Physical Therapy
Pilates
Gyrotonic®

12930 Ventura Blvd.
Suite 226A
Studio City, CA 91604
818-907-0008 phone
818-907-0088 fax
www.coreconditioningpt.com

2520 West Olive Ave
Suite 300
Burbank, CA 91505
818-729-9419 phone
818-729-9559 fax
www.coreconditioningpt.com

Our Mission

At Core Conditioning we strive to enhance the overall health and quality of life for our clients. We want to help create a balanced lifestyle that will contribute to the individual's long-term physical, emotional, and social growth. We aim to provide high quality rehabilitation in a safe, serene and nurturing environment. Our goal is to create the best combination of physical therapy and state of the art integrated fitness to improve overall well-being and awaken the spirit by offering a variety of healing modalities.

Cancellation/Change Policies

Cancelling a Physical Therapy Appointment
If you cancel a PT appointment less than 24 hours prior to your scheduled time, you are subject to a $75 late cancellation fee. Cancellation fees may not be applied towards your deductible, or billed to your insurance company.

Rescheduling Physical Therapy Appointments
In the event that you must re-schedule a PT appointment, we will do our best to accommodate your preferred time and date.

Cancellation Lists
If you are unable to book an appointment at your preferred time, please request to have your name placed on our cancellation list for the date and time of your choice. You will be contacted if the time becomes available.

Cancelling a Pilates Appointment
If you cancel a Pilates appointment less than 24 hours prior to your scheduled time, you are subject to a late cancellation fee equivalent to the full session rate. This applies to Private, semi-private, and group classes.

Understanding the Billing Process

Billing Facts
Know your insurance plan's coverage provisions and requirements. Be sure to read your benefits handbook and question your insurance company on any areas that are unclear.

Price quotes for services are estimates only. Your final bill will reflect your total charges, monies paid and any outstanding balances due.

Our billing and insurance liaison is available Monday through Friday from 8:30am – 5:00pm. Please feel free to call with any questions or concerns at 818 907-0008

Medicare
We bill Medicare and your secondary insurance following receipt of Medicare's payment. Once your secondary insurance has been billed, you will receive periodic statement advising you of the balance due.

Private Insurance
We will bill your contracted insurance carrier. You will not be billed while the claim is in process. Upon receipt of their payment or denial, we will bill you for co-insurance, deductibles and non-covered services based on your responsibilities established by your insurance provider

Cash
For patients who wish to pay for physical therapy services directly, make payment at the time services are rendered.

Balance Billing-Patient Responsibility
If you are unable to pay for your portion of your bill in full, please contact us to arrange mutually acceptable payment options.

We Want To Hear From You!!

Please take any opportunity to let us know how we can better serve you and make you experience at Core more enjoyable. We have provided customer comment boxes at both of our locations or complete our online survey at http://www.surveymonkey.com/s.aspx?sm=tGlKf8sCGxOCy_2b0AJPhxxA_3d_3d if you would prefer to stay anonymous.

Make Pilates A Part of Your Life!

For a more detailed list of frequently asked questions, class schedules or more information about the services we offer, Please visit us on the web at:

www.coreconditioningpt.com

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New Patient Form

Date:	Evaluating Therapist:	
First Name:	Last Name:	Middle Init.:

Home Address

City	State	Zip Code
Home Phone: ( ) -	Work Phone: ( ) -	Other Phone: ( ) -

Social Security: - -	Birthdate: / /	Age:	Sex: M / F

Driver's License:	Email Address:
Status: Married / Single / Divorced / Separated / Widowed	Student: No / Full-time / Part-time

Emergency Contact:	Relationship:	Phone: ( ) -

Employer:	Employment: Full / Part / Not Working / Retired
Address:	Phone: ( ) -

Doctor:	Phone: ( ) -

Address:

Whom, other than your doctor, may we thank for your referral?

Injury Type: Work / Auto / Home / Other:	Injury Date: / /

Area(s) Being Treated:

Claim / Authorization / Referral #:		Lawyer Involvement: Yes / No
Attorney:	Phone: ( ) -	Fax: ( ) -

Attorney's Address:

Primary Insurance:

Insured's Name:	Social Security: - -	D.O.B.: / /

Secondary Insurance:

Insured's Name:	Social Security: - -	D.O.B.: / /

Patient Signature	Date

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Medical History Form

Patient Name: ______________________ **DOB:** ____________ **Age:** ____________

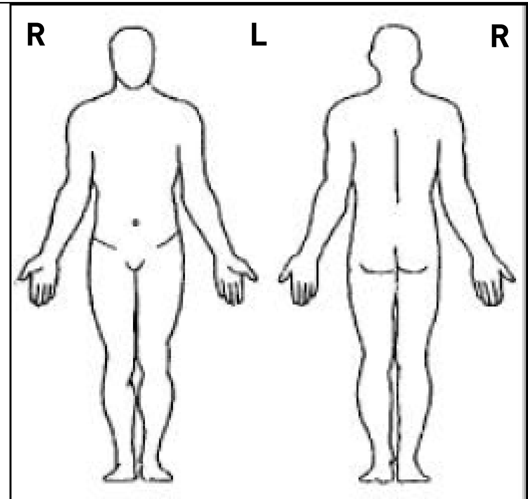
Injury / Condition: ______________________

Date of Injury / Onset: ______________________

Type of Surgery & Date: ______________________

Next Doctor's Appointment: ______________________

Previous Treatment: ______________________



Have you ever had any imaging performed?

____ X-Ray ____ MRI
____ CT Scan ____ Doppler
____ Ultrasound

Have you recently noted any of the following?

____ Weight Loss/Gain ____ Weakness ____ Pregnancy/IUD ____ Pain at Night
____ Nausea/Vomiting ____ Fever/Chills/Sweats ____ Cramps when walking ____ Headaches
____ Fatigue ____ Numbness/Tingling ____ Change in Vision/Hearing ____ Insomnia

Do you have now, or have you ever had any of the following?

____ Surgeries ____ Sprains/Strains ____ Heart Problems
____ Circulation Problems/Clots ____ Easy Bruising/Bleeding ____ Indigestion/Heartburn
____ Loss of Consciousness ____ Diabetes ____ Cancer
____ Asthma/Breathing Problems ____ Leg/Ankle Swelling ____ Fainting
____ Fractures ____ Blood Pressure Problems ____ Motor Vehicle Accident
____ Lung Disease ____ Urinary Problems/Infections ____ Allergies/Skin Sensitivity

Explain and give approximate dates for any items indicated above.

____

Are you currently taking any medications? Yes / No Name/Type of Medication: ______________________

Type of Pain: Sharp / Burning / Aching / Tingling / Numbness / Other: ______________________

Rate your pain (average) on a scale of 1 to 10 (1=light, 10=severe) ______________________

What do you hope to get out of your treatment?

____

What are your physical or fitness goals?

Currently: ______________________

In 6 Months: ______________________

In 12 Months: ______________________

Is there anything else you would like to include or ask your physical therapist?

____

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Consent Form

Physical Therapy is a patient care service provided in response to a wide range of medical care needs of outpatients of all ages regardless of gender, color, race, creed, national origin, or disability.

The purpose of physical therapy is to treat disease, injury and disability by evaluation examination, testing and use of rehabilitative procedures, mobilization, massage, exercises and physical agents to aid the patient in achieving their maximum potential within their capabilities: and to accelerate convalescence and reduce the length of the functional recovery. All procedures will be thoroughly explained to you before you are asked to perform them.

You are expected to cooperate fully with the evaluation and treatment program. Because of the nature of services provided, you might be asked to disrobe. If this is necessary, your privacy, modesty and dignity will be considered at all times by the staff. Should you fell uncomfortable or embarrassed, you may refuse the procedure and/or request another therapist.

There are certain inherent risks with physical therapy treatments because you will be asked to exert effort and perform activities with increasing degrees of difficulty which could cause an increase in your current level of pain or discomfort or an aggravation to your existing injury. You will be able to stop treatment if you feel any discomfort or pain. Your physical therapist will take every precaution to ensure that you are protected from any potentially hazardous situation. You will never be forced to perform any procedure which you do not wish to perform.

Because of the nature of the procedures performed with the clinical setting, your communication with family and friends may be restricted. Core Conditioning reserves the right to restrict visitors and outside communication at any time during your treatment sessions to ensure you receive the maximum therapeutic value from treatment.

Based on the above information, I ____ , agree to cooperate fully, to participate in all physical therapy procedures, and to comply with the plan of care as it is established. I have read the consent form and authorize release of medical information to appropriate third parties.

Patient Signature ____________________________________Date ______________

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Office Policy

CONSENT FOR CARE & TREATMENT Your physical therapist will complete an evaluation by examination and interview. Your individual treatment program will then be designed. A variety of treatment techniques may be used. I, the undersigned, do hereby agree and give my consent for Core Conditioning to furnish physical therapy care and treatment considered necessary and proper in evaluating or treating my physical condition.

ASSIGNMENT OF INSURANCE BENEFITS I hereby authorize Core Conditioning to furnish Information to insurance carriers concerning this treatment and I hereby assign all payment for services rendered.

WORKERS' COMPENSATION CLAIMS If you claim Workers' Compensation benefits and are Subsequently denied such benefits, you may be held responsible for the total amount of charges for services rendered you.

CANCELLATION & NO-SHOW POLICY We require 24 hours notice in the event of a cancellation. The charge for cancellation without proper notice is $75 for physical therapy visits and the full price for a massage or Pilates visit. This charge will not be covered by insurance, but will have to be paid by you personally prior to receiving additional treatment.

FINANCIAL POLICY We bill your personal insurance carrier solely as a courtesy to you. You Are responsible for your bill. We require that arrangements for payment of your estimated share be made at each visit. If your insurance carrier does not remit payment to us within 60 days, the balance owed will be due in full from you. In the event that your insurance company requests a refund of payments made to us, you may be responsible for the amount of money refunded to your insurance company. If any payment is made directly to you by the insurance company for services billed by us, you recognize an obligation to promptly remit the payment(s) to us. If formal collections procedures become necessary, you will be responsible for additional costs incurred. Your insurance benefits as quoted to us by your insurance carrier have been reviewed with you. We assume no liability for any errors made by your insurance carrier in this quotation. We have reviewed these benefits with you and you agree to pay your portion of this bill.

Estimated patient payment / co-pay / deductible amount per visit $ ____________________

Arrangements for payment of patient's co-pay / deductible amount (circle one)

I will pay each visit　　　　　　I will pay weekly in advance

The above information has been read and explained to me. I UNDERSTAND MY RESPONSIBILITY FOR THE PAYMENT OF MY ACCOUNT. *Core Conditioning reserves the right to refuse service to anyone.*

____

Patient / Guardian / Responsible Party Signature　　　　Date

____

Clinic Representative　　　　Date

CONSENT FOR TREATMENT OF A MINOR

As parent and/or legal guardian, I authorize Core Conditioning to treat the minor patient named in the attached forms while I am not present.

Parent / Guardian Signature: ______________________________ Date: ____________

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Notice of Privacy Practices

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.

USES AND DISCLOSURE OF YOUR MEDICAL INFORMATION

For Treatment: We may use medical information about you to provide you with medical treatment or services. **For Payment:** We may use and disclose medical information about you so that the treatment and services you receive at our practice may be billed and payment may be collected from you, an insurance company, or a third party. **For Health Care Operations:** We may use and disclose medical information about you for operations of our health care practice. **For Individuals Involved in Your Care or Payment for Your Care:** We may release medical information about you to a friend or family member who is involved in your medical care. **For Health-Related Services and Treatment Alternatives:** We may use and disclose medical information to tell you about health-related services or recommend possible treatment options or alternatives that may be of interest to you. **As Required by Law:** We will disclose medical information about you when required to do so by federal, state, or local law. **To Avert a Serious Threat to Health or Safety:** We may use and disclose medical information about you when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person. **For Military and Veterans:** If you are a member of the armed forces, we may release medical information about you as required by military command authorities. **For Workers' Compensation:** We may release medical information about you for workers' compensation or similar programs. **For Public Health Risks:** We may disclose medical information about you for public health activities. **For Health Oversight Activities:** We may disclose medical information to a health oversight agency for activities authorized by law. **For Lawsuits and Disputes:** If you are involved in a lawsuit or a dispute, we may disclose medical information about you in response to a court or administrative order. **For Law Enforcement:** We may release medical information if asked to do so by law enforcement officials. **For Coroners, Medical Examiners, and Funeral Directors:** We may release medical information to a coroner or medical examiner. **For National Security and Intelligence Activities:** We may release medical information about you to authorized federal officials for intelligence, counterintelligence, and other national security activities authorized by law. **For Protective Services for the President and Others:** We may disclose medical information about you to authorized federal officials so they may provide protection to the President, other authorized persons or foreign heads of state or conduct special investigations. **For Inmates:** If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may release medical information about you to the correctional institution or law enforcement official.

YOUR RIGHTS REGARDING YOUR MEDICAL INFORMATION

Your Right to Inspect and Copy: To inspect and copy your medical information, you must submit your request in writing. We may deny your request to inspect and copy, in limited circumstances. If you are denied access to medical information, you may request in writing, that the denial be reviewed. **Your Right to Ammend:** If you feel that medical information we have about you is incorrect or incomplete, you may request an amendment in writing. Your request may be denied if you do not include a reason to support the request. **Your Right to an Accounting of Disclosures:** You have the right to request in writing, a list accounting for any disclosures of your medical information we have made, except for uses and disclosures for treatment, payment, and health care operations, as previously described. **Your Right to Request Restrictions:** You have the right to request a restriction or limitation on the medical information we use or disclose about you for treatment, payment, or health care operations. We are not required to agree to your request. **Your Right to Request Confidential Communications:** You have the right to request in writing that we communicate with you about medical matters in a certain way or at a certain location. **Your Right to a Paper Copy of this Notice:** You have the right to a paper copy of this notice at any time.

Changes to this Notice: We reserve the right to change this notice, and will post the current notice in our facility. **Complaints:** If you believe your privacy rights have been violated, you may file a complaint with the practice or with the Secretary of the Department of Health and Human Services. **Other Uses of Medical Information:** Other uses and disclosures of medical information not covered by this notice or the laws that apply to us will be made only with your written permission. If you provide us permission to use or disclose medical information about you, you may revoke that permission, in writing, at any time. If you revoke your permission, we will no longer use or disclose medical information about you for the reasons covered by your written authorization. You understand that we are unable to take back any disclosures we have already made with your permission, and that we are required to retain our records of the care that we provided you.

By my signature below, I acknowledge receipt of a copy of the Notice of Privacy Practices.

____

Patient or Personal Representative Signature　　　　　　Date

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CANCELLATION & NO-SHOW POLICY

We require **24 hours notice** in the event of a cancellation. It is your responsibility, when you call, to have an alternative time in mind to insure that you will receive the prescribed number of treatments.

There is a $75 charge for cancellation without proper notice (24 hours).
This charge will not be covered by insurance or lien, but must be paid by you personally prior to receiving additional treatment. If you're having physical therapy massage or private Pilates session, and cancel without proper notice, you are responsible for full price of services.

Thank you for your cooperation. **Core Conditioning** is looking forward to your speedy recovery.

I have read this document and fully understand my responsibilities.

Patient Signature Date

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Dear Valued Customer,

Core Conditioning requires a current prescription (RX) signed by a Doctor in order to treat you for physical therapy. As a courtesy to you, Core Conditioning will provide a blank RX for you to take to your treating Doctor. Please have your prescription signed and bring it with you to your next appointment.

Please understand that we need a current RX in order to bill your insurance company. In the event that your insurance does not pay for services rendered, you will be responsible for outstanding balances and/or obtaining a back dated RX.

Core Conditioning would like to thank you in advance for your cooperation.

Patient Signature___________________________ Date__________

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Fear Avoidance Beliefs Questionnaire (Physical Activity)

Here are some of the things other patients have told us about their pain. For each statement please mark the number from 0-6 to indicate how much physical activities such as bending, lifting, walking or driving affect or would affect your back pain.

	Completely Disagree			Unsure			Completely Agree
My pain was caused by physical activity	0	1	2	3	4	5	6
*Physical activity makes my pain worse	0	1	2	3	4	5	6
*Physical activity might harm my back	0	1	2	3	4	5	6
*I should not do physical activities which (might) make my pain worse	0	1	2	3	4	5	6
*I cannot do physical activities which (might) make my pain worse	0	1	2	3	4	5	6

FABQ(PA) Score:_____ ☐Greater than 19 ☐Less than 12 (For * questions only)

Fear Avoidance Beliefs Questionnaire (Work)

The following statements are about how your normal work affects or would affect your back.

	Completely Disagree			Unsure			Completely Agree
*My pain was caused by my work or by an accident at work	0	1	2	3	4	5	6
*My work aggravated my pain	0	1	2	3	4	5	6
I have a claim for compensation for my pain	0	1	2	3	4	5	6
*My work is too heavy for me	0	1	2	3	4	5	6
*My work makes or would make my pain worse	0	1	2	3	4	5	6
*My work might harm my back	0	1	2	3	4	5	6
*I should not do my regular work with my present pain	0	1	2	3	4	5	6
I cannot do my normal work with my present pain	0	1	2	3	4	5	6
I cannot do my normal work until my pain is treated	0	1	2	3	4	5	6
*I do not think that I will be back to my normal work within 3 months	0	1	2	3	4	5	6
I do not think that I will ever be able to go back to work	0	1	2	3	4	5	6

FABQ(PA) Score:_____ ☐Greater than 19 ☐Less than 12 (For * questions only)

Copyright 1993, with permission from International Association for the Study of Pain (Waddell et al 1993)

Patient Summary Form

PSF-750 (Rev:2/18/2009)

Instructions
Please complete this form within the specified timeline and fax to the specified fax number as indicated on Plan Summary or plan information previously provided.

*Fax number may vary by plan.

Patient Information

Patient name — Last | First | MI

◯ Female ◯ Male

Patient date of birth

Patient address | City | State | Zip code

Patient insurance ID# | Health plan | Group number

Referring physician (if applicable) | Date referral issued (if applicable) | Referral number (if applicable)

Provider Information

1. Name of the billing provider or facility (as it will appear on the claim form) | 2. Federal tax ID(TIN) of entity in box #1

1 MD/DO 2 DC 3 PT 4 OT 5 Both PT and OT 6 Home Care 7 ATC 8 MT 9 Other ____

3. Name and credentials of the individual performing the service(s)

4. Alternate name (if any) of entity in box #1 | 5. NPI of entity in box #1 | 6. Phone number

7. Address of the billing provider or facility indicated in box #1 | 8. City | 9. State | 10. Zip code

Provider Completes This Section:

Date you want *THIS* submission to begin:

Cause of Current Episode

1. Traumatic
2. Unspecified
3. Repetitive
4. Post-surgical →
5. Work related
6. Motor vehicle

Date of Surgery

Type of Surgery

1. ACL Reconstruction
2. Rotator Cuff/Labral Repair
3. Tendon Repair
4. Spinal Fusion
5. Joint Replacement
6. Other ____________

Diagnosis (ICD code)

Please ensure all digits are entered accurately

1° ___ ___ ___ • ___ ___

2° ___ ___ ___ • ___ ___

3° ___ ___ ___ • ___ ___

4° ___ ___ ___ • ___ ___

Patient Type

1. New to your office
2. Est'd, new injury
3. Est'd, new episode
4. Est'd, continuing care

Nature of Condition

1. Initial onset (within last 3 months)
2. Recurrent (multiple episodes of < 3 months)
3. Chronic (continuous duration > 3 months)

DC ONLY

Anticipated CMT Level

◯ 98940 ◯ 98942
◯ 98941 ◯ 98943

Current Functional Measure Score

Neck Index ____ DASH ____ ________ ____ (other)

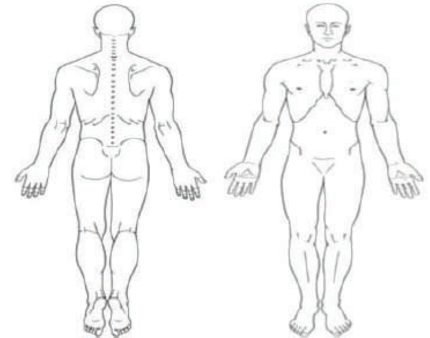
Back Index ____ LEFS ____

Patient Completes This Section:

(Please fill in selections completely)

Symptoms began on:

Indicate where you have pain or other symptoms:



1. Briefly describe your symptoms:

2. How did your symptoms start?

3. Average pain intensity:

Last 24 hours: **no pain** 0 1 2 3 4 5 6 7 8 9 10 **worst pain**

Past week: **no pain** 0 1 2 3 4 5 6 7 8 9 10 **worst pain**

4. How often do you experience your symptoms?

1. Constantly (76%-100% of the time)
2. Frequently (51%-75% of the time)
3. Occasionally (26% - 50% of the time)
4. Intermittently (0%-25% of the time)

5. How much have your symptoms interfered with your usual daily activities? (including both work outside the home and housework)

1. Not at all
2. A little bit
3. Moderately
4. Quite a bit
5. Extremely

6. How is your condition changing, since care began at *this* facility?

0. **N/A — This is the initial visit**
1. Much worse
2. Worse
3. A little worse
4. No change
5. A little better
6. Better
7. Much better

7. In general, would you say your overall health right now is...

1. Excellent
2. Very good
3. Good
4. Fair
5. Poor

Patient Signature: X ______________________________ **Date:** ______________

Back Index

ACN Group, Inc. Form BI-100

ACN Group, Inc. Use Only rev 3/27/2003

Patient Name ______________________ **Date** __________

This questionnaire will give your provider information about how your back condition affects your everyday life. Please answer every section by marking the one statement that applies to you. If two or more statements in one section apply, please mark the one statement that most closely describes your problem.

Pain Intensity

⓪ The pain comes and goes and is very mild.
① The pain is mild and does not vary much.
② The pain comes and goes and is moderate.
③ The pain is moderate and does not vary much.
④ The pain comes and goes and is very severe.
⑤ The pain is very severe and does not vary much.

Sleeping

⓪ I get no pain in bed.
① I get pain in bed but it does not prevent me from sleeping well.
② Because of pain my normal sleep is reduced by less than 25%.
③ Because of pain my normal sleep is reduced by less than 50%.
④ Because of pain my normal sleep is reduced by less than 75%.
⑤ Pain prevents me from sleeping at all.

Sitting

⓪ I can sit in any chair as long as I like.
① I can only sit in my favorite chair as long as I like.
② Pain prevents me from sitting more than 1 hour.
③ Pain prevents me from sitting more than 1/2 hour.
④ Pain prevents me from sitting more than 10 minutes.
⑤ I avoid sitting because it increases pain immediately.

Standing

⓪ I can stand as long as I want without pain.
① I have some pain while standing but it does not increase with time.
② I cannot stand for longer than 1 hour without increasing pain.
③ I cannot stand for longer than 1/2 hour without increasing pain.
④ I cannot stand for longer than 10 minutes without increasing pain.
⑤ I avoid standing because it increases pain immediately.

Walking

⓪ I have no pain while walking.
① I have some pain while walking but it doesn't increase with distance.
② I cannot walk more than 1 mile without increasing pain.
③ I cannot walk more than 1/2 mile without increasing pain.
④ I cannot walk more than 1/4 mile without increasing pain.
⑤ I cannot walk at all without increasing pain.

Personal Care

⓪ I do not have to change my way of washing or dressing in order to avoid pain.
① I do not normally change my way of washing or dressing even though it causes some pain.
② Washing and dressing increases the pain but I manage not to change my way of doing it.
③ Washing and dressing increases the pain and I find it necessary to change my way of doing it.
④ Because of the pain I am unable to do some washing and dressing without help.
⑤ Because of the pain I am unable to do any washing and dressing without help.

Lifting

⓪ I can lift heavy weights without extra pain.
① I can lift heavy weights but it causes extra pain.
② Pain prevents me from lifting heavy weights off the floor.
③ Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned (e.g., on a table).
④ Pain prevents me from lifting heavy weights off the floor, but I can manage light to medium weights if they are conveniently positioned.
⑤ I can only lift very light weights.

Traveling

⓪ I get no pain while traveling.
① I get some pain while traveling but none of my usual forms of travel make it worse.
② I get extra pain while traveling but it does not cause me to seek alternate forms of travel.
③ I get extra pain while traveling which causes me to seek alternate forms of travel.
④ Pain restricts all forms of travel except that done while lying down.
⑤ Pain restricts all forms of travel.

Social Life

⓪ My social life is normal and gives me no extra pain.
① My social life is normal but increases the degree of pain.
② Pain has no significant affect on my social life apart from limiting my more energetic interests (e.g., dancing, etc).
③ Pain has restricted my social life and I do not go out very often.
④ Pain has restricted my social life to my home.
⑤ I have hardly any social life because of the pain.

Changing degree of pain

⓪ My pain is rapidly getting better.
① My pain fluctuates but overall is definitely getting better.
② My pain seems to be getting better but improvement is slow.
③ My pain is neither getting better or worse.
④ My pain is gradually worsening.
⑤ My pain is rapidly worsening.

Index Score = [Sum of all statements selected / (# of sections with a statement selected x 5)] x 100

Back Index Score

Neck Index

ACN Group, Inc. Form NI-100

ACN Group, Inc. Use Only rev 3/27/2003

Patient Name ______________________ **Date** __________

This questionnaire will give your provider information about how your neck condition affects your everyday life. Please answer every section by marking the one statement that applies to you. If two or more statements in one section apply, please mark the one statement that most closely describes your problem.

Pain Intensity

⓪ I have no pain at the moment.
① The pain is very mild at the moment.
② The pain comes and goes and is moderate.
③ The pain is fairly severe at the moment.
④ The pain is very severe at the moment.
⑤ The pain is the worst imaginable at the moment.

Personal Care

⓪ I can look after myself normally without causing extra pain.
① I can look after myself normally but it causes extra pain.
② It is painful to look after myself and I am slow and careful.
③ I need some help but I manage most of my personal care.
④ I need help every day in most aspects of self care.
⑤ I do not get dressed, I wash with difficulty and stay in bed.

Sleeping

⓪ I have no trouble sleeping.
① My sleep is slightly disturbed (less than 1 hour sleepless).
② My sleep is mildly disturbed (1-2 hours sleepless).
③ My sleep is moderately disturbed (2-3 hours sleepless).
④ My sleep is greatly disturbed (3-5 hours sleepless).
⑤ My sleep is completely disturbed (5-7 hours sleepless).

Lifting

⓪ I can lift heavy weights without extra pain.
① I can lift heavy weights but it causes extra pain.
② Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned (e.g., on a table).
③ Pain prevents me from lifting heavy weights off the floor, but I can manage light to medium weights if they are conveniently positioned.
④ I can only lift very light weights.
⑤ I cannot lift or carry anything at all.

Reading

⓪ I can read as much as I want with no neck pain.
① I can read as much as I want with slight neck pain.
② I can read as much as I want with moderate neck pain.
③ I cannot read as much as I want because of moderate neck pain.
④ I can hardly read at all because of severe neck pain.
⑤ I cannot read at all because of neck pain.

Driving

⓪ I can drive my car without any neck pain.
① I can drive my car as long as I want with slight neck pain.
② I can drive my car as long as I want with moderate neck pain.
③ I cannot drive my car as long as I want because of moderate neck pain.
④ I can hardly drive at all because of severe neck pain.
⑤ I cannot drive my car at all because of neck pain.

Concentration

⓪ I can concentrate fully when I want with no difficulty.
① I can concentrate fully when I want with slight difficulty.
② I have a fair degree of difficulty concentrating when I want.
③ I have a lot of difficulty concentrating when I want.
④ I have a great deal of difficulty concentrating when I want.
⑤ I cannot concentrate at all.

Recreation

⓪ I am able to engage in all my recreation activities without neck pain.
① I am able to engage in all my usual recreation activities with some neck pain.
② I am able to engage in most but not all my usual recreation activities because of neck pain.
③ I am only able to engage in a few of my usual recreation activities because of neck pain.
④ I can hardly do any recreation activities because of neck pain.
⑤ I cannot do any recreation activities at all.

Work

⓪ I can do as much work as I want.
① I can only do my usual work but no more.
② I can only do most of my usual work but no more.
③ I cannot do my usual work.
④ I can hardly do any work at all.
⑤ I cannot do any work at all.

Headaches

⓪ I have no headaches at all.
① I have slight headaches which come infrequently.
② I have moderate headaches which come infrequently.
③ I have moderate headaches which come frequently.
④ I have severe headaches which come frequently.
⑤ I have headaches almost all the time.

Index Score = [Sum of all statements selected / (# of sections with a statement selected x 5)] x 100

Neck Index Score

THE LOWER EXTREMITY FUNCTIONAL SCALE

We are interested in knowing whether you are having any difficulty at all with the activities listed below because of your lower limb Problem for which you are currently seeking attention. Please provide an answer for **each** activity.

Today, do you or would you have any difficulty at all with:

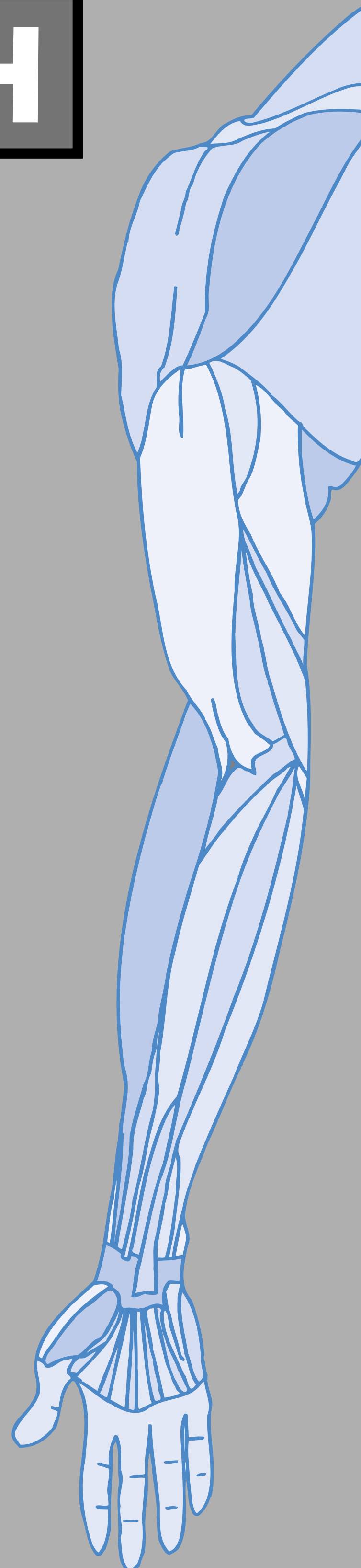
	Activities	Extreme Difficulty or Unable to Perform Activity	Quite a Bit of Difficulty	Moderate Difficulty	A Little Bit of Difficulty	No Difficulty
1	Any of your usual work, housework, or school activities.	0	1	2	3	4
2	Your usual hobbies, re creational or sporting activities.	0	1	2	3	4
3	Getting into or out of the bath.	0	1	2	3	4
4	Walking between rooms.	0	1	2	3	4
5	Putting on your shoes or socks.	0	1	2	3	4
6	Squatting.	0	1	2	3	4
7	Lifting an object, like a bag of groceries from the floor.	0	1	2	3	4
8	Performing light activities around your home.	0	1	2	3	4
9	Performing heavy activities around your home.	0	1	2	3	4
10	Getting into or out of a 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 (about 1 flight of 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
	Column Totals:					

Minimum Level of Detectable Change (90% Confidence): 9 points **SCORE: _____/ 80**

Please submit the sum of responses.

Reprinted from Binkley, J., Stratford, P., Lott, S., Riddle, D., & The North American Orthopaedic Rehabilitation Research Network, The Lower Extremity Functional Scale: Scale development, measurement properties, and clinical application, Physical Therapy, 1999, 79, 4371-383, with permission of the American Physical Therapy Association.

THE DASH



INSTRUCTIONS

This questionnaire asks about your symptoms as well as your ability to perform certain activities.

Please answer *every question*, based on your condition in the last week, by circling the appropriate number.

If you did not have the opportunity to perform an activity in the past week, please make your *best estimate* on which response would be the most accurate.

It doesn't matter which hand or arm you use to perform the activity; please answer based on your ability regardless of how you perform the task.

DISABILITIES OF THE ARM, SHOULDER AND HAND

Please rate your ability to do the following activities in the last week by circling the number below the appropriate response.

	NO DIFFICULTY	MILD DIFFICULTY	MODERATE DIFFICULTY	SEVERE DIFFICULTY	UNABLE
1. Open a tight or new jar.	**1**	**2**	**3**	**4**	**5**
2. Write.	**1**	**2**	**3**	**4**	**5**
3. Turn a key.	**1**	**2**	**3**	**4**	**5**
4. Prepare a meal.	**1**	**2**	**3**	**4**	**5**
5. Push open a heavy door.	**1**	**2**	**3**	**4**	**5**
6. Place an object on a shelf above your head.	**1**	**2**	**3**	**4**	**5**
7. Do heavy household chores (e.g., wash walls, wash floors).	**1**	**2**	**3**	**4**	**5**
8. Garden or do yard work.	**1**	**2**	**3**	**4**	**5**
9. Make a bed.	**1**	**2**	**3**	**4**	**5**
10. Carry a shopping bag or briefcase.	**1**	**2**	**3**	**4**	**5**
11. Carry a heavy object (over 10 lbs).	**1**	**2**	**3**	**4**	**5**
12. Change a lightbulb overhead.	**1**	**2**	**3**	**4**	**5**
13. Wash or blow dry your hair.	**1**	**2**	**3**	**4**	**5**
14. Wash your back.	**1**	**2**	**3**	**4**	**5**
15. Put on a pullover sweater.	**1**	**2**	**3**	**4**	**5**
16. Use a knife to cut food.	**1**	**2**	**3**	**4**	**5**
17. Recreational activities which require little effort (e.g., cardplaying, knitting, etc.).	**1**	**2**	**3**	**4**	**5**
18. Recreational activities in which you take some force or impact through your arm, shoulder or hand (e.g., golf, hammering, tennis, etc.).	**1**	**2**	**3**	**4**	**5**
19. Recreational activities in which you move your arm freely (e.g., playing frisbee, badminton, etc.).	**1**	**2**	**3**	**4**	**5**
20. Manage transportation needs (getting from one place to another).	**1**	**2**	**3**	**4**	**5**
21. Sexual activities.	**1**	**2**	**3**	**4**	**5**

DISABILITIES OF THE ARM, SHOULDER AND HAND

	NOT AT ALL	SLIGHTLY	MODERATELY	QUITE A BIT	EXTREMELY
22. During the past week, *to what extent* has your arm, shoulder or hand problem interfered with your normal social activities with family, friends, neighbours or groups? *(circle number)*	1	2	3	4	5

	NOT LIMITED AT ALL	SLIGHTLY LIMITED	MODERATELY LIMITED	VERY LIMITED	UNABLE
23. During the past week, were you limited in your work or other regular daily activities as a result of your arm, shoulder or hand problem? *(circle number)*	1	2	3	4	5

Please rate the severity of the following symptoms in the last week. *(circle number)*

	NONE	MILD	MODERATE	SEVERE	EXTREME
24. Arm, shoulder or hand pain.	1	2	3	4	5
25. Arm, shoulder or hand pain when you performed any specific activity.	1	2	3	4	5
26. Tingling (pins and needles) in your arm, shoulder or hand.	1	2	3	4	5
27. Weakness in your arm, shoulder or hand.	1	2	3	4	5
28. Stiffness in your arm, shoulder or hand.	1	2	3	4	5

	NO DIFFICULTY	MILD DIFFICULTY	MODERATE DIFFICULTY	SEVERE DIFFICULTY	SO MUCH DIFFICULTY THAT I CAN'T SLEEP
29. During the past week, how much difficulty have you had sleeping because of the pain in your arm, shoulder or hand? *(circle number)*	1	2	3	4	5

	STRONGLY DISAGREE	DISAGREE	NEITHER AGREE NOR DISAGREE	AGREE	STRONGLY AGREE
30. I feel less capable, less confident or less useful because of my arm, shoulder or hand problem. *(circle number)*	1	2	3	4	5

DASH DISABILITY/SYMPTOM SCORE = _____ ([(sum of n responses / n) - 1] x 25, where n is the number of completed responses.)

A DASH score may <u>not</u> be calculated if there are greater than 3 missing items.

DISABILITIES OF THE ARM, SHOULDER AND HAND

WORK MODULE (OPTIONAL)

The following questions ask about the impact of your arm, shoulder or hand problem on your ability to work (including homemaking if that is your main work role).

Please indicate what your job/work is:______________________________

❒ I do not work. (You may skip this section.)

Please circle the number that best describes your physical ability in the past week. Did you have any difficulty:

	NO DIFFICULTY	MILD DIFFICULTY	MODERATE DIFFICULTY	SEVERE DIFFICULTY	UNABLE
1. using your usual technique for your work?	1	2	3	4	5
2. doing your usual work because of arm, shoulder or hand pain?	1	2	3	4	5
3. doing your work as well as you would like?	1	2	3	4	5
4. spending your usual amount of time doing your work?	1	2	3	4	5

SPORTS/PERFORMING ARTS MODULE (OPTIONAL)

The following questions relate to the impact of your arm, shoulder or hand problem on playing *your musical instrument or sport or both*.

If you play more than one sport or instrument (or play both), please answer with respect to that activity which is most important to you.

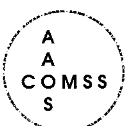
Please indicate the sport or instrument which is most important to you:____________________

❑ I do not play a sport or an instrument. (You may skip this section.)

Please circle the number that best describes your physical ability in the past week. Did you have any difficulty:

	NO DIFFICULTY	MILD DIFFICULTY	MODERATE DIFFICULTY	SEVERE DIFFICULTY	UNABLE
1. using your usual technique for playing your instrument or sport?	1	2	3	4	5
2. playing your musical instrument or sport because of arm, shoulder or hand pain?	1	2	3	4	5
3. playing your musical instrument or sport as well as you would like?	1	2	3	4	5
4. spending your usual amount of time practising or playing your instrument or sport?	1	2	3	4	5

SCORING THE OPTIONAL MODULES: Add up assigned values for each response; divide by 4 (number of items); subtract 1; multiply by 25.
An optional module score may not be calculated if there are any missing items.



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