The Body Cleansing and Detoxification Center

295 Bloomfield Avenue
(at Station Square)
Commercial Suite 5
Montclair NJ 07042

Enter on
Lackawanna Plaza

# Your Zerona pre-screening visit.

1. Please fill out the office forms enclosed. It will take about 30 minutes.

2. An authorized person will review your history.

3. You will have a courtesy consultation with a licensed medical practitioner.

4. Any necessary nutritional supplements will be recommended or made available for purchase.

5. After examination and nutritional testing, you will be given your supplement regimen and your Zerona treatments will be scheduled.

6. This process may take anywhere from 20 minutes, to as long as one hour.

7. During this visit the findings from your Zerona pre-screening will be reviewed and we will determine whether you are an appropriate candidate for Zerona treatments at this time. If so, the treatment options will be presented to you as well as the estimated cost and time frame of treatment. You will be given an opportunity to get all of your questions answered at this time.

8. Zerona treatment will **NOT** be given on this visit.

9. If, as a result of the Zerona pre-screening consultation, you are interested in pursuing Wholistic or Chiropractic care, contact Rhonda at 973 744-1155 to schedule a New Patient appointment.

**Expectations**

We understand that you have the expectation to reduce body fat and that is the goal of this care. As with all types of health care and medical care there are no guarantees made in any way shape or form except that we will do everything possible to help your body reduce its body fat and balance its nutritional needs; and when we have done all we can, we will let you know and advise you of other options. Our success rate of helping people in this office is about 90-95%. With regard to how long it will take to reduce body fat and feel better, in some cases results are seen after the first treatment, while in others it is more gradual. There are many variables that impact fat-reduction time; these include your compliance with our recommendations, overall lifestyle, diet and other factors that may be unique to you. **(Please remove all jewelry and turn off cell phones before entering examination or treatment room.)**


# Financial Policies

# Accounts Receivable Policy Letter

We first want to thank you for choosing The Body Cleansing and Detoxification Center. We consider it a privilege to serve you.

With service in mind, effective **01/01/2012**, we are advising new patients, and updating existing patients, to our new payment and billing policies to avoid possible misunderstandings or difficulties at a later date.

By far the majority of our patients regularly pay their accounts within a reasonable amount of time. In order to insure the level of service you require and deserve, without added cost, we have integrated a new program to hold down our operating expenses. Our new payment policy and program ensures that **your account** will not be penalized to cover costs incurred by us from those who do not pay in a timely manner. The accounts receivable policy that we follow states that:

1. **Insurance.** Zerona treatments are **NOT** covered by any insurance plan with which we are participating; payment in full is expected in advance or at each visit.

2. **Payment arrangements.** Electronic payment arrangements can be made using e-checks, credit or debit cards. A processing fee of $25.00 will be added to your account and is due in addition to any balance and interest charges owed. Account balances over 30 (thirty) days are subject to interest charges of 1 ½% per month (18% per year). Unpaid accounts reaching 60 days will be automatically transferred to Transworld Systems, Inc. for the purposes of collecting on your account. .

3. **Non-covered services.** Please be aware Zerona treatments, and perhaps all, of the services you receive may be non-covered or not considered reasonable or medically necessary by your insurance company. If you still opt to receive these services, you must pay for them in full at the time of your visit unless other arrangements have been made ***prior*** to receiving them.

4. **Proof of identification and residence.** All patients must complete our new patient information form before the pre-screening. We must obtain a copy of your driver's license with current address.

*We thank you in advance for your understanding, support and agreement in this matter.*

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If you have any questions regarding this policy, or would like to discuss your account at any time, please feel free to contact Rhonda at 973-744-1155 to arrange a confidential review of your account.

Sincerely,

The Staff at
**The Body Cleansing and Detoxification Center**

First visit:
No cost (nutritional supplements are billed separately)

Duration is dependent on patient's presentation.

Description - ***Zerona pre*-screening**

1. **A detailed history**
2. A concise Applied Kinesiology examination which includes an overview of nutritional needs
3. Body fat testing and measurement
4. If any other examinations, lab tests or X-rays are needed, you will be notified at this time.

Second visit
Cost $333.33

Duration is 40- 60 minutes

Description: - First Zerona treatment and complimentary detoxification foot bath

Our goal each and every visit is to reduce the fat content in your fat cells. We do this using a variety of therapies that may include recommendations for nutritional supplements, lifestyle changes, exercises, and use of essential oils. Percussive therapy to address cellulite is also available at an additional cost.

Additional Zerona treatments thereafter
Cost $333.33 per treatment

Duration is 40- 60 minutes

Description – Zerona treatment
If additional weight loss, nutritional, detoxification or well-body services are warranted or desired, an appropriate referral can be made.

I _____, have read, understand and agree to abide by the terms as outlined and applying to The Body Cleansing and Detoxification Center, I understand that my insurer *will not* cover costs of Zerona treatments and that I am responsible and agree to pay them.

**Signature:_____**

**Print name _____ Date _____**

Full Name _____

Phone number_____ Work number_____

Address (include city, state and zip)

_____

Date of birth _____ Age _____ M ___ F ___ Marital status _____ No. of children ____

Occupation _____ Referred by _____

Soc. Sec#_____ -_____- _____ Email address _____@ _____. _____

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Please check the appropriate space for any of the following symptoms that you now have or have had previously. This is a confidential health questionnaire. You may skip any symptom you have NEVER experienced.

**O = Occasional F = Frequent C = Constant**

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O F C **General**

☐☐☐ Allergy
☐☐☐ Chills
☐☐☐ Convulsions
☐☐☐ Dizziness
☐☐☐ Fainting
☐☐☐ Fatigue
☐☐☐ Fever
☐☐☐ Headaches
☐☐☐ Insomnia
☐☐☐ Excess weight loss
☐☐☐ Excess weight gain
☐☐☐ Nervousness
☐☐☐ Depression
☐☐☐ Sweats
☐☐☐ Tremors

**Muscle and joint**

☐☐☐ Arthritis
☐☐☐ Foot trouble
☐☐☐ Hernia
☐☐☐ Low back pain
☐☐☐ Neck pain
☐☐☐ Poor posture
☐☐☐ Sciatica

Pain/Numbness in:

☐☐☐ Shoulders
☐☐☐ Arms
☐☐☐ Elbows
☐☐☐ Wrists/Hand
☐☐☐ Hips
☐☐☐ Legs
☐☐☐ Knees
☐☐☐ Feet

O F C **Gastrointestinal**

☐☐☐ Belching or gas
☐☐☐ Colitis
☐☐☐ Constipation
☐☐☐ Diarrhea
☐☐☐ Indigestion
☐☐☐ Distention
☐☐☐ Excess hunger
☐☐☐ Gallbladder problems
☐☐☐ Hemorrhoids
☐☐☐ Liver problems
☐☐☐ Nausea
☐☐☐ Stomach pain
☐☐☐ Poor appetite
☐☐☐ Vomiting

**EENT**

☐☐☐ Asthma
☐☐☐ Colds/Flu
☐☐☐ Crossed eyes
☐☐☐ Deafness
☐☐☐ Dental decay
☐☐☐ Ear problems
☐☐☐ Enlarged glands
☐☐☐ Eye pain
☐☐☐ Near-sightedness
☐☐☐ Far-sightedness
☐☐☐ Gum problems
☐☐☐ Hay fever
☐☐☐ Hoarseness
☐☐☐ Nasal obstruction
☐☐☐ Nosebleeds
☐☐☐ Sinus problems
☐☐☐ Sore throats

O F C **Cardiorespiratory**

Blood pressure:

☐☐☐ *High*
☐☐☐ *Low*
☐☐☐ High cholesterol
☐☐☐ Chest pain
☐☐☐ Poor circulation
☐☐☐ Rapid pulse
☐☐☐ Slow pulse
☐☐☐ Ankle swelling
☐☐☐ Chronic cough
☐☐☐ Difficulty breathing
☐☐☐ Wheezing

Spitting up:

☐☐☐ *Blood*
☐☐☐ *Phlegm*

**Skin**

☐☐☐ Boils
☐☐☐ Bruise easily
☐☐☐ Dryness
☐☐☐ Hives or rash
☐☐☐ Itching
☐☐☐ Varicose veins

Genitourinary

☐☐☐ Bed-wetting
☐☐☐ Blood in urine
☐☐☐ Frequent urination
☐☐☐ Painful urination
☐☐☐ Pus in urine
☐☐☐ Kidney stones
☐☐☐ Prostate problems

For women only:

Date of last period (day 1):_____

Birth control:_____

☐☐☐ Menstrual problems
☐☐☐ Hot flashes
☐☐☐ Irregular cycle
☐☐☐ Menopausal symptoms

What is your major complaint?_____

How long have you had this condition?_____

Have you had this or similar conditions in the past?_____

Is this problem getting worse?_____ Constant?_____ Worse in morning?_____ Evening?_____

Is this interfering with work?_____ Sleep?_____ Exercise?_____ Other?_____

What do you believe is wrong with you?_____

List other problems you have now_____

_____

List past operations and dates_____

_____

Have you ever been hospitalized other than for surgery?_____

Have you ever had any mental or emotional disorder?_____

Have you had any other injury in the past two years?_____

Are you taking medication?_____ Describe_____

Are you taking nutritional supplements?_____ Describe_____

_____

What foods, drugs, etc. are you allergic to?_____

_____

Do you have any dental problems?_____ Dentist name: _____

Do you wear arch supports?_____ Heel lifts?_____ Special shoes?_____ What is your shoe size?_____

Date of your last physical exam?_____ Dr.:_____

Habits (describe with amounts):

Alcohol_____ Coffee_____

Cigarettes_____ Drugs not listed above_____

Describe your present exercise habits (or attach additional page):_____

_____

Please list the main health problems in your family:

Name: Relation: Problem:

_____

_____

_____

In case of emergency, please list the name and number of a friend or relative NOT living with you:

_____

**Signature**:_____ **Date**:_____

**Name** _____ **Date**_____

**Instructions**: Number the boxes *that apply to you*. Use (**1**) for **MILD** symptoms (occurring once or twice a year), (**2**) for **MODERATE** symptoms (occurring several times a year), and (**3**) for **SEVERE** symptoms (you are aware of the symptom almost constantly). Leave blank if symptom does not apply to you.

| | | |
|---|---|---|
| | **GROUP ONE** | |
| 1. ☐ Acid foods upset<br>2. ☐ Get chilled often<br>3. ☐ "Lump" in throat<br>4. ☐ Dry mouth/eyes/nose<br>5. ☐ Pulse speeds after meal<br>6. ☐ Keyed up—fail to calm<br>7. ☐ Cuts heal slowly | 8. ☐ Gag easily<br>9. ☐ Unable to relax; startle easily<br>10. ☐ Extremities cold, clammy<br>11. ☐ Strong light irritates<br>12. ☐ urine amount reduced<br>13. ☐ Heart pound after retiring | 14. ☐ "Nervous" stomach<br>15. ☐ Appetite reduced<br>16. ☐ Cold sweat often<br>17. ☐ Fever easily raised<br>18. ☐ Neuralgia-like pains<br>19. ☐ Staring, blink little<br>20. ☐ Sour stomach frequently |
| | **GROUP TWO** | |
| 21. ☐ Joint stiffness after arising<br>22. ☐ Muscle/leg/ toe cramps at night<br>23. ☐ "Butterfly" stomach, cramps<br>24. ☐ Eyes or nose watery<br>25. ☐ Eyes blink often<br>26. ☐ Eyelids swollen, puffy<br>27. ☐ Indigestion soon after meal | 28. ☐ Always seem hungry; feel "lightheaded" often<br>29. ☐ Digestion rapid<br>30. ☐ Vomiting frequent<br>31. ☐ Hoarseness frequent<br>32. ☐ Breathing irregular<br>33. ☐ Pulse slow; feels "irregular"<br>34. ☐ Gagging reflex slow | 35. ☐ Difficulty swallowing<br>36. ☐ Constipation, diarrhea alternating<br>37. ☐ "Slow Starter"<br>38. ☐ Get "Chilled frequently<br>39. ☐ Perspire easily<br>40. ☐ Circulation poor, sensitive in cold<br>41. ☐ Subject to colds, asthma, bronchitis |
| | **GROUP THREE** | |
| 42. ☐ Eat when nervous<br>43. ☐ Excessive appetite<br>44. ☐ Hungry between meals<br>45. ☐ Irritable before meals<br>46. ☐ Get "Shaky" if hungry<br>47. ☐ Fatigue, eating relieves<br>48. ☐ "Lightheaded" if meals delayed | 49. ☐ Heart palpitates if meal missed or delayed<br>50. ☐ Afternoon headaches<br>51. ☐ Have had reaction to overeating sweets<br>52. ☐ Awaken after few hours sleep—hard to get back to sleep | 53. ☐ Crave candy or coffee in afternoon<br>54. ☐ Moods of depression—"blues" or melancholy<br>55. ☐ Abnormal craving for sweets or snacks |
| | **GROUP FOUR** | |
| 56. ☐ Hands and feet go to sleep easily, numbness<br>57. ☐ Sigh frequently, "air hunger"<br>58. ☐ Aware of "breathing heavily"<br>59. ☐ High-altitude discomfort<br>60. ☐ Open windows in closed room<br>61. ☐ Susceptible to colds and fevers<br>62. ☐ afternoon "yawner" | 63. ☐ Get "drowsy" often<br>64. ☐ Swollen ankles, worse at night<br>65. ☐ Muscle cramps, worse during exercise; get "charley horses"<br>66. ☐ Shortness of breath on exertion<br>67. ☐ Dull pain in chest or radiating into left arm, worse on exertion | 68. ☐ Bruise easily, "black and blue" spots<br>69. ☐ Tendency to anemia<br>70. ☐ "Nosebleeds" frequently<br>71. ☐ Noises in head, or "ringing in ears"<br>72. ☐ Tension under the breastbone, or feeling of "tightness," worse on exertion |
| | **GROUP FIVE** | |
| 73. ☐ Dizziness<br>74. ☐ Dry skin<br>75. ☐ Burning feet<br>76. ☐ Blurred vision<br>77. ☐ Itching skin and feet<br>78. ☐ Excessive falling hair<br>79. ☐ Frequent skin rashes<br>80. ☐ Bitter, metallic taste in mouth in mornings<br>81. ☐ Bowel movements painful or difficult<br>80. ☐ Worrier, feel insecure | 81. ☐ Feeling queasy; headache over eyes<br>82. ☐ Greasy foods upset<br>83. ☐ Stools light-colored<br>84. ☐ skin peels on foot soles<br>85. ☐ Pain between shoulder blades<br>86. ☐ Use laxatives<br>87. ☐ Stools alternate from soft to watery<br>88. ☐ History of gallbladder attacks or gallstones | 89. ☐ Sneezing attacks<br>90. ☐ Dreaming, nightmare-type bad dreams<br>91. ☐ Bad breath (halitosis)<br>92. ☐ Milk products cause distress<br>93. ☐ Sensitive to hot weather<br>94. ☐ Burning or itching anus<br>95. ☐ Crave sweets |

96. ☐ Loss of taste for meat
97. ☐ Lower bowel gas several hours after eating
98. ☐ Burning stomach sensations, eating relieves

## GROUP SIX

99. ☐ Coated tongue
100. ☐ Pass large amounts of foul-smelling gas
101. ☐ Indigestion ½-1 hour after eating; may be up to 3-4 hours

102. ☐ Mucous colitis or "irritable bowel
103. ☐ Gas shortly after eating
104. ☐ Stomach "bloating" after eating

## GROUP SEVEN

(A)

105. ☐ Insomnia
106. ☐ Nervousness
107. ☐ Can't gain weight
108. ☐ Intolerance to heat
109. ☐ Highly emotional
110. ☐ Flush easily
111. ☐ Night sweats
112. ☐ Thin, moist skin
113. ☐ Inward trembling
114. ☐ Heart palpitates
115. ☐ Increased appetite without weight gain
116. ☐ Pulse fast at rest
117. ☐ Eyelids and face twitch
118. ☐ Irritable and restless
119. ☐ Can't work under pressure

(B)

120. ☐ Increase in weight
121. ☐ Decrease in appetite
122. ☐ Fatigue easily
123. ☐ Ringing in ears
124. ☐ Sleepy during day
125. ☐ Sensitive to cold
126. ☐ Dry or scaly skin
127. ☐ Constipation
128. ☐ Mental sluggishness
129. ☐ Hair coarse, falls out
130. ☐ Headaches upon arising, wear off during day
131. ☐ Slow pulse, below 65
132. ☐ Frequency of urination
133. ☐ Impaired hearing
134. ☐ Reduced initiative

(C)

135. ☐ Failing memory
136. ☐ Low blood pressure
137. ☐ Increased sex drive
138. ☐ Headaches, "splitting or rending" type
139. ☐ Decreased sugar tolerance

(D)

140. ☐ Abnormal thirst
141. ☐ Bloating of abdomen
142. ☐ Weight gain around hips or waist
143. ☐ Sex drive reduced or lacking
144. ☐ Tendency to ulcers, colitis
145. ☐ Increased sugar tolerance
146. ☐ Women: menstrual disorders
147. ☐ Young girls: lack of menstrual function

(E)

148. ☐ Dizziness
149. ☐ Headaches
150. ☐ Hot flashes
151. ☐ Increased blood pressure
152. ☐ Hair growth on face or body (female)
153. ☐ Sugar in urine (not diabetes)
154. ☐ Masculine tendencies on

(F)

155. ☐ Weakness, dizziness
156. ☐ Chronic fatigue
157. ☐ blood pressure
158. ☐ Nails weak, ridged
159. ☐ Tendency to hives
160. ☐ Arthritic tendencies
161. ☐ Perspiration increase
162. ☐ Bowel disorders
163. ☐ Poor circulation
164. ☐ Swollen ankles
165. ☐ Crave salt
166. ☐ Brown spots or bronzing on skin
167. ☐ Allergies—tendency to asthma
168. ☐ Weakness after colds, influenza
169. ☐ Exhaustion—Muscular and nervous
170. ☐ respiratory

## GROUP EIGHT A: Female Only

171. ☐ Easily fatigued
172. ☐ Premenstrual stress
173. ☐ Painful menses
174. ☐ Depressed feelings before menstruation
175. ☐ Menstruation excessive

176. ☐ Painful breast
177. ☐ Menstruate too frequently
178. ☐ Vaginal discharge
179. ☐ Hysterectomy/ovaries removed

180. ☐ Hot flashes
181. ☐ Menses scanty or missed
182. ☐ Acne, worse at menses
183. ☐ Depression long-standing

## Group Eight B: Male Only

184. ☐ Prostate trouble
185. ☐ Urination difficult or dribbling
186. ☐ Night urination frequent
187. ☐ Depression

188. ☐ Pain on inside of legs or heel
189. ☐ Feeling of incomplete bowel evacuation
190. ☐ Lack of energy

191. ☐ Migrating aches and pains
192. ☐ Tire too easily
193. ☐ Avoid activity
194. ☐ Leg nervousness at night
195. ☐ Diminished sex drive

## GROUP NINE

196. ☐ Sleep after meals
197. ☐ Bloated after meals
198. ☐ Poor concentration after meals

199. ☐ Diabetes in family
200. ☐ High blood pressure, cholesterol, or triglycerides
201. ☐ Always hungry

202. ☐ Fingers swollen or tight after exercise
203. ☐ Heart disease, stroke, breast cancer in family

| | | |
|---|---|---|
| 204. ☐ Aspirin improves symptoms<br>205. ☐ Menstrual cramps<br>206. ☐ Chronic inflammation | **GROUP TEN**<br>207. ☐ Dry itchy skin or scalp<br>208. ☐ React badly to sweets or excess carbohydrates | 209. ☐ Eat restaurant or fast food often<br>210. ☐ Spring allergies |
| 211. ☐ Low blood pressure<br>212. ☐ Poor circulation<br>213. ☐ Slow metabolism | **GROUP ELEVEN**<br>214. ☐ Intolerant to noise<br>215. ☐ Slow or irregular heartbeat | 216. ☐ Headaches with feeling or tight band around head<br>217. ☐ Carbohydrate intolerance |
| 218. ☐ Tense, irritable, and high-strung<br>219. ☐ High blood pressure | **GROUP TWELVE**<br>220. ☐ Poor fat metabolism<br>221. ☐ Restless, jumpy, and shaky legs | 222. ☐ Overreact to caffeine<br>223. ☐ Tendency to spasm<br>224. ☐ Rapid heartbeat |

Important: Please list below the five main complaints you have in order of their importance.

1. _____
2. _____
3. _____
4. _____
5. _____

**(Please do not write below this line.)**

Doctor's notes:

Name _____ Age _____ Sex ____

1. Are you taking medication? ……Yes_____ No_____
   If yes, list the kind and dosage and whether it is taken on a regular basis. _____
   _____
   _____
   Do you feel the medication is helping you? ……Yes____ No_____
2. Are you taking nutritional supplements? ……Yes_____ No_____
   If yes, list the kind and dosage and whether they are taken on a regular basis. _____
   _____
   _____
   Do you feel the nutritional supplements are helping you? For example, do you notice a specific improvement in the way you feel? _____
3. Approximately how many regular-size drinking glasses of water do you drink per day? _____
   Is the water usually regular tap water, or special water such as distilled, spring or well water?
   _____
4. If you are a smoker, what do you smoke (cigarettes, pipe, etc.) and how many daily?
   _____
5. How often do you consume alcohol?
   Never_____ Once in a while _____ Often _____ Daily _____
6. How many cups of regular coffee (caffeinated) do you drink daily? _____
7. How many cups of decaffeinated coffee do you drink per day? _____
8. How many cups of tea or glasses of iced tea do you drink per day? _____
9. Approximately what percentage of your food is of the "convenience" variety? (Example: Hamburger Helpers, TV dinners, frozen pot pies, pizza, etc.)_____
10. When you eat out, do you prefer the "quick food" approach, such as McDonald's, Burger King, etc.
    _____
11. Do you use extra salt on your food at the table?……..Yes _____ No _____
12. Do you eat a lot of condiments such as catsup and other spicy foods?……Yes _____ No_____
13. Do you like sour foods such as lemon (unsweetened ), dill pickles, and other pickled foods?…….. ……..Yes _____ No_____
14. Do you avoid or cut fat from your meat? ……Yes_____ No_____
15. Do you use butter or margarine?……..Yes_____ No_____
16. Do you like oil-type dressings on your salad?…….Yes_____ No_____
17. Do you enjoy eating cheese? ……...Yes_____ No_____
18. Do you drink milk?…….. Yes_____ No_____
    How much per day? _____ is it pasteurized?……Yes_____ No_____
19. Do you like foods with a high sugar content, such as cake, donuts, etc? Yes_____ No_____
20. When you eat a donut, do you prefer to have it plain, with frosting, or filled?_____
21. Do you eat sugar-coated cereal?……..Yes_____ No_____
    When you eat cereal, how many teaspoons of sugar do you use on an average-size serving? _____
22. How many teaspoons of sugar do you use in coffee or tea? _____
23. How many soft drinks do you consume daily? _____

24. Do you try, as often as possible, to drink sugar-free soft drinks and use artificial sweeteners with coffee and food?…… …… …Yes_____ No_____
25. What kind of fruit do you prefer to eat?… …Fresh _____Canned _____ Sugar-free_____
26. Do you often feel hungry, no matter how much you eat? …… ……..Yes_____ No_____
27. When you eat bread, is it white or whole wheat? _____
28. Do you usually eat breakfast?…… ……Yes_____ No_____
29. Do you usually feel better after eating? …… …….Yes_____ No_____
30. Do you usually feel worse after eating? …… ……Yes_____ No_____
31. Do you snack a lot between the three major meals? …… .Yes_____ No_____
32. When you have a snack, what type of food do you prefer? For example, sweet roll, cookies, cheese, cracker, fruit, vegetables. _____
    _____
    _____
    _____
33. Do you frequently skip meals?……..Yes_____ No_____
34. Do you have to watch what you eat to avoid gaining weight?……..Yes_____ No_____
35. Do you have more than one meal per day that lacks a vegetable other than corn, potatoes, peas, or green beans? …… ……Yes_____ No_____
36. Are there days when you do not eat any raw vegetables?…… …….Yes_____ No_____
37. Do any foods create problems? If so, describe the problem.
    _____
    _____
    _____
38. What foods do you especially like? _____
    _____
    _____
39. What foods do you dislike?_____
    _____
    _____
40. Do you feel your diet is excessive in some respect? … ……...Yes_____ No_____
    If yes, describe. _____
    _____
    _____
41. Do you feel your diet is deficient in some respect?…… ……..Yes_____ No_____
    If yes, describe. _____
    _____
    _____

Notes

_____
_____
_____
_____
_____
_____

Reprinted, by permission, from D. Walther, 1988, *Nutrition questionnaire (Pueblo, CO: Systems DC).*

# *Visual Analog Scale of Spinal Pain*

***Name_____ Date _____/_____/_____***

***Please mark your involvement with pain in the following locations and situations on the 1 to 10 scale; from no involvement (0) to maximum involvement (10). Mark with a vertical line like this:***

***1. Do you have any pain in your neck? How severe is it?***

***0 . . . . | . . . . | . . . . | . . . . |. . . . | . . . . | . . . . | . . . . | . . . . | . . . . 10***

***No pain*** ***Intolerable***

***2. Do you have any pain between your shoulder blades? How severe is it?***

***0 . . . . | . . . . | . . . . | . . . . |. . . . | . . . . | . . . . | . . . . | . . . . | . . . . 10***

***No pain*** ***Intolerable***

***3. Do you have any pain in your low back? How severe is it?***

***0 . . . . | . . . . | . . . . | . . . . |. . . . | . . . . | . . . . | . . . . | . . . . | . . . . 10***

***No pain*** ***Intolerable***

***4. Do you have any pain at night? How severe is it?***

***0 . . . . | . . . . | . . . . | . . . . |. . . . | . . . . | . . . . | . . . . | . . . . | . . . . 10***

***No pain*** ***Intolerable***

***5. Does activity give you pain? Yes___ No___ If so, how much activity is required to cause pain?***

***0 . . . . | . . . . | . . . . | . . . . |. . . . | . . . . | . . . . | . . . . | . . . . | . . . . 10***

***A great deal of activity*** ***Almost no activity***

***6. Do you use pain killers? Yes_____ No_____ If so how much relief do you get from them?***

***0 . . . . | . . . . | . . . . | . . . . |. . . . | . . . . | . . . . | . . . . | . . . . | . . . . 10***

***Complete relief*** ***No relief***

***7. Do you have any stiffness in your neck and/or back?***

***0 . . . . | . . . . | . . . . | . . . . |. . . . | . . . . | . . . . | . . . . | . . . . | . . . . 10***

***No stiffness*** ***Intolerable stiffness***

***8. Do you have any pain in your shoulder and/or arm? (mark for right and left.)***

***Right 0 . . . . | . . . . | . . . . | . . . . |. . . . | . . . . | . . . . | . . . . | . . . . | . . . . 10***

***Left 0 . . . . | . . . . | . . . . | . . . . |. . . . | . . . . | . . . . | . . . . | . . . . | . . . . 10***

***None at all*** ***Intolerable***

***9. Does your pain interfere with the use of your arm and/or hand? (mark for right and left.)***

***Right 0 . . . . | . . . . | . . . . | . . . . |. . . . | . . . . | . . . . | . . . . | . . . . | . . . . 10***

***Left 0 . . . . | . . . . | . . . . | . . . . |. . . . | . . . . | . . . . | . . . . | . . . . | . . . . 10***

***No interference*** ***Not able to use at all***

***10. Do you have numbness of tingling in your arm and/or hand? (mark for right and left.)***

***0 . . . . | . . . . | . . . . | . . . . |. . . . | . . . . | . . . . | . . . . | . . . . | . . . . 10***

***None at all*** ***Intolerable***

***11. Do you have headaches? If so, how severe are they?***

***0 . . . . | . . . . | . . . . | . . . . |. . . . | . . . . | . . . . | . . . . | . . . . | . . . . 10***

***None at all*** ***Intolerable***

***12. How frequent are your headaches if you have them?***

***0 . . . . | . . . . | . . . . | . . . . |. . . . | . . . . | . . . . | . . . . | . . . . | . . . . 10***

***Infrequent*** ***All the time***

***13. To what extent does your back pain interfere with your freedom to walk?***

***0 . . . . | . . . . | . . . . | . . . . |. . . . | . . . . | . . . . | . . . . | . . . . | . . . . 10***

***Complete freedom to walk*** ***Unable to walk because of pain***

***14. To what extent does your pain interfere with your ability to stand still?***

***0 . . . . | . . . . | . . . . | . . . . |. . . . | . . . . | . . . . | . . . . | . . . . | . . . . 10***

***Can stand for hour or more*** ***Not able to stand still at all***

***15. To what extent does your pain interfere with you sitting in a chair?***

***0 . . . . | . . . . | . . . . | . . . . |. . . . | . . . . | . . . . | . . . . | . . . . | . . . . 10***

***Complete comfort*** ***Cannot sit in a chair at all***

***16. Is your pain worse when riding in a car?***

***0 . . . . | . . . . | . . . . | . . . . |. . . . | . . . . | . . . . | . . . . | . . . . | . . . . 10***

***Complete freedom to ride*** ***Unable to ride in car at all***

***17. What pain do you have when lying down in bed?***

***0 . . . . | . . . . | . . . . | . . . . |. . . . | . . . . | . . . . | . . . . | . . . . | . . . . 10***

***Complete comfort*** ***No comfort at all***

***18. What is your overall handicap in your complete life style because of pain?***

***0 . . . . | . . . . | . . . . | . . . . |. . . . | . . . . | . . . . | . . . . | . . . . | . . . . 10***

***Completely free to perform any task*** ***Totally handicapped***

***19. To what extent does you pain interfere with your work?***

***0 . . . . | . . . . | . . . . | . . . . |. . . . | . . . . | . . . . | . . . . | . . . . | . . . . 10***

***No interference at all*** ***Totally incapable of work***

***20. To what extent does your work have to be modified so that you are able to do your job?***

***0 . . . . | . . . . | . . . . | . . . . |. . . . | . . . . | . . . . | . . . . | . . . . | . . . . 10***

***No adjustment to work*** ***So much adjustment that I have had to change jobs***