any complaints in the involved area before? ____YES ____NO

If so what were the complaints: _____

Are your work activities restricted as a result of this accident? ____YES ____NO

Since this injury are your symptoms: ____Improving ____Getting worse ____Same

DRIVER INFORMATION

Driver of the other vehicle/ Name: _____

Insurance Company: _____ Policy #: _____ Claim #: _____

Driver of vehicle in which you were injured/ Name: _____

Insurance Company: _____ Policy #: _____ Claim #: _____

List the year, make and model of the other vehicle:

YEAR _____ ___ MAKE _____ MODEL _____

List the year, make and model of the vehicle in which you were injured :

YEAR _____ ___ MAKE _____ MODEL _____

What is the estimated cost of damage to the vehicle you were in? _____

Which of the following car parts broke during the accident? (please circle)

Windshield Right/left side window Steering wheel Back of the front seat

Other: _____ Other: _____

Have you retained an attorney? ____YES ____NO Name: _____

Address: _____ Phone: (_____) _____-_____

Doctor Signature: _____

Patient Signature: _____

Rushmore Family
CHIROPRACTIC

NAME: _____ DATE: _____/_____/_____

HISTORY OF ILLNESS/ INJURY/ PAIN

LOCATION

Chief complaint and its location: _____

_____

TIMING & DURATION

How often do you experience this pain? ____Constant ____Frequent ____Intermittent ____Occasional

What caused the onset? _____

_____

Date of the onset? _____/_____/_____

SEVERITY

On a scale of 0 to 10 representing no pain and 10 being the most severe pain imaginable, use the key below to rate the severity of your pain.

0 = None 1 = Minimal 2 = Very Mild 3 = Mild 4 = Mild to Moderate 5 = Moderate
6 = Moderate 7 = Mildly Severe, Restricts Some Activity 8 = Severe, Limits Most Activity
9 = Very Severe 10 = Excruciating

Sitting here today, right now, what is the intensity of your pain on a scale of 0 to 10?

_____0 _____1 _____2 _____3 _____4 _____5 _____6 _____7 _____8 _____9 _____10

What is the least intense the symptom has been on a scale of 0 to 10?

_____0 _____1 _____2 _____3 _____4 _____5 _____6 _____7 _____8 _____9 _____10

What is the most intense the symptom has been on a scale of 0 to 10?

_____0 _____1 _____2 _____3 _____4 _____5 _____6 _____7 _____8 _____9 _____10

ASSOCIATED SIGNS & SYMPTOMS

Please check those that apply ➡ _____Inflexibility ____Stiffness _____Spasms _____Cramps

If this pain radiates or travels, please identify where to: _____

_____

QUALITY

How would you best describe the sensation of the pain/ symptom:

_____Sharp _____Stabbing _____Aching _____Pins & Needles _____Pounding _____Shooting
_____Burning _____Dull _____Tingling/ Numb _____Throbbing _____Crawling _____Stinging

MODIFYING FACTORS

What aggravates the pain/ symptom?

_____Sneezing _____Lifting _____Exercising _____Looking up/down _____Walking
_____Coughing _____Sitting _____Stooping _____Looking side/side _____Standing
_____Stress _____Driving _____Getting out of bed _____Pushing _____Pulling
_____Repetitive Movements _____Carrying _____Straining at BM _____Climbing stairs _____Getting in/out of car

Other: _____

What relieves this pain/ symptom?

_____Resting _____Sleeping _____Lifting _____Exercising _____Looking up/down
_____Shower _____Advil _____Stooping _____ Looking side/side _____Mineral Ice
_____Other: _____

Over the past weeks/ months this complaint is: _____Improving _____Getting worse _____About the same

Have you seen anyone for this condition? _____YES _____NO WHOM? _____

How did you hear about us? _____Have you been to a chiropractor before? If yes, who? _____

Doctor Signature: _____
Patient Signature: _____

Rushmore Family
CHIROPRACTIC

NAME: _____ DATE: _____/_____/_____

SECONDARY COMPLAINT & LOCATION

Location: _____ Sitting here today, right now, what is the intensity of your pain on a scale of 0 to 10?

_____0 _____1 _____2 _____3 _____4 _____5 _____6 _____7 _____8 _____9 _____10

What is the least intense the symptom has been on a scale of 0 to 10?

_____0 _____1 _____2 _____3 _____4 _____5 _____6 _____7 _____8 _____9 _____10

What is the most intense the symptom has been on a scale of 0 to 10?

_____0 _____1 _____2 _____3 _____4 _____5 _____6 _____7 _____8 _____9 _____10

ASSOCIATED SIGNS & SYMPTOMS Please check those that apply ➡ _____Inflexibility ____Stiffness _____Spasms _____Cramps

IF the pain radiates of travels, please identify where to: _____

QUALITY

How would you best describe the sensation of the pain/ symptom:

_____Sharp _____Stabbing _____Aching _____Pins & Needles _____Pounding _____Shooting

_____Burning _____Dull _____Tingling/ Numb _____Throbbing _____Crawling _____Stinging

Over the past weeks/ months this complaint is: _____Improving _____Getting worse _____About the same

THIRD COMPLAINT & LOCATION

Location: _____ Sitting here today, right now, what is the intensity of your pain on a scale of 0 to 10?

_____0 _____1 _____2 _____3 _____4 _____5 _____6 _____7 _____8 _____9 _____10

What is the least intense the symptom has been on a scale of 0 to 10?

_____0 _____1 _____2 _____3 _____4 _____5 _____6 _____7 _____8 _____9 _____10

What is the most intense the symptom has been on a scale of 0 to 10?

_____0 _____1 _____2 _____3 _____4 _____5 _____6 _____7 _____8 _____9 _____10

ASSOCIATED SIGNS & SYMPTOMS Please check those that apply ➡ _____Inflexibility ____Stiffness _____Spasms _____Cramps

IF the pain radiates of travels, please identify where to: _____

QUALITY

How would you best describe the sensation of the pain/ symptom:

_____Sharp _____Stabbing _____Aching _____Pins & Needles _____Pounding _____Shooting

_____Burning _____Dull _____Tingling/ Numb _____Throbbing _____Crawling _____Stinging

Over the past weeks/ months this complaint is: _____Improving _____Getting worse _____About the same

KEY VALUE QUESTIONS

1. What is your pain keeping you from doing that is most important in your life?

   _____

   _____

2. What do you enjoy doing most in your life?

   _____

   _____

NOTES / COMMENTS:

_____

_____

_____

Doctor Signature: _____

Patient Signature: _____

Rushmore Family
CHIROPRACTIC

NAME: _____ DATE: _____/_____/_____

Please place a checkmark by the condition that applies to you: P = Present ● N = Not Present ● PP = If it has ever been present in the past

P	N	PP	
			Fatigue
			Fever
			Chills
			Night Sweats
			Fainting
			Nervousness
			Concentration Loss

P	N	PP	
			Irritability
			Depression
			Memory Loss
			Headache
			Muscle Pain
			Muscle Weakness
			Muscle Cramps

P	N	PP	
			Joint Stiffness
			Spinal Curvature
			Back Pain
			Hot Joints
			Joint Swelling
			Stiff Neck
			Lumps / Masses

P	N	PP	
			Seizures
			Dizziness
			Tremors
			Loss of Sensation
			Loss of Coordination
			Paralysis

P = Present ● N = Not Present ● PP = If it has ever been present in the past ● Do the same for your family

Family History Key: F = Father● M = Mother● B = Brother ● S = Sister● GF = GrandFather● GM = GrandMother

Family History

P	**N**	**PP**	**Past Problem**	**When and Explanation of Condition** (use back if needed)	**F**	**M**	**B**	**S**	**GF**	**GM**
			Cancer							
			Stroke							
			Thyroid Problems							
			Asthma							
			Heart Attack							
			HIV							
			Angina/ Chest Pain							
			Diabetes							
			Arthritis							
			Other							

List any allergies: _____

_____

Do you have a pacemaker? ____ YES ____NO

Are you Pregnant? ____YES ____NO

Do you think you may be pregnant? ____YES ____NO

FOR DOCTOR'S USE ONLY- PATIENT PLEASE PROCEED TO PAGE 4

REVIEW OF SYSTEMS

SYSTEM REVIEWED

Allergic / Immunologic
Constitutional
Endocrine
Gastrointestinal
Genitourinary
Integumentary
Neurological
Respiratory
Cardiovascular
Ears/Nose/ Mouth
Eyes
All Other system reviews negative
Hematological / Lymphatic
Musculoskeletal
Psychiatric

Notes / Comments: _____

_____

_____

_____

_____

_____

Doctor Signature: _____

Patient Signature: _____

Rushmore Family
CHIROPRACTIC

NAME: _____ DATE: _____/_____/_____

PLEASE LIST PAST SURGERIES:

1. _____ Year_____ 2. _____ Year _____

3. _____ Year_____ 4. _____ Year _____

5. _____ Year_____ 6. _____ Year _____

List any other key slips, falls or accidents you've had from childhood to present:	**DATE**	**Have you taken:**	**YES**	**NO**	**YEAR**
1)		Insulin			
2)		Cortisone			
3)		Thyroid Medicine			
4)		Male/ Female Hormones			
5)		Blood Pressure			
What medications are you currently taking? (Include Date)		Tranquilizers/ Sedatives			
1)	4)	Birth Control			
2)	5)				
3)	6)				
Known allergies to medications:					
Hospitalizations:					

Marital Status: ____Married ____Divorced ____Single ____Separated ____Widowed

Number of Children: _____ Children's Name(s): _____

Frequency of Exercise: ____Never ____Rarely ____Occasionally ____Moderately ____Regularly

Intensity of Exercise: ____Low Level ____Medium Level ____High Level ____Competition Level

Sufficient Rest: ____Never ____Rarely ____Occasionally ____Moderately

Hours of Sleep: ____6 ____8 ____10 ____More than 10

Well Balanced diet: ____Never ____Rarely ____Occasionally ____Moderately

Do you Smoke? ____NO ____Occasionally ____1 to 2 ____2 to 3 ____4 to 5 ____More than 5packs/day

Do you drink caffeinated beverages? ____NO ____Occasionally ____1 to 2 ____2 to 3 ____4 to 5 ____More than 5packs/day

Do you drink alcoholic beverages? ____NO ____Occasionally ____1 to 2 ____2 to 3 ____4 to 5 ____More than 5packs/day

Have you ever used street drugs? ____YES ____NO

Hobbies: _____

_____

Patient history was obtained from: ____Patient (Self) ____Father ____Mother ____Son ____Daughter

Notes / Comments: _____

_____

_____

_____

_____

_____

_____

_____

Doctor Signature: _____

Patient Signature: _____

Rushmore Family
CHIROPRACTIC

NAME: _____ DATE: _____/_____/_____

Automobile Accident Verification

INSURANCE INFORMATION

Do you have Med Pay? ____YES ____NO

If yes, name of insured: _____

Insurance Company: _____ Insurance Phone #: (____) _____-_____

Insurance Address: _____

City: _____ State: _____ Zip: _____

Adjuster Name: _____

Adjuster Phone: (_____) _____-_____ Adjuster Fax: (_____) _____-_____

CLAIM NUMBER: _____ Date of injury: _____/_____/_____

Amount of Med Pay: _____

Are funds still available: ____YES ____NO How much: _____

IF NOT MED PAY

Name of person at fault: _____

At fault party insurance company: _____

Insurance Address: _____

City: _____ State: _____ Zip: _____

Adjuster Name: _____

Adjuster Phone: (_____) _____-_____ Adjuster Fax: (_____) _____-_____

CLAIM NUMBER: _____ Date of injury: _____/_____/_____

Doctor Signature: _____
Patient Signature: _____

Rushmore Family
CHIROPRACTIC

NAME: _____ DATE: _____/_____/_____

Oswestry Low Back Pain Disability Questionnaire

Instructions

This questionnaire has been designed to give us information as to how your back or leg pain is affecting your ability to manage in everyday life. Please answer by checking ONE box in each section for the statement which best applies to you. We realize you may consider that two or more statements in any one section apply but please just shade out the spot that indicates the statement which most clearly 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 (e.g. washing, dressing)

- ☐ 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 can manage most 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 me extra pain.
- ☐ Pain prevents me from lifting heavy weights off the floor I can manage if they are conveniently placed (e.g., 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 only lift very light weights.
- ☐ I cannot lift or carry anything.

SECTION 4: Walking

- ☐ Pain does not prevent me walking any distance.
- ☐ Pain prevents me from walking more than 1 mile.
- ☐ Pain prevents me from walking more than 1/2 mile.
- ☐ Pain prevents me from walking more than 100 yards.
- ☐ I can only walk using a stick or crutches.
- ☐ I am in bed most of the time.

SECTION 5: Sitting

- ☐ I can sit in any chair as long as I like.
- ☐ I can only sit in my favorite chair as long as I like.
- ☐ Pain prevents me sitting more than 1 hour.
- ☐ Pain prevents me from sitting more than 30 minutes.
- ☐ 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 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 30 minutes.
- ☐ 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 gives 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 limiting my more energetic interests, e.g. sport.
- ☐ Pain has restricted my social life and I do not go out as often.
- ☐ Pain has restricted my 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 me extra pain.
- ☐ Pain is bad but I manage journeys over 2 hours.
- ☐ Pain restricts me to journeys of less than 1 hour.
- ☐ Pain restricts me to short necessary journeys less than 30 minutes.
- ☐ Pain prevents me from traveling except to receive treatment.

Score:

Doctor Signature: _____

Patient Signature: _____

Rushmore Family
CHIROPRACTIC

NAME: _____ DATE: _____/_____/_____

Neck Disability Index

This questionnaire has been designed to give us 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 that applies to you. We realize you may consider the two or more statements in any one section relate to you, but please just mark the box that most closely describes your problem.

SECTION 1: Pain Intensity

- ☐ I have no pain at the moment.
- ☐ The pain is mild at the moment.
- ☐ The pain comes and goes and is moderate.
- ☐ The pain is moderate and does not very much.
- ☐ The pain is very severe, but comes and goes.
- ☐ The pain is severe and does not very much.

SECTION 2: Personal Care (e.g. washing, dressing)

- ☐ 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 can manage most 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 me extra pain.
- ☐ Pain prevents me from lifting heavy weights off the floor I can manage if they are conveniently placed (e.g., 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 only lift very light weights.
- ☐ I cannot lift or carry anything.

SECTION 4: Reading

- ☐ I can read as much as I want to 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 cannot read as much as I want because of severe neck pain.
- ☐ I cannot read at all.

SECTION 5: Headache

- ☐ 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 work 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 my car without 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 my car at all because of severe pain in my neck.
- ☐ I cannot drive my car at all.

SECTION 9: 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)

SECTION 10: Recreation

- ☐ I am able to engage in all recreational activities with no pain in my neck at all.
- ☐ I am able to engage in all recreational activities with some pain in my neck.
- ☐ I am able to engage in most, but not all, recreational activities because of pain in my neck.
- ☐ I am able to engage in a few of my usual 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 recreational activities at all.

Score:

Doctor Signature: _____

Patient Signature: _____

Rushmore Family
CHIROPRACTIC

NAME: _____ DATE: _____/_____/_____

Activities of Daily Living Assessment

Rate your current difficulties by placing the appropriate number in the box.
If an activity does not cause pain or if pain does not affect an activity, leave box blank.

[1] This activity causes some pain, but it is of minor annoyance.

[2] This activity causes a significant amount of pain.

[3] I cannot perform this activity due to pain and disability.

Self-Care and Personal Hygiene

- ☐ Bathing
- ☐ brushing teeth
- ☐ making bed
- ☐ putting on pants
- ☐ doing dishes
- ☐ putting on shoes
- ☐ doing laundry
- ☐ washing face
- ☐ putting on shirt
- ☐ cooking
- ☐ grooming hair
- ☐ taking out trash
- ☐ going to bathroom or sitting on toilet

Physical Activities

- ☐ standing
- ☐ walking
- ☐ reaching
- ☐ bending right
- ☐ twisting right
- ☐ sitting
- ☐ squatting
- ☐ bending
- ☐ bending left
- ☐ twisting left
- ☐ reclining
- ☐ bending back
- ☐ kneeling
- ☐ looking left
- ☐ looking right

Functional Activities

- ☐ carrying small objects
- ☐ lifting w eight off table
- ☐ push/pull standing
- ☐ carrying large objects
- ☐ climbing stairs/incline
- ☐ exercising upper body
- ☐ exercising lower body
- ☐ carrying purse/case
- ☐ lifting objects off floor
- ☐ push/pull seated

Social & Recreational Activities

- ☐ jogging
- ☐ biking
- ☐ swimming
- ☐ dancing
- ☐ golfing
- ☐ bowling
- ☐ hunting
- ☐ fishing
- ☐ gardening
- ☐ basketball
- ☐ soccer
- ☐ hockey
- ☐ competitive sports

Difficulties with Travel

- ☐ driving in car
- ☐ riding as passenger
- ☐ entering and exiting vehicle
- ☐ driving for long periods of time
- ☐ riding as passenger for long period of time

Other Activities

- ☐ concentrating
- ☐ studying
- ☐ listening
- ☐ reading
- ☐ writing
- ☐ using computer
- ☐ sleeping
- ☐ sexual relation

Score:

Doctor Signature: _____

Patient Signature: _____