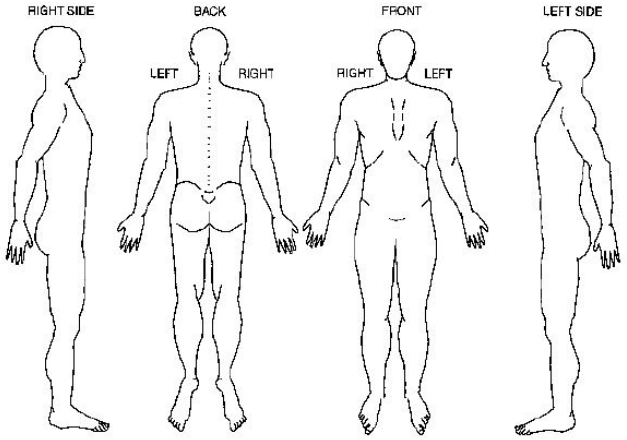
For Staff: Appt Date: ___/___/____ Staff Initials: _____

Parliament
CHIROPRACTIC

Patient Name: _____ Date: _____/_____/_____

In order to utilize your Therapy Benefits, your insurance company wants us to collect clinical information from you to determine whether the procedure is Medically Necessary.

1. What is the **primary** area you want treated?



2. Is this a new condition? □ Yes □ No
3. What date did this condition start? ____/____/_____
4. Briefly describe the cause of your primary condition: _____
   _____
5. Have you had this condition longer than 3 months? □ Yes □ No
6. In the past 3 years, how many times has this condition occurred? □ 1 □ 2 □ 3 □ ≥4
7. Is this for Post-Surgical Care? □Yes □ No
   a. If yes, please list the surgery: _____ Date: __/___/____
8. Has there been any unusual activity that adversely effected your progress with this condition (e.g. "over did" something, suffered an additional injury, unable to complete home program, etc.)? □ Yes □ No
   a. If yes, please explain what happened: _____
9. Do you have radiating pain/numbness/tingling to or below your knee(s)? □ Yes □ No
10. Do you have radiating pain/numbness/tingling to or below your elbow(s)? □ Yes □ No
11. Average level of pain you experienced last 24 hours (0 = no pain, 10 = worst pain): _____
12. Average level of pain you experienced last week? (0 = no pain, 10 = worst pain) : _____

Please Initial: _____

For Staff: Appt Date: ___/___/____ Staff Initials: _____

13. How frequent are your symptoms?
    □ 0-25% of the time □ 26-50% of the time □ 51-75% of the time □ 76-100% of the time
14. How much have your symptoms interfered with your daily activities?
    □ Not at all □ A little bit □ Moderately □ Quite a bit □ Extremely
15. How is your condition changing since care at this facility?
    □ Not at all □ A little bit □ Moderately □ Quite a bit □ Extremely □ First visit N/A
16. In general, how would you say your overall health is right now?
    □ Excellent □ Very good □ Good □ Fair □ Poor
17. Has your back pain spread down your leg(s) at some time in the last 2 weeks?
    □ Yes □ No
18. Have you had pain in the shoulder or neck at some time in the last 2 weeks?
    □ Yes □ No
19. Have you only walked short distances because of your back pain?
    □ Yes □ No
20. In the last 2 weeks, have you dressed more slowly than usual because of back pain?
    □ Yes □ No
21. Do you think it's not really safe for a person with a condition like yours to be physically active?
    □ Yes □ No
22. Have worrying thoughts been going through your mind a lot of the time?
    □ Yes □ No
23. Do you feel that your back pain is terrible and it's never going to get any better?
    □ Yes □ No
24. In general, have you stopped enjoying all the things you usually enjoy?
    □ Yes □ No
25. Overall, how bothersome has your back pain been in the last 2 weeks?
26. □ Not at all □ A little bit □ Moderately □ Quite a bit □ Extremely

Briefly describe your symptoms:

_____

_____

How did your symptoms start?

_____

_____

Please Initial: _____

Patient Name: _____ Date: _____/_____/_____

Neck/Upper Back (NDI)

- **Current Pain Intensity**:
  - No Pain
  - Very mild
  - Moderate
  - Fairly Severe
  - Very Severe
  - Worst Imaginable
- **Personal Care**:
  - I can look after myself without extra pain
  - I can look after myself but it causes extra pain
  - It is painful, I am slow and careful
  - I need some help but can manage most
  - I need help every day in most aspects
  - I do not get dressed, I wash with difficulty and stay in bed
- **Lifting**:
  - I can lift heavy weights without extra pain
  - I can lift heavy weights but it gives extra pain
  - Pain prevents me lifting heavy weights off the floor, I can manage conveniently placed weights
  - Pain prevents me from lifting heavy wights but I can manage light to medium weights if they are conveniently placed
  - I can only lift light weights
  - I cannot lift or carry anything
- **Reading**:
  - I can read as much as I want to without pain
  - I can read as much as I want to with slight pain
  - I can read as much as I want to with moderate pain
  - I can't read as much as I want to because of moderate pain
  - I can hardly read at all because of severe pain
  - I cannot read at all
- **Headaches**
  - I have no headaches at all
  - I have slight headaches, infrequently
  - I have moderate headaches, infrequently
  - I have moderate headaches, frequently
  - I have severe headaches, frequently
  - I have headaches, almost all the time
- **Concentration**
  - I can concentrate fully without difficulty
  - I can concentrate fully with slight difficulty
  - I have a fair degree of difficulty in concentrating
  - I have a lot of difficulty in concentrating
  - I have a great deal of difficulty in concentrating
  - I cannot concentrate at all.
- **Work**
  - I can do as much work as I want
  - 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 can't do any work at all
- **Driving**
  - I can drive my car without pain
  - I can drive my car as long as I want with slight pain
  - I can drive my car as long as I want with moderate pain
  - I can't drive my car as long as I want because of moderate pain
  - I can hardly drive at all because of severe pain
  - I can't drive my car at all
- **Sleeping**
  - I have no trouble sleeping
  - My sleep is slightly disturbed (> 1 hr sleepless)
  - My sleep is mildly disturbed (1-2 hrs sleepless)
  - My sleep is moderately disturbed (2-3 hrs sleepless)
  - My sleep is greatly disturbed (3-5 hrs sleepless)
  - My sleep is completely disturbed (5-7 hrs sleepless)
- **Recreation**
  - I can engage in all my recreation activities without pain
  - I can engage in all my recreation activities with some pain
  - I can engage in most but not all of my usual recreation activities because of pain
  - I can engage in a few of my usual recreation activities because of pain
  - I can hardly do any recreation activities
  - I can't do any recreation activities

For Staff:

Score: ____/50 Multiply by 100% = ____ %points

For each section, first statement = 0, last = 5. Add up total, divide by 50, multiply by 100%. If a section is blank, divide by 45.

Patient Initials: _____

Patient Name: _____ Date: _____/_____/_____

Low Back Pain (Oswestry)

Current Pain Intensity:
- No Pain
- Very mild
- Moderate
- Fairly Severe
- Very Severe
- Worst Imaginable

Personal Care:
- I can look after myself without extra pain
- I can look after myself but it causes extra pain
- It is painful, I am slow and careful
- I need some help but can manage most
- I need help every day in most aspects
- I do not get dressed, I wash with difficulty and stay in bed

Lifting:
- I can lift heavy weights without extra pain
- I can lift heavy weights but it gives extra pain
- Pain prevents me lifting heavy weights off the floor, I can manage conveniently placed weights
- Pain prevents me from lifting heavy wights but I can manage light to medium weights if they are conveniently placed
- I can only lift light weights
- I cannot lift or carry anything

Walking:
- Pain does not prevent me walking any distance
- Pain prevents me from walking more than a mile
- Pain prevents me from walking more than ½ 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

Sitting
- I can sit in any chair as long as I like
- I can only sit in my favorite chair for as long as I like
- Pain prevents me sitting more than one 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

Standing
- I can stand as long as I want without extra pain
- I can stand as long as I want but with extra pain
- Pain prevents me from standing for more than 1 hour
- Pain prevents me from standing more than 30 min
- Pain prevents me from standing more than 10 min
- Pain prevents me from standing at all

Sex Life (if applicable)
- My sex life is normal and causes no extra pain
- My sex life is normal but with 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

Social Life
- My social life is normal without extra pain
- My social life is normal but increases the pain
- Pain has no significant effect apart from limiting more energetic interests (such as sports)
- 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

Sleeping
- I have no trouble sleeping
- My sleep is slightly disturbed (> 1 hr sleepless)
- My sleep is mildly disturbed (1-2 hrs sleepless)
- My sleep is moderately disturbed (2-3 hrs sleepless)
- My sleep is greatly disturbed (3-5 hrs sleepless)
- My sleep is completely disturbed (5-7 hrs sleepless)

Traveling
- I can travel anywhere without pain
- I can travel anywhere but it gives me extra pain
- Pain is bad but I manage a journey over two hours
- Pain restricts me to journeys of less than one hour
- Pain restricts me to short necessary journeys under 30 minutes
- Pain prevents me from traveling except to receive treatment

For Staff:

Score: ____/50 Multiply by 100% = ____ %points

For each section, first statement = 0, last = 5. Add up total, divide by 50, multiply by 100%. If a section is blank, divide by 45.

Patient Initials: _____

Patient Name: _____ Date: _____/_____/_____

Shoulder/Arm/Hand

Please rate your ability to do the following activities in the last week (circle):

	No Difficulty	Mild Difficulty	Moderate Difficulty	Severe Difficulty	Unable to do
1. Open a tight/ new jar	1	2	3	4	5
2. Do heavy household chores	1	2	3	4	5
3. Wash your back	1	2	3	4	5
4. Use a knife to cut food	1	2	3	4	5
5. Recreational activities where you use force with your arm/shoulder/hand such as tennis or using a hammer	1	2	3	4	5
6. Carry a shopping bag	1	2	3	4	5

	Not at all	Slightly	Moderate	Quite a Bit	Extremely
7. In the past week, to what extent has your shoulder/arm/hand interfered with your normal social activities	1	2	3	4	5

	None	Mild	Moderate	Severe	Extreme
8. In the past week, were you limited in your work or other daily activities	1	2	3	4	5

	None	Mild	Moderate	Severe	Extreme
9. Arm, shoulder or hand pain	1	2	3	4	5
10. Tingling in your shoulder, arm, or hand	1	2	3	4	5

	No Difficulty	Mild Difficulty	Moderate Difficulty	Severe Difficulty	So much I cannot sleep
11. In the past week, how much difficulty have you had sleeping due to pain	1	2	3	4	5

For Staff:

Score: _____

To calculate score: Add up the numbers on the responses, divide by 11 (or the number of questions answered), subtract 1, and multiple by 25

OR

([Sum of responses/number of responses] -1) x 25

Patient Initials: _____

Patient Name: _____ Date: _____/_____/_____

Hip/Leg/Knee

Activity	Extreme difficulty/ Unable to do	Quite a bit of difficulty	Moderate Difficulty	Mild Difficulty	No Difficulty
1. Usual work/school activities	0	1	2	3	4
2. Usual hobbies, recreational or sporting	0	1	2	3	4
3. Getting in or out of the bath	0	1	2	3	4
4. Walking between rooms	0	1	2	3	4
5. Putting on your shoes/socks	0	1	2	3	4
6. Squatting	0	1	2	3	4
7. Lifting a bag of groceries from the floor	0	1	2	3	4
8. Performing light activities around home	0	1	2	3	4
9. Performing heavy activities around home	0	1	2	3	4
10. Getting into or out of car	0	1	2	3	4
11. Walking 2 blocks	0	1	2	3	4
12. Walking a mile	0	1	2	3	4
13. Going up or down 10 stairs	0	1	2	3	4
14. Standing for 1 hour	0	1	2	3	4
15. Sitting for 1 hour	0	1	2	3	4
16. Running on even ground	0	1	2	3	4
17. Running on uneven ground	0	1	2	3	4
18. Making sharp turns while running fast	0	1	2	3	4
19. Hopping	0	1	2	3	4
20. Rolling over in bed	0	1	2	3	4
Totals					

For Staff:

Score: _____% Functional

To calculate score: Add up total score, divide by 80, and multiply by 100

Patient Initials: _____