FLOCK
CHIROPRACTIC

CONFIDENTIAL HEALTH INFORMATION
NEW PATIENT - AUTO CLAIM

Please allow our staff to photocopy your insurance details.
All information you supply is confidential; we comply with all federal privacy standards.

Gail Y. Flock, D.C.
1550 Biddle Rd., Ste D,
Medford, OR 97504
P:(541) 779-9650
F:(541) 779-5315

Personal Information

Name _____ Birth Date _____ Date _____

Address _____ Age _____

◯ Female ◯ Male

City _____ State _____ Zip _____ SSN _____

May we contact you at work?
◯ No ◯ Yes

Home Phone _____ Cell Phone _____ Work phone _____

Preferred Method of Contact:
◯ Home Phone
◯ Cell phone
◯ Work phone

Email _____ Driver's License _____

Marital Status: S M D W

Spouse's Name (if applicable) _____

Occupation _____ Employer _____

Have you consulted a chiropractor before?
◯ No ◯ Yes
If so, whom? When?

Primary Care Provider _____

Emergency Contact

Name _____ Relationship _____ Phone _____

Acknowledgement of Receipt: Flock Chiropractic's Notice of Privacy Practices

I have received a copy of this office's Notice of Privacy Practices. I understand that I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

Conduct, plan and direct my treatment and follow-up among the health care providers who may be directly and indirectly involved in providing my treatment.

Obtain payment from third-party payers.

Conduct normal health care operations such as quality assessments and accreditation.

Please list below the names and your relationship of people to whom you authorize Flock Chiropractic to release your private health information:

Name **Relationship**

_____

_____

_____

_____

Signature of Patient, Parent, Legal Guardian or Patient's Legal Representative _____ Date _____

Activities of Daily Living What kind of negative effect does your condition have on your ability to function in the following situations? **0 = No effect, 1 = Mild, 2 = Moderate, 3 = Severe**

Sitting	0	1	2	3	Climbing Stairs	0	1	2	3	Using a computer	0	1	2	3
Standing	0	1	2	3	Concentrating	0	1	2	3	Rising out of a chair	0	1	2	3
Walking	0	1	2	3	Showering/bathing	0	1	2	3	Getting into/out of a car	0	1	2	3
Lying down	0	1	2	3	Getting dressed	0	1	2	3	Driving	0	1	2	3
Bending over	0	1	2	3	Exercising	0	1	2	3	Grocery shopping	0	1	2	3
Lifting objects	0	1	2	3	Getting to sleep	0	1	2	3	Household chores	0	1	2	3
Reaching overhead	0	1	2	3	Staying asleep	0	1	2	3	Yard work	0	1	2	3
Looking over shoulder	0	1	2	3	Love life	0	1	2	3	Caring for family	0	1	2	3

Medications and Supplements Please list all prescriptions, over the counter drugs, natural supplements, enzymes, vitamins and minerals that you are currently taking.

_____ _____ _____

_____ _____ _____

_____ _____ _____

Review of systems Chiropractic care focuses on the integrity of your nervous system, which controls and regulates your entire body. Please check the circle beside any condition that you've **had** in the past or currently **have** and initial to the right.

	Had	*Have*		*Had*	*Have*		*Had*	*Have*	
Musculoskeletal	○	○	Osteoporosis	○	○	Neck pain	○	○	Knee injuries
	○	○	Arthritis	○	○	Back problems	○	○	Foot/ankle pain
	○	○	Scoliosis	○	○	Hip disorders	○	○	Shoulder problems
	○	○	TMJ issues	○	○	Poor posture	○	○	Elbow/wrist pain
Neurological	○	○	Anxiety	○	○	Headache	○	○	Pins and needles
	○	○	Depression	○	○	Dizziness	○	○	Numbness
Cardiovascular	○	○	High blood pressure	○	○	Angina	○	○	High cholesterol
	○	○	Low blood pressure	○	○	Excessive Bruising	○	○	Poor circulation
Respiratory	○	○	Asthma	○	○	Emphysema	○	○	Shortness of breath
	○	○	Apnea	○	○	Hay fever	○	○	Pneumonia
Digestive	○	○	Anorexia/bulimia	○	○	Food sensitivities	○	○	Constipation
	○	○	Ulcer	○	○	Heartburn	○	○	Diarrhea
Sensory	○	○	Blurred vision	○	○	Hearing loss	○	○	Loss of smell
	○	○	Ringing in ears	○	○	Ear infection	○	○	Loss of taste
Skin	○	○	Skin cancer	○	○	Eczema	○	○	Hair loss
	○	○	Psoriasis	○	○	Acne	○	○	Rash
Endocrine	○	○	Thyroid issues	○	○	Hypoglycemia	○	○	Swollen glands
	○	○	Immune disorders	○	○	Frequent infection	○	○	Low energy
Genitourinary	○	○	Kidney stones	○	○	Bedwetting	○	○	Erectile dysfunction
	○	○	Infertility	○	○	Prostate issues	○	○	PMS symptoms
Constitutional	○	○	Fainting	○	○	Poor appetite	○	○	Weakness
	○	○	Low libido	○	○	Sudden weight gain or loss (circle one)	○	○	Fatigue

_____ _____ _____

Patient's Name Signature Date

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FLOCK CHIROPRACTIC

Health History Identify your past health history, including accidents, injuries, illnesses and treatments. Please complete each section fully.

Illnesses Check the illnesses you've **had** in the past or **have** now.

Had	*Have*		*Had*	*Have*		*Had*	*Have*	
◯	◯	AIDS	◯	◯	Goiter	◯	◯	Polio
◯	◯	Alcoholism	◯	◯	Gout	◯	◯	Rheumatic fever
◯	◯	Allergies	◯	◯	Heart disease	◯	◯	Scarlet fever
◯	◯	Arteriosclerosis	◯	◯	Hepatitis	◯	◯	Sexually transmitted disease
◯	◯	Cancer	◯	◯	HIV positive	◯	◯	Stroke
◯	◯	Chicken pox	◯	◯	Malaria	◯	◯	Tuberculosis
◯	◯	Diabetes	◯	◯	Measles	◯	◯	Typhoid fever
◯	◯	Epilepsy	◯	◯	Multiple sclerosis	◯	◯	Ulcer
◯	◯	Glaucoma	◯	◯	Mumps	◯	◯	Other _____

Operations Surgical interventions, which may or may not have included hospitalization.

◯	◯	Appendix removal	◯	◯	Eye surgery	◯	◯	Tonsillectomy
◯	◯	Bypass surgery	◯	◯	Hysterectomy	◯	◯	Vasectomy
◯	◯	Cancer	◯	◯	Pacemaker	◯	◯	Cosmetic surgery
◯	◯	Spine	◯	◯	Elective surgery	◯	◯	Other
		_____			_____			_____

Injuries Have you ever…?

	When?		*When?*
◯ Had a fractured bone	_____	◯ Been injured in an accident	_____
◯ Had a spine or nerve disorder	_____	◯ Used a crutch or other support	_____
◯ Been knocked unconscious	_____	◯ Used neck or back bracing	_____

Social History	*Daily*	*Weekly*	*How much?*		*Daily*	*Weekly*	*How much?*
Alcohol use	◯	◯	_____	Soft drinks	◯	◯	_____
Coffee use	◯	◯	_____	Water intake	◯	◯	_____
Tobacco use	◯	◯	_____	Job pressure/stress	◯	◯	_____
Exercise	◯	◯	_____	Recreational drugs	◯	◯	_____
Pain relievers	◯	◯	_____	Hobbies: _____			

Family History	Family member	Notes (for Dr. Flock's use)
◯ Cancer	_____	_____
◯ Heart disease	_____	_____
◯ Diabetes	_____	_____
◯ Other: _____	_____	_____

For office use only: Height _____ Weight _____ Blood pressure _____ / _____

_____ _____ _____

Patient's Name Signature Date

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FLOCK CHIROPRACTIC

Financial Policy

In order to help you determine your responsibility toward payment for services, please read the following and initial your preference for the method of payment for your account. Please notify this office if the status of your insurance changes.

Initial an option and write the corresponding letter in the blank below.

Private pay, no insurance:

A _____ As I have no insurance, I agree to assume all responsibility and to keep my account current by paying for services when they are rendered. As allowed by Oregon state law, I am requesting a "Time of Service Discount" when I pay for my services on the same day that services are performed.

Private pay, patient filing own claims:

B _____ I have insurance, but I wish to file my claims personally, and I agree to assume all responsibility and to keep my account current by paying for each visit at the time services are rendered. As allowed by Oregon state law, I am requesting a "Time of Service Discount" when I pay for my services on the same day that services are performed. I am requesting a "Super Bill" be provided to me which includes the diagnosis so that I can submit a claim to my insurance company.

Health or auto insurance:

C _____ I would like Flock Chiropractic to bill my auto insurance claim or health insurance. I understand that I am responsible for the costs of treatment, should my insurance company deny coverage for the claim submitted on my behalf. I acknowledge that it is my responsibility to find out whether my insurance covers all services rendered. I understand that if I let the office know which services are not covered by my health insurance, I will be eligible to pay the "Time of Service" discount for those services. I understand that I will be required to pay all co-pays or co-insurance percentages as stated in my insurance plan contract.

By my signature, I request option _____ as the method by which I will pay for my services performed in this clinic.

I am aware of the office's no show and 24-hour cancellation policy and understand that I will be charged a fee of $50 for missing an appointment without giving 24 hours notice.

_____
Signature

Acknowledgements To set clear expectations, improve communications and help you get the best results in the shortest

Initials

_____ I grant permission to be called to confirm or reschedule appointments and to be sent occasional cards, letters, emails or health information as an extension of my care in this office.

_____ To the best of my ability, the information I have supplied is complete and truthful. I have not misrepresented the presence, severity or cause of my health concern.

Informed Consent to Treatment

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy, on me (or on the patient named below, for whom I am legally responsible) by Dr. Gail Y. Flock, D.C.

I have had an opportunity to discuss with the doctor of chiropractic named above and/or with other office or clinic personnel the nature and purpose of chiropractic adjustments and other procedures. I understand that results are not guaranteed.

I understand and am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment, including but not limited to fractures, disc injuries, strokes, dislocations and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely upon the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known to her, is in my best interest.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above-named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

_____ _____ _____
Patient's Name Signature Date

FLOCK CHIROPRACTIC

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MOTOR VEHICLE ACCIDENT QUESTIONNAIRE

Gail Y. Flock, D.C.
1550 Biddle Rd., Ste D
Medford, OR 97504
P:(541) 779-9650
F:(541) 779-5315

Name **Date**

Date and time of injury: _____ City and Street where injury occurred:

Estimated damage to vehicle: _____ _____

Do you have auto insurance coverage? ◯ Yes ◯ No
Insurance Company: _____

Have you reported this injury to your insurance company? ◯ Yes ◯ No

Please notify our office if you retain an attorney.

Claim Number: _____
Adjustor's Name: _____
Adjustor's Phone: _____

Did the police come to the accident scene and make a report? ◯ Yes ◯ No

Your vehicle's make, model and year: _____ Estimated speed at impact: _____ mph

The other vehicle's make, model and year: _____ Estimated speed at impact: _____ mph

Describe the collision in your own words: _____

_____

_____

_____

_____

Collision Description (check all that apply to you)

◯ Driver ◯ Front passenger ◯ Rear passenger ◯ Pedestrian

◯ Rear-end impact ◯ Head-on impact ◯ Right side impact ◯ Left side impact

◯ Roll-over ◯ Hit guardrail/tree ◯ Ran off road ◯ Hit and run

At the time of impact, your vehicle was:

◯ Slowing down ◯ At a complete stop

◯ Gaining speed ◯ Moving at a steady speed

At the time of impact, the other vehicle was:

◯ Slowing down ◯ At a complete stop

◯ Gaining speed ◯ Moving at a steady speed

During and after impact, your vehicle…

◯ Kept going straight, not hitting anything ◯ Kept going straight, hitting the car in front ◯ Was hit by another vehicle

◯ Spun around, not hitting anything ◯ Spun around, hitting another car ◯ Spun around, hitting an object other than a car

Describe yourself during the collision (check only those that apply to you)

◯ You were unaware of the impending collision

◯ You were aware of the impending collision and braced yourself

◯ Your body, torso and head were facing straight ahead

◯ You had your head and/or torso turned at the time of impact (circle: to the left or right)

◯ You were wearing a seat belt (with shoulder harness? Y N)

◯ You were holding onto the steering wheel at the time of impact

◯ You lost consciousness. For how long? _____

_____
Signature

Did anything hit your body from inside or outside the vehicle? Or did your body hit something?

_____

_____

When did you first notice any pain after the injury? ◯ Immediately ◯ ____ hrs later ◯ ____ days later

Type of head restraint: ◯ movable ◯ fixed ◯ no head restraint

Position of head restraint: ◯ At the top of the back of your head ◯ Midway at the back of your head
◯ At the lower part of the back of your head ◯ At the level of your neck

Emergency Treatment

Did you go to the emergency room after the collision? ◯ Yes ◯ No
If yes, name of ER: _____

Did you go to the emergency room by ambulance? ◯ Yes ◯ No

Did you or another person drive you to the emergency room? ◯ Yes ◯ No

Were you hospitalized overnight? ◯ Yes ◯ No

Did the ER doctor take x-rays? ◯ Yes ◯ No

If yes: ◯ skull ◯ neck ◯ chest ◯ low back ◯ arm/leg

Did the ER doctor give you pain medication and/or muscle relaxants? ◯ Yes ◯ No

Did you have any cuts, lacerations or bruises? ◯ Yes ◯ No

Were you given a neck collar or brace to wear? ◯ Yes ◯ No

Check the symptoms you have noticed since the collision:

◯ Headache	◯ Irritability	◯ Tension	◯ Cold hands/feet
◯ Neck pain	◯ Chest pain	◯ Shortness of breath	◯ Bussing in ears
◯ Neck stiffness	◯ Dizziness	◯ Fatigue	◯ Loss of balance
◯ Sleeping problems	◯ Head seems too heavy	◯ Depression	◯ Upset stomach
◯ Back pain	◯ Tingling in arms/legs	◯ Eyes sensitive to light	◯ Bowel changes
◯ Nervousness	◯ Numbness in arms/legs	◯ Memory loss	◯ Loss of smell/taste

Are you having difficulty completing your normal activities as a result of the accident? ◯ Yes ◯ No

If yes, describe in detail: _____

_____

If you did not see a doctor within the first week after the collision, indicate why: _____

_____

Describe any physical complaints you had before the collision: _____

_____

Have you ever been in a collision before? ◯ Yes ◯ No
If yes, describe (including date, type of collision, injuries and treatment): _____

_____

_____

Have you been able to work since the injury? ◯ Yes ◯ No

If no, you were off work: ◯ partially ◯ completely Dates: _____ to _____

_____ _____ _____
Patient's Name Signature Date

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FLOCK CHIROPRACTIC

Primary Complaint

The primary symptom that prompted me to seek care today is:

_____
_____
_____

Secondary Complaint

The secondary symptom that prompted me to seek care today is:

_____
_____
_____

Intensity How extreme are your symptoms?

0 1 2 3 4 5 6 7 8 9 10

Mild Mod Severe

Intensity How extreme are your symptoms?

0 1 2 3 4 5 6 7 8 9 10

Mild Mod Severe

Duration How often do you experience this?

◯ Constant ◯ Frequent ◯ Occasional ◯ Intermittent

Duration How often do you experience this?

◯ Constant ◯ Frequent ◯ Occasional ◯ Intermittent

Quality of Symptoms

◯ Numbness ◯ Tingling ◯ Stiffness ◯ Dull ache
◯ Cramping ◯ Nagging ◯ Sharp ◯ Throbbing
◯ Stabbing ◯ Burning ◯ Shooting ◯ Other

Quality of Symptoms

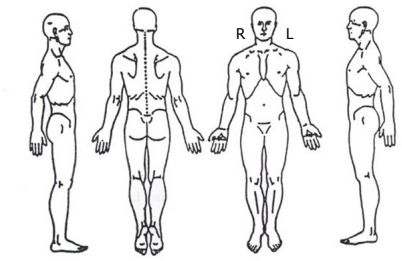
◯ Numbness ◯ Tingling ◯ Stiffness ◯ Dull ache
◯ Cramping ◯ Nagging ◯ Sharp ◯ Throbbing
◯ Stabbing ◯ Burning ◯ Shooting ◯ Other

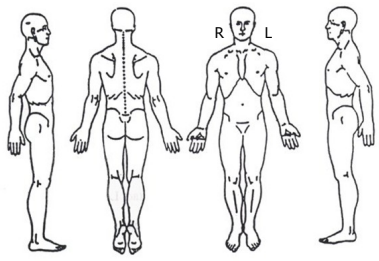
Location

Where does it hurt? Circle the area(s) on the illustration. "O" for current condition, "X" for conditions experienced in the past.

Location

Where does it hurt? Circle the area(s) on the illustration. "O" for current condition, "X" for conditions experienced in the past.





Radiation Where does your pain radiate or shoot to?

_____

Radiation Where does your pain radiate or shoot to?

_____

Aggravating or Relieving Factors

Makes it worse: _____

Makes it better: _____

Aggravating or Relieving Factors

Makes it worse: _____

Makes it better: _____

Prior Interventions What have you done for relief?

◯ Ice ◯ Heat
◯ Homeopathic Remedies ◯ Over-the-counter drugs
◯ Prescription medication ◯ Acupuncture
◯ Massage ◯ Chiropractic
◯ Physical therapy ◯ Surgery
◯ Other _____

Prior Interventions What have you done for relief?

◯ Ice ◯ Heat
◯ Homeopathic Remedies ◯ Over-the-counter drugs
◯ Prescription medication ◯ Acupuncture
◯ Massage ◯ Chiropractic
◯ Physical therapy ◯ Surgery
◯ Other _____

Neck Disability Index Questionnaire

This questionnaire is designed to help us better understand how your neck pain affects your ability to life activities.
Please mark the one that most closely describes your situation **right now**.

Name: _____ Date: _____

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.

Reading

- ◯ I can read as much as I want with no neck pain.
- ◯ I can read as much as I want with slight neck pain.
- ◯ I can read as much as I want with moderate neck pain.
- ◯ I can't read as much as I want because of moderate neck pain.
- ◯ I can't read as much as I want because of severe neck pain.
- ◯ I can't read at all because of the pain.

Concentration

- ◯ I can concentrate fully without difficulty.
- ◯ I can concentrate fully with slight difficulty.
- ◯ I have a fair degree of difficulty concentrating.
- ◯ I have a lot of difficulty concentrating.
- ◯ I have a great deal of difficulty concentrating.
- ◯ I can't 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 can't do my usual work.
- ◯ I can hardly do any work at all.
- ◯ I can't do any work at all.

Personal Care

- ◯ I can look after myself normally without causing extra pain.
- ◯ I can look after myself normally, but it causes extra pain.
- ◯ It is painful to look after myself, and I am slow and careful.
- ◯ I need some help but manage most of my personal care.
- ◯ I need help every day in most aspects of self care.
- ◯ I do not get dressed. I wash with difficulty and stay in bed.

Sleeping

- ◯ I have no trouble sleeping.
- ◯ My sleep is slightly disturbed for less than 1 hour.
- ◯ My sleep is mildly disturbed for up to 1-2 hours.
- ◯ My sleep is moderately disturbed for up to 2-3 hours.
- ◯ My sleep is greatly disturbed for up to 3-5 hours.
- ◯ My sleep is completely disturbed for up to 5-7 hours.

Lifting

- ◯ I can lift heavy objects without causing extra pain.
- ◯ can lift heavy weights, but it gives me extra pain.
- ◯ Pain prevents me from lifting heavy weights off the floor but I can manage if items are conveniently positioned (e.g. on a table).
- ◯ Pain prevents me from lifting heavy weights, but I can manage light weights if they are conveniently positioned.
- ◯ I can lift only very light weights.
- ◯ I cannot lift or carry anything at all.

Recreation

- ◯ I have no neck pain during all recreational activities.
- ◯ I have some neck pain with all recreational activities.
- ◯ I have some neck pain with a few recreational activities.
- ◯ I have neck pain with most recreational activities.
- ◯ I can hardly do recreational activities due to neck pain.
- ◯ I can't do any recreational activities due to neck pain.

Driving

- ◯ I can drive my car without neck pain.
- ◯ I can drive as long as I want with slight neck pain.
- ◯ I can drive as long as I want with moderate neck pain.
- ◯ I can't drive as long as I want because of moderate neck pain.
- ◯ I can hardly drive at all because of severe neck pain.
- ◯ I can't drive my car at all because of neck pain.

Headaches

- ◯ I have no headaches at all.
- ◯ I have slight headaches that come infrequently.
- ◯ I have moderate headaches that come infrequently.
- ◯ I have moderate headaches that come frequently.
- ◯ I have severe headaches that come frequently.
- ◯ I have headaches almost all the time.

_____
Signature

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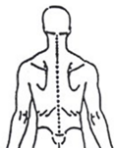
FLOCK
CHIROPRACTIC

Back Pain Index Questionnaire



This form is designed to help us better understand how your back pain affects your ability to manage everyday life activities. Please mark the one that most closely describes your situation **today**.

Name: _____ Date: _____

Pain Intensity

- ◯ The pain comes and goes and is very mild.
- ◯ The pain is mild and does not vary much.
- ◯ The pain comes and goes and is moderate.
- ◯ The pain is moderate and does not vary much.
- ◯ The pain comes and goes and is severe.
- ◯ The pain is severe and does not vary much.

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 1 hour.
- ◯ Pain prevents me from sitting more than 30 min.
- ◯ Pain prevents me from sitting more than 10 min.
- ◯ I avoid sitting because it increases pain immediately.

Standing

- ◯ I can stand as long as I want without pain.
- ◯ I have some pain while standing but it does not increase with time.
- ◯ I cannot stand longer than 1 hour without increasing pain.
- ◯ I cannot stand longer than 30 min without increasing pain.
- ◯ I cannot stand longer than 10 min without increasing pain.
- ◯ I avoid standing because it increases pain immediately.

Walking

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

Personal Care

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

Changing Degree of Pain

- ◯ My pain is rapidly getting better.
- ◯ My pain fluctuates but is definitely getting better overall.
- ◯ My pain seems to be getting better but improvement is slow.
- ◯ My pain is getting neither better nor worse.
- ◯ My pain is gradually worsening.
- ◯ My pain is rapidly worsening.

Sleeping

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

Lifting

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

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 restricted my social life and I do not go out very often.
- ◯ Pain has restricted my social life to my home.
- ◯ Pain has no significant affect on my social life apart from limiting my more energetic interests (e.g. dancing, etc).
- ◯ I have hardly any social life because of the pain.

Traveling

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

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Signature

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FLOCK
CHIROPRACTIC