TO OUR NEW PATIENTS:

Welcome to Pain Relief Solutions. Your care and comfort are most important to us. To make your visit with us as pleasant as possible, please sign in at the front desk when you arrive for your appointment and have a seat. In order to better serve our patients, we have adopted the following policies and procedures:

OFFICE POLICIES

PLEASE BRING THE FOLLOWING ITEMS WITH YOU ON YOUR FIRST APPOINTMENT: (i) picture ID card; (ii) insurance card; (iii) authorization form; and (iv) for those patients who are seeing a physician, (a) a list or bottles of all medications the patient is taking, (b) the patient's x-ray imaging reports, and (c) the patient's other medical records.

PLEASE COMPLETE AND BRING IN ALL OF THE REGISTRATION PAPERWORK. You must complete the paperwork before seeing a provider. If you have not had the opportunity to fill out the paperwork prior to your appointment, please arrive 45 minutes early. Those able to complete their paperwork prior to their appointment, please arrive 15 minutes early.

PLEASE BE ON TIME. Like you, we are extremely busy and must budget our time efficiently. If you are late for your appointment, you may have to reschedule your appointment. Patients who fail to cancel an appointment within 24 hours of the appointment time will be subject to a $50.00 fee billed directly to the patient.

YOU MUST SHOW YOUR INSURANCE CARD AT EACH VISIT. We will bill most insurance companies for our patients as a courtesy, provided we have all the necessary information. It is your responsibility to verify with the carrier as to whether the medical services provided to you/the patient (e.g. consults, procedures, tests) are covered by your/the patient's insurance. Any deductible, copayment, or balance not paid by a patient's insurance is the patient's financial responsibility. This applies to all insurances, including Medicare.

CO-PAYMENTS AND DEDUCTIBLES ARE DUE WHEN SERVICES ARE RENDERED. If a patient does not have or is unable to pay the patient's copayment at the time of the patient's appointment, the patient will have to reschedule the appointment until such time as the patient can pay it. We are sorry, but there can be no exception. Insured patients are responsible for all charges not paid by their insurance within 45 days after the date of service. Payment arrangements can be made on an individual basis at our discretion. We do not accept checks marked with "Payment in Full" or words of similar meaning when the amount of the check is less than the amount charged to the patient. Any deposit of such a check is inadvertent, is not a satisfaction of the full amount owed by the patient, and will be considered a partial payment. We reserve the right to withdraw the extension of credit. There is a service fee of $20 on all returned checks.

DISCLOSURE OF INFORMATION. Disclosure of insurance and other information is necessary in order for services received by a patient to be paid in full. If the patient's ailment or injury is due to any type of personal injury, accident, or malicious conduct for which the patient is seeking damages, you/the patient must notify us and sign a lien in our favor. Your failure to make necessary disclosures might make the patient personally responsible for all charges incurred by the patient for services rendered by us.

Thank you for taking the time to read this material. Your cooperation is much appreciated.

AGREEMENT. I agree to be bound by the policies and procedures above, and I agree to pay reasonable attorney's fees and costs should legal proceedings be necessary to collect any portion of the patient's bill or to enforce this agreement.

CONSENT TO TREATMENT. I hereby consent to the patient's evaluation and treatment by Pain Relief Solutions ("PRS") and PRS's healthcare providers. I authorize PRS and the patient's physician to (i) consult with any other physician should he/she believe it necessary; and/or (ii) engage the services of another physician if any surgical procedure is to be performed. I agree to pay for such consult and/or services.

PARTICIPATION IN MEDICAL EDUCATION PROGRAM. I understand that (i) PRS is a teaching institution; and (ii) the patient may participate as a teaching subject in PRS's medical education program and may receive treatment from fellows unless PRS is notified to the contrary in writing.

Patient's Signature: _____ Date: _____

Patient's Name: _____ Date of Birth: _____

Representative's Signature: _____ Date: _____

Representative's Name: _____ Rel. to Pt.: _____

Patient Name:_____	DOB:_____
Sex: Male / Female	SSN:_____
Marital Status:_____	DL/ID#:_____
Preferred Language:_____	Ethnicity & Race:_____
Occupation:_____	Employer Name:_____
Employer Phone:_____	Employer Address:_____
Primary Insurance:_____	Policy #:_____
Secondary Insurance:_____	Policy #:_____

Home / Mobile / Work Phone:_____ Home / Mobile / Work Phone:_____

I consent to receive communication at the numbers above from Pain Relief Solutions ("PRS") regarding (i) the patient's appointments; (ii) the patient's healthcare; and (iii) the collection of the patient's unpaid medical bills and other debts. I understand and agree that such communication may (i) include calls, voicemail and/or text messages, and pages; (ii) contain confidential information; (iii) involve charges by my phone service provider; and (iv) be generated by an automated dialing system or an automatic telephone dialing system and may use a prerecorded message. I understand that cellular/mobile/wireless communication is not a secure form of communication.

Mailing Address:_____ E-mail:_____

I consent to receive communication at the addresses provided above from PRS. I understand that (i) while PRS will use the minimum necessary information, PRS will not encrypt any information I request to be sent by e-mail; (ii) unencrypted e-mail is not a secure form of communication; and (iii) the risks include an unauthorized third-party accessing my/the patient's e-mail and/or the disclosure or misdirection to, or interception by, an unauthorized third-party of the confidential or sensitive information that may be contained in an unencrypted e-mail. I wish to receive written communication in envelopes / e-mails marked "CONFIDENTIAL."

PRS may communicate with the following persons about the patient's healthcare, billing/insurance information, and appointments:

	Name	Rel. to pat.	Address	Phone	Emergencies only
1.					Yes / No
2.					Yes / No

I understand and agree that (i) PRS cannot guarantee the security and confidentiality of phone and e-mail communication; (ii) PRS is not liable for improper disclosure of information received by and/or stored in devices and/or accounts associated with the phone numbers and/or e-mail addresses provided above; (iii) I may contact PRS in writing to request a restriction on communications as stated in PRS's Notice of Privacy Practices; (iv) I will notify PRS whenever the information above changes; and (v) a copy of this form will be provided to me upon my request. I HEREBY CONSENT TO THE COMMUNICATIONS DESCRIBED HEREIN.

Patient's Signature: _____ Date: _____

Patient's Name: _____ Date of Birth: _____

ASSIGNMENT OF INSURANCE BENEFITS. I hereby irrevocably assign to Pain Relief Solutions ("PRS") all of the patient's rights and benefits under the patient's insurance contract/policy for payment for services rendered to the patient at/by PRS. I hereby authorize PRS to (i) file insurance claims on the patient's behalf for services rendered to the patient at/by PRS; and (ii) release any information that may be necessary for processing applications for financial benefit. I further authorize payment of insurance benefits to be paid directly to PRS.

Patient's Signature: _____ Date: _____

Patient's Name: _____ Date of Birth: _____

NOTICE OF PRIVACY PRACTICES OF: Pain Relief Solutions

Effective Date: 12/01/2018

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. **Please review it carefully.**

Our Responsibilities. Pain Relief Solutions is required by the Health Insurance Portability and Accountability Act ("HIPAA") and other applicable laws to maintain the privacy and security of your Protected Health Information ("PHI"). We will promptly inform you if a breach occurs that may have compromised the privacy or security of your PHI. We must follow the duties and privacy practices described in, and give you a copy of, this notice. We will not use or disclose your information other than as described here unless you authorize us in writing. For more information, please visit www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.

Our Uses and Disclosures. We typically use or disclose your health information in the following ways:

1. Treatment. We may use and disclose your PHI for treatment purposes and share it with other healthcare providers who are treating you. For example, a specialist physician treating you for a specific condition may refer you to, and provide your PHI to, your primary care physician.

2. Payment. We may use and disclose your PHI to bill and get paid for our services. For example, we may give information about your treatment to your insurance to collect payment for the treatment.

3. Healthcare Operations. We may use and disclose PHI to operate our practice. For example, we may use your PHI to manage your care and improve the quality of our services. We may contact you to remind you of an appointment or to inform you of treatment alternatives or other benefits and services. PHI may be disclosed to business associates that provide services to us if the PHI is necessary for their services.

Other Uses and Disclosures. We are allowed—and may be required—to share your PHI in other ways. For more information, visit http://www.hhs.gov/hipaa/for-individuals/guidance-materials-for-consumers/index.html.

1. Public Health and Safety. PHI may be shared as necessary to help prevent or reduce a serious threat to anyone's health or safety. PHI may be also shared to (i) prevent, and notify persons who may have been exposed to, disease; (ii) report vital events; (iii) report suspected abuse, neglect, or domestic violence (including child abuse/neglect); (v) report adverse reactions to medications; and (vi) help with product recalls.

2. Health Oversight Activities and Workers' Compensation. PHI may be disclosed to a health oversight agency as authorized by law. PHI may be disclosed for workers' compensation claims.

3. Law Enforcement. PHI may be disclosed to a law enforcement official or as required or permitted by law or in compliance with a court order or a grand jury subpoena. Such disclosures include (i) reporting a crime on our premises; (ii) helping identify or locate a suspect, fugitive, material witness, or missing person; (iii) reporting a death we suspect may be caused by a crime; and (iv) reporting the occurrence, location, and victim of a crime in case of an emergency.

4. Required by Law. PHI must be shared if required by federal or state law. The Department of Health and Human Services may require us to share your PHI to verify our compliance with federal privacy laws.

5. Legal Actions. If you are involved in a lawsuit, PHI may be disclosed in response to (i) a subpoena or other lawful process by someone involved in the lawsuit, but only if efforts have been made to inform you of the request or obtain an order protecting the PHI requested; or (ii) a court or administrative order.

6. Clinical Research Studies. Your PHI may be used and disclosed in the conduct of clinical research studies. Research studies must have gone through a special approval process to protect patient safety and confidentiality; however, prior to the approval process, researchers may be allowed to access limited data to identify patients who may be included in the study as long as they do not copy or remove any PHI. After receiving approval, researchers may contact you regarding your interest in participating in the study. You become part of the study only if you agree to join. We use a third-party Electronic Health Record ("EHR") Provider and participate in the EHR Provider's research network. As permissible under HIPAA and as provided under the agreement between us and our EHR Provider, the EHR Provider and its contractors may use de- identified patient information and aggregated data for purposes of research, public health, or healthcare operations or any purpose for which patient authorization is obtained.

7. Coroners, Medical Examiners, and Funeral Directors. PHI may be disclosed to a coroner, medical examiner, or funeral director as necessary for their duties. HIPAA protects a decedent's PHI for fifty (50) years after the person's death.

8. Organ Donation. PHI of organ donors may be disclosed to organ procurement organizations. 9.Inmates. If you are an inmate of a correctional institution or in the custody of a law enforcement officer, your PHI may be disclosed to the institution or the officer as permitted or required by law.

10. Special Government Functions. PHI may be disclosed to federal officials for (i) national security activities; and (ii) the protection of the President or other heads of state. If you are/were a member of the armed forces, your PHI may be disclosed to military authorities as permitted or required by law.

Your Choices. Unless you object, (i) a family member, friend, or other person involved in your care or the payment for your care may receive PHI that relates to their involvement; and (ii) disaster relief organizations may receive PHI to coordinate your care or to notify your family and friends of your location or condition in case of a disaster. If you are unable to tell us your preference (ex. you are unconscious), we may share your PHI if we believe it is in your best interest. We may contact you for fundraising efforts, but you can tell us not to contact you again.

Uses and Disclosures that Require Written Authorization. The following uses and disclosures require your written authorization: (i) marketing; (iii) sale of your PHI; and (iii) most disclosures of psychotherapy notes. Furthermore, not every use or disclosure of your PHI is listed on this notice. Uses and disclosures of PHI not described above require your written authorization. You may revoke your authorization at any time by submitting a written revocation to us. A revocation will not affect prior uses and disclosures made in reliance on your authorization.

Your Rights.

1.Right to Inspect and Copy. You have the right to inspect and receive a paper or electronic copy of your PHI—other than psychotherapy notes. You may ask our Medical Records Department how to do this. A copy or summary of your PHI will be made available within thirty (30) days (or fewer as required by state law) of your written request. We may charge you a reasonable, cost-based fee. A fee will not be charged if the PHI is needed to claim Social Security benefits or other state or federal needs-based benefits. Requests may be denied in certain circumstances, but you may have the denial reviewed.

2.Right to Request an Amendment. To correct your PHI, you must send us a written request. Your request may be denied. You will be informed of the denial within sixty (60) days of your request.

3.Right to Accounting Disclosures. You have the right to request a list of times we disclosed your PHI except for treatment, payment, or operational disclosures and disclosures you authorized. The list can only go back six (6) years prior to the date of your request. To get such a list, you must send a written request to our Medical Records Department. We provide one (1) free accounting a year but charge a reasonable, cost-based fee for a list provided within twelve (12) months of a prior list.

4. Right to Request Confidential Communications. You may ask us to contact you in a specific way (ex. home or work phone) or to send mail to another address. We will accommodate all reasonable requests.

5. Right to Request Restrictions. You may ask us in writing to restrict the use or disclosure of your PHI for treatment, payment, or healthcare operations. We are not required to approve the request, and we may deny the request if it would affect your care. If you ask us to restrict the use and disclosure of your PHI to a health plan and such PHI pertains solely to a healthcare item or service for which you have paid out-of-pocket in full, we will comply with the restriction unless a law requires us to share the PHI.

6. Right to Representation. If you have a medical attorney-in-fact, legal guardian, or (if you are a minor) parent, such person can exercise your rights and make choices regarding your PHI. We verify any claim of authority to act on another's behalf.

7. Right to a Paper Copy of this Notice. You may ask for a paper copy of this notice at any time, even if you agreed to receive this notice electronically. We will promptly provide you with a paper copy.

Changes to this Notice. We can change the terms of this notice, and the changes will apply to all PHI we have about you. The new notice will be posted in our office and on our website: www.synovationmedicalgroup.com.

For More Information or to Report a Problem. You may contact us for additional information. If you believe your right has been violated, you can file a complaint with either our HIPAA Privacy and Security Officer or the U.S. Department of Health and Human Services Office for Civil Rights. We will not retaliate against you for filing a complaint.

Office for Civil Rights

200 Independence Avenue, S.W. Washington, D.C. 20201

Phone: (877)696-6775

Fax: (909)204-7867

http://www.hhs.gov/ocr/privacy/hipaa/complaints/index.html

CONSENT TO THE USE AND DISCLOSURE OF HEALTH INFORMATION FOR TREATMENT, PAYMENT, AND HEALTHCARE OPERATIONS

Patient Name: _____ ("Patient")

I understand that as part of Patient's healthcare, Pain Relief Solutions ("Healthcare Provider") originates and maintains paper and/or electronic records describing Patient's health history, symptoms, examination and test results, diagnoses, treatment, any plan for future care or treatment, and other information relating to Patient's healthcare. I understand that this information serves the following purposes:

- A basis for planning Patient care and treatment;
- A means of communication among the health professionals contributing to Patient's care;
- A source of information for applying Patient's information to Patient's bill;
- A means by which a third-party payer can verify the services provided; and
- A tool for healthcare operations such as assessing quality and staff competence.

I understand that as part of Healthcare Provider's treatment, payment, and healthcare operations, it may be necessary to disclose Patient's health information to another person or entity.

I hereby consent to the foregoing uses and disclosures, including disclosures in electronic format.

I acknowledge receipt of Healthcare Provider's Notice of Privacy Practices (the "Notice") that provides a detailed description of the uses and disclosures of Patient's protected health information. I understand the rights and privileges described on the Notice.

I understand that Healthcare Provider reserves the right to change the content of the Notice and their privacy practices and to apply such changes to protected health information that was created or received prior to the issuance of a revised Notice, in accordance with Federal Regulations. Should Healthcare Provider make such changes, I understand that the revised Notice will be made available at Healthcare Provider's website at www.caseyfishermd.com, at their office, and to me – upon my request – by mail / electronic(Circle one) transmission.

I wish to have the following restrictions on the use and/or disclosure of Patient's information:

_____

I understand that Healthcare Provider is not required to agree to the requested restrictions, except as specified on the Notice. I understand that I may revoke this consent in writing, except to the extent that Healthcare Provider has already taken action in reliance thereon. I understand that by refusing to give consent or revoking this consent, Healthcare Provider may refuse to treat Patient as permitted by Federal Regulations.

I acknowledge receipt of the Notice, and I fully understand and **accept / decline (circle one)** the terms of this consent.

Patient's Signature: _____ Date: _____

Patient's Name: _____ Date of Birth: _____

Representative's Signature: _____ Date: _____

Representative's Name: _____ Rel. to Pt.: _____

Name: _____Phone:_____

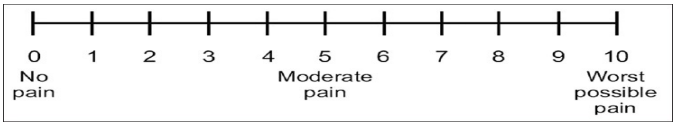
Today's Date: _____ Date of Birth: _____ Do you smoke?: Yes / No

Height: _____ Weight: _____ Allergies:_____

Diabetes: Yes / No Do you have any new medical problems?_____

PAIN ASSESSMENT

On a scale from Zero (0) to Ten (10), please rank your pain today:



Where does it hurt the worst?_____Where else does it hurt?_____

Does the pain radiate? Yes / No Where? _____

Is this a new problem? Yes / No How long have you had this problem? _____ days / months / years

Describe your pain: (circle all) Sharp Stabbing Dull Aching Burning Electrical Throbbing Shooting

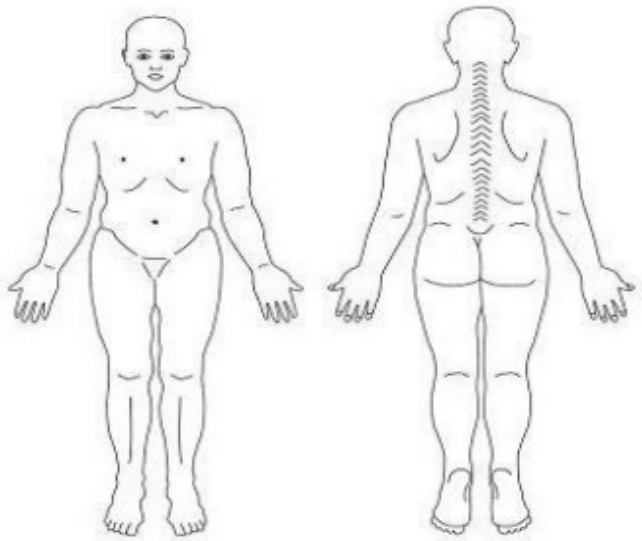
What is the severity? Mild / Moderate / Severe Is the pain *constant* or *intermittent*? (circle one)

What makes you pain worse? (circle all) Walking Sitting Bending Extension Twisting Working Exercise Cold

What makes your pain better? (circle all) Heat Ice Laying Down Rest Stretching Medication Procedures/Injections

Associated Symptoms: (circle all) Numbness Tingling Weakness Incontinence Depression Fatigue Anxiety

Mark on the diagram to the right everywhere you are having pain:



MEDICATIONS / THERAPIES / IMAGING

What is your preferred pharmacy?_____

Pain relief from current medication regimen? _____ %

Are they effective? Yes / No Do you need refills? Yes / No

Any Side Effects? Yes / No What? _____

Recent procedure? _____ Pain relief: _____ %

Recent imaging? Yes / No Type? _____

Other treatments (circle all): Physical Therapy Home Exercise

TENS Chiropractor Meditation/Relaxation Acupuncture

Other:_____

Patient's Signature _____

********** *for office use only* **********

Description	Description Blood Pressure_____/_____ Pulse_____ EPCS?_____
Imaging	X-Ray MRI CT Body Part:_____
Procedure	CESI LESI TFESI TPI SI joint inj MBB RFA PRP Other Location:_____
	Fluoro U/S Sedation: local oral IV
SCS / Pump	Psych Trial Implant
Referral	Neurology EMG/NCS Psych Rheum Addiction Ortho Neurosurgery Physical Therapy Other_____
Med Management	UDS Med Management ORT
Follow-Up	4 weeks 8 weeks PRN Post Op Other_____
Insurance	PPO HMO MPMG SRS SCMG CCIPA VMG CHG Molina Care1st Medicare Medical VA Tricare WC
Provider/MA Notes	

Patient Name: _____ Date:_____ Age:_____ DOB:_____

General Health History

1. Do you have a problem with any of the following?

   ☐ Heart ☐ Lungs ☐ Liver ☐ Kidneys ☐ Stomach/Ulcer ☐ Stroke ☐ Diabetes ☐ High Blood Pressure

   ☐ Other Health conditions:_____

2. List all surgeries you've had with the year:_____

_____

_____

3. Current Medications: _____

_____

_____

4. Do you have any of the following symptoms? (please circle)

Headache	Dizziness	Vision Problems	Additional comments or concerns:
Hearing Problems	Neck Pain	Shortness of Breath	_____
Chest Pain	Cough	Nausea	_____
Vomiting	Diarrhea	Constipation	_____
Blood in stool	Dark Tarry Stool	Abdominal Pain	_____
Pelvic Pain	Pain on Urination	Urinary Problems	_____
Rash	Itching	Tender muscles	_____
Back Pain	Stiff Joints	Swollen Joints	_____
Loss of Balance	Weakness of Limbs	Numbness of hand	_____
Numbness of arm	Numbness of Leg	Numbness of feet	_____
Fever	Chills	Poor Sleep	_____
Weight Loss	Weight Gain		_____

5. Does your pain cause you to suffer any of the following? ☐ Frustration ☐ Anxiety ☐ Depression ☐ Insomnia/Sleeplessness
6. Suicidal Thoughts: When was the last time?_____
7. Have you ever attempted suicide?_____

Social History

1. Do you use tobacco? Yes / No Freq:_____Type:_____

   Did you quit? Yes / No How long ago?_____How long ago?_____

2. Do you drink alcohol? Yes / No How often:_____ Type:_____
3. Do you use illicit drugs? Yes / No Have you ever used illicit drugs? Yes / No

   If so please specify type: ☐ Cocaine ☐ Heroin ☐ Methamphetamine ☐ Other:_____

4. Do you see now or have you seen a psychiatrist/psychologist? Yes / No

The Corrado-Gottlieb TOPS

Name:_____ Date:_____

Age:_____ Gender:_____

Please mark one response for each of the following questions or statements:

1. What is your highest level of education?

   ☐ Did not complete high school ☐ Completed high school/GED ☐ Some college ☐ College degree or higher

2. What is your marital status?

   ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Living with Partner

3. On a scale from 0 to 10 (with O being an absence of pain and 10 being the most intense pain), what is the lowest your pain has been during the past six months?

   ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

4. On a scale from 0 to 10 (with O being an absence of pain and 10 being the most intense pain), rate your average pain level over last six months.

   ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

5. I feel like giving up because things will not get better for me.

   ☐ Always ☐ Often ☐ Sometimes ☐ Rarely/Never

6. I believe that I will be happier in the future than I am now.

   ☐ Always ☐ Often ☐ Sometimes ☐ Rarely/Never

7. I believe I will be able to return to work and/or successfully perform the activities of daily living.

   ☐ Always ☐ Often ☐ Sometimes ☐ Rarely/Never

8. I lack interest or pleasure in the things I used to enjoy.

   ☐ Always ☐ Often ☐ Sometimes ☐ Rarely/Never

9. I feel tired, fatigued, run down, and/or lethargic.

   ☐ Always ☐ Often ☐ Sometimes ☐ Rarely/Never

10. I have trouble thinking and concentrating.

    ☐ Always ☐ Often ☐ Sometimes ☐ Rarely/Never

11. I feel incapable of managing my pain.

    ☐ Always ☐ Often ☐ Sometimes ☐ Rarely/Never

Oswestry Disability Questionnaire

Name:_____ Date:_____

This questionnaire has been designed to give us information as to how your 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 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 (eg. 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 lifting heavy weights off the floor but I can ☐manage if they are conveniently placed, e.g. on a table
- ☐ Pain prevents me 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 from 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

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 for 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 of sleep
- ☐ Because of pain I have less than 4 hours of sleep
- ☐ Because of pain I have less than 2 hours of 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. 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

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 two hours
- ☐ Pain restricts me to journeys of less than one hour
- ☐ Pain restricts me to short necessary journeys of under 30 minutes
- ☐ Pain prevents me from traveling except to receive treatment

Source: Fairbank, JCT & Pynset, PB (2000) The Oswestry Disability Index. SPINE, Volume 25, Number 22, pp 2940-2953