# Lighthouse Chiropractic Health Center

**710 Dodge Avenue, Suite C**
**Elk River, MN 55330**
**(763) 441-1701**

## Personal Information

Today's Date ______________________

Last Name _____________________ MI ______ First Name ______________________ Age __________

Home Address ____________________________________________________________________________________

City/State ____________________________________________________ Zip Code ______________________

Social Security _____________________________________ Date of Birth _______________________________

Home Phone ______________________ Work Phone ______________________ Cell Phone _____________________

Employer __________________________________________ Occupation ________________________________

Sex: M F Martial Status: (Circle One) Minor Single Married Widowed Divorced Separated

Email Address ____________________________________________

Name of Spouse/Parent ___________________________________ Date of Birth _______________________

Emergency Contact __________________________________ Relationship ______________ Phone ______________

Who may we thank for referring you to our office? _______________________________________________________

Is this visit for: Personal __________ Work Comp __________ Auto Injury _________

## Health Insurance Information

Who is responsible for this account? ___________________________________________________________________

Relationship to Patient _______________________________________________________________________________

Insurance Company _________________________________________________________________________________

Policy # _________________________________________ Group # ______________________________________

Is patient covered by additional insurance? ☐ Yes ☐ No

Subscriber's Name _________________________________________________________________________

Subscriber's Date of Birth __________________________ SS# ____________________________________

Relationship to Patient _______________________________________________________________________________

**WE NEED A COPY OF YOUR INSURANCE CARD**

## Authorization and Assignment

I authorize Lighthouse Chiropractic Health Center to release any information deemed appropriate concerning my physical condition to any insurance company, attorney or adjuster in order to process any claim for reimbursement of charges incurred by me.

I authorize the direct payment to you of any sum I now or hereafter owe you by my attorney out of the proceeds of any settlement of my case, and by any insurance company obligated to make payment to me or you based in whole or in part upon the charges made for your services.

I understand that whatever amounts you do not collect from insurance proceeds (whether it be all or part of what is due) I personally owe you.

I, the undersigned do hereby appoint Lighthouse Chiropractic Health Center authority necessary to endorse and cash my checks, drafts or money orders which are made payable to the undersigned or as co-payee with this clinic when said payments are due to services rendered on behalf of the undersigned by the clinic.

I understand and agree that health and accident insurance policies are an agreement between an insurance carrier and me. I clearly understand and agree that all services rendered me are charges directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered me will be immediately due and payable. I understand I will be charged a 1.25% month interest fee for all accounts over 90 days past due. I will also be responsible for any costs of collection, attorney's fee or court costs required to collect my bill.

## Informed Consent

I hereby authorize physicians and staff of Lighthouse Chiropractic to treat my condition as deemed appropriate. The doctor will not be held responsible for any pre-existing medically diagnosed conditions.

I certify that the above information is correct to the best of my knowledge. I will not hold my doctor or any staff member of Lighthouse Chiropractic responsible for any errors or omissions that I may have made in the completion of this form.

Chiropractic, as well as all other types of health care, is associated with potential risks in the delivery of treatment. Therefore, it is necessary to inform the patient of such risks prior to initiating care. While chiropractic treatment is remarkably safe, you need to be informed about the potential risks related to your care to allow you to be fully informed before consenting to treatment.

Chiropractic is a system of health care delivery and therefore, as with any health care delivery system, we cannot promise a cure for any symptom, condition or disease as a result of treatment in this office. An attempt to provide you with the very best care is our goal, and if the results are not acceptable, we will refer you to another provider who we feel can further assist you.

**Specific Risk Possibilities Associated with Chiropractic Care:**

**Soreness** – Chiropractic adjustments and therapy modalities are sometimes accompanied by post treatment soreness. This is normal and acceptable accompanying response to chiropractic care and therapy modalities. While it is not generally dangerous, please advise your doctor if you experience soreness and discomfort.

**Soft Tissue Injury** - Occasionally chiropractic treatment may aggravate a disc injury, or cause other minor joint ligament, tendon, or other soft tissue injury.

**Rib Injury** – Manual adjustments to the thoracic spine, in rare cases, may cause rib injury or fracture. Precautions such as pre-adjustment x-rays are taken for cases considered at risk. Treatment is performed carefully to minimize such risk.

**Therapy Burn** – Heat generated by Therapy modalities may cause minor burns to the skin. This is rare, but if it occurs, you should report it to your doctor or a staff member.

**Stroke** – Stroke is the most serious complication of chiropractic treatment. The most recent studies estimate that the incidence of this type of stroke is 1 in every 5 million upper cervical adjustments.

**Other Problems** – There are occasionally other types of side effects associated with chiropractic care. While these are rare, they should be reported to your doctor promptly.

If you have any questions concerning this form or the above statements, please ask your doctor.

*Having carefully read the above Authorization and Assignment and Informed Consent, I hereby give my consent to have chiropractic treatment administered and authorize the assignment of payments. I clearly understand that all services rendered to me are charged directly to me and that I am personally responsible for payment.*

**Patient, Parent, Guardian or Personal Representative's Signature** ______________________________

**Please Print Name of Patient, Parent, Guardian, or Personal Representative** ______________________________

**Date** ____________________ **Relationship to Patient** ______________________________

# Lighthouse Chiropractic Health Center, Inc.
# 2014 Present Complaint Form

**Patient Name** ___________________________________________ **Date** _________________________

1. **Reason for visit**?___________________________________________________________________________________

2. **When did your symptoms appear**? _____________________________________ **Is this a pre-existing condition**? Yes No

3. **Describe how your problem began**? __________________________________________________________________

4. **How did this problem begin**? (Circle all that apply) Suddenly Gradually Accident Sports injury Work injury Fall

5. **Please describe the character of your current pain** (check all that apply) ☐ Sharp/Stabbing ☐ Sharp/Dull ☐ Aches ☐ Dull Weakness ☐ Throbbing/Gnawing ☐ Numbness/Tingling ☐ Shooting ☐ Gripping/Constricting ☐ Burning ☐ Tender/Sore ☐

6. **Does the pain radiate or tingle?** No Yes, ☐ to Shoulder ☐ to elbow ☐ to fingers ☐ to hip ☐ to knee ☐ to toes

7. **How often are the complaints present**? ☐ Constant (76-100%) ☐ Frequent (51-75%) ☐ Occasional (26-50%) ☐ Intermittent (25% or less)

8. **Since your problem began is the pain**? ☐ Increasing ☐ Decreasing ☐ Not Changing

9. **What makes the problem better**? ☐ Nothing ☐ Laying Down ☐ Walking ☐ Standing ☐ Sitting ☐ Movement/Exercise

10. **What makes the problem worse**? ☐ Nothing ☐ Laying Down ☐ Walking ☐ Standing ☐ Sitting ☐ Movement/Exercise

11. Symptoms are **better** at: ☐ AM ☐ Midday ☐ PM Symptoms are **worse** at: ☐ AM ☐ Midday ☐ PM

12. **Were you previously treated for a different occurrence of this same condition**?

If yes by: ☐ Chiropractor ☐ MD ☐ Therapist ☐ Other___________________ (Specify dates and type of treatment with results) ___________________________________________________________________________

13. **How would you grade your stress level**? ☐ No Stress ☐ Minimal Stress ☐ Moderate Stress ☐ Greatly Stressed

14. **Are you pregnant**? ☐ Yes ☐ No Due Date _________________________

15. **Have you ever had any surgeries or hospitalization**? ☐ Yes ☐ No Please list:

| Type of Hospitalization/Surgery: | Date | Type of Hospitalization/Surgery | Date |
|---|---|---|---|
| ______________________ | ________ | ______________________ | ________ |
| ______________________ | ________ | ______________________ | ________ |

| EXERCISE | WORK ACTIVITY | HABITS | |
|---|---|---|---|
| ☐ None | ☐ Sitting | ☐ Smoking | Packs/Day _______________ |
| ☐ Moderate | ☐ Standing | ☐ Alcohol | Drinks/Week ______________ |
| ☐ Daily | ☐ Light Labor | ☐ Coffee/Caffeine Drinks | Cups/Day_________________ |
| ☐ Heavy | ☐ Heavy Labor | ☐ High Stress Level | Reason _________________ |

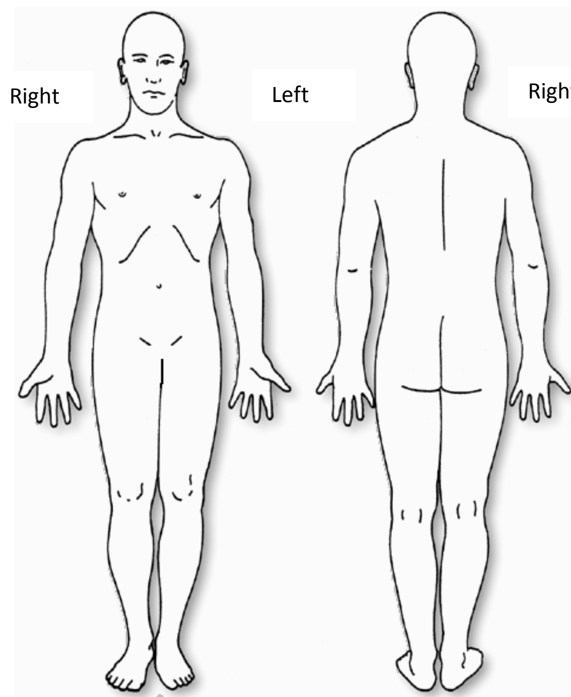
| MEDICATIONS | ALLERGIES | VITAMINS/HERBS/MINERALS |
|---|---|---|
| ____________________ | ____________________ | ____________________ |
| ____________________ | ____________________ | ____________________ |
| ____________________ | ____________________ | ____________________ |
| ____________________ | ____________________ | ____________________ |

Pharmacy Name ________________________________ Pharmacy Phone (____) ____________________

16. **Have you been x-rayed or received MRI, CAT scan in the last 12-18 months**? ☐Yes ☐No When?______________________

17. **Check those activities below during which you experience difficulty or pain**:

__Lying on back __Getting in/out of car __Pulling __Sitting __Standing for long periods
__Lying on side __Dressing Self __Reaching __Bending forward __Sneezing
__Turning over in bed __Sexual Activity __Kneeling __Bending forward __Coughing
__Lying on stomach __Pushing __Stooping __Walking __Other_________________________




18. **Mark on the diagram where you are having the following symptoms:**

Pain: XXX Numbness: OOO Aching: /////

19. **Pain Scale: 0 1 2 3 4 5 6 7 8 9 10**
(no pain) (worst pain)

20. **Headaches: Yes No Frequency:** __________________

**How long have you suffered from headaches:** ______________

**Side:** Right Left Both

**Location:** Forehead Temple Behind Eyes Back of Head

21. **What treatments have you done?**

☐ Physical Therapy ☐ Heat ☐ Ice
☐ Home Exercises ☐ Tens Unit ☐ Chiropractic
☐ Trigger Point Injections ☐ Braces ☐ Surgery
☐ Joint Injections ☐ Facet Injections ☐ MRI
☐ Epidural Injections ☐ Pain Medications ☐ Nerve Test
☐ Anti-Inflammatory Medications ☐ Stretching

Present:

Weight: ____________ pounds

Height: _____ ft _____ inches

22. **Review of Systems:** Please check if you have recently experienced the following:

CONSTITUTIONAL
☐ Weight loss-last 6 months
☐ Fever
☐ Chills
☐ Night Sweats

GASTROINTESTINAL
☐ Vomiting/Nausea
☐ Diarrhea
☐ Heartburn
☐ Constipation
☐ Abdominal Pain

GENITO-URINARY
☐ Bladd Problems

RESPIRATORY
☐ Shortness of Breath
☐ Cough

SKIN
☐ Skin wounds or ulcers

FEMALE
☐ Bladder Problems

CARDIOVASULAR
☐ Chest pain
☐ Palpitations
☐ Shortness of breath w/breathing

MUSCULOSKELETAL
☐ Joint Pain
☐ Joint Swelling

HEMATOLOGY
☐ Taking blood thinning meds

NERVOUS SYSTEM
☐ Blurry Vision ☐ Numbness ☐ Muscle Jerking ☐ Loss of Sleep ☐ Pain going to fingers
☐ Dizziness ☐ Fainting ☐ Ringing Ears ☐ Confusion ☐ Pain going past knee

**Patient, Parent, Guardian or Personal Representative's Signature** ____________________________________________

**Please Print Name of Patient, Parent, Guardian, or Personal Representative** ____________________________________

**Date** ____________________________ **Relationship to Patient** ______________________________________

# Lighthouse Chiropractic Health Center, Inc.
## Health History

If you have ever had a listed symptom in the past, please check that symptom in the Past column. If you are presently troubled by a particular symptom, check that symptom in the Present column.

| Past | Present | |
|---|---|---|
| ☐ | ☐ | Neck pain |
| ☐ | ☐ | Shoulder pain |
| ☐ | ☐ | Pain in upper Arm or Elbow |
| ☐ | ☐ | Hand Pain |
| ☐ | ☐ | Upper Back Pain |
| ☐ | ☐ | Low Back Pain |
| ☐ | ☐ | Pain in Upper Leg or Hip |
| ☐ | ☐ | Pain in Lower Leg or Knee |
| ☐ | ☐ | Pain in Ankle or Foot |
| ☐ | ☐ | Jaw Pain |
| ☐ | ☐ | Swelling of Joint (Specify Joints) |
| ☐ | | ________________________________ |
| ☐ | ☐ | Stiffness of Joints (Specify Joints) ________________________________ |

| Past | Present | |
|---|---|---|
| ☐ | ☐ | Menopause Symptoms |
| ☐ | ☐ | Painful Urination |
| ☐ | ☐ | Loss of Bladder Control |
| ☐ | ☐ | Frequent Urination |
| ☐ | ☐ | Abdominal Pain |
| ☐ | ☐ | Difficulty in Swallowing |
| ☐ | ☐ | Heartburn/Indigestion |
| ☐ | ☐ | Constipation |
| ☐ | ☐ | Rash |
| ☐ | ☐ | Dermatitis or Eczema |

| Past | Present | |
|---|---|---|
| ☐ | ☐ | Fainting |
| ☐ | ☐ | Dizziness |
| ☐ | ☐ | Muscular In coordination |
| ☐ | ☐ | Rapid Heart Beat |
| ☐ | ☐ | Loss of Appetite |
| ☐ | ☐ | Abnormal weight loss |
| ☐ | ☐ | Chronic Sinusitis |

| Past | Present | |
|---|---|---|
| ☐ | ☐ | Convulsions |
| ☐ | ☐ | Headache |
| ☐ | ☐ | Tinnitus (Ear Noise) |
| ☐ | ☐ | Chest Pains |
| ☐ | ☐ | Abnormal weight gain |
| ☐ | ☐ | Chronic Cough |

Listed below are common diseases and disorders. Please indicate whether you have had a particular disorder in the past or presently troubled by a listed disorder.

| Past | Present | |
|---|---|---|
| ☐ | ☐ | Depression |
| ☐ | ☐ | Aortic Aneurysm |
| ☐ | ☐ | High Blood Pressure |
| ☐ | ☐ | Angina |
| ☐ | ☐ | Heart Attack |
| ☐ | ☐ | Stroke |
| ☐ | ☐ | Asthma |
| ☐ | ☐ | Cancer |
| ☐ | ☐ | Prostate Problems |
| ☐ | ☐ | Anorexia |

| Past | Present | |
|---|---|---|
| ☐ | ☐ | Emphysema (chronic lung disorders) |
| ☐ | ☐ | Arthritis |
| ☐ | ☐ | Diabetes |
| ☐ | ☐ | Ulcer |
| ☐ | ☐ | Kidney Stones |
| ☐ | ☐ | Bladder Infection |
| ☐ | ☐ | Kidney Disorders |
| ☐ | ☐ | Other______________________ |
| ☐ | ☐ | ___________________________ |

# Lighthouse Chiropractic Health Center, Inc.
# Family Health History

**Patient Name:** ________________________________________________ **Date:** ___________________________

Please review the below listed diseases and conditions and indicate those that are **current** health problems of a family member by the designation **C** under his or her column. The designation **P** should be used to indicate a **past** problem. Leave blank those spaces that do not apply. If you require more space, please let us know.

| | **Father** | **Mother** | **Spouse** | **Brother (s)** | **Sister (s)** | | **Children** |
|---|---|---|---|---|---|---|---|
| **CONDITION** | **Age_____** | **Age_____** | **Age_____** | **Age_____** | **Age_____** | **Age_____** | **Age_____** |
| Arthritis | | | | | | | |
| Asthma-Hay Fever | | | | | | | |
| Back Trouble | | | | | | | |
| Bursitis | | | | | | | |
| Cancer | | | | | | | |
| Diabetes | | | | | | | |
| Disc Problem | | | | | | | |
| Emotional Problem | | | | | | | |
| Emphysema | | | | | | | |
| Epilepsy | | | | | | | |
| Headaches | | | | | | | |
| High Blood Pressure | | | | | | | |
| Insomnia | | | | | | | |
| Kidney Problem | | | | | | | |
| Liver Trouble | | | | | | | |
| Migraine | | | | | | | |
| Nervousness | | | | | | | |
| Neuritis | | | | | | | |
| Pinched Nerve | | | | | | | |
| Scoliosis | | | | | | | |
| Sinus Trouble | | | | | | | |
| Stomach Trouble | | | | | | | |
| | | | | | | | |
| Other: | | | | | | | |
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |

If any of the above family members are deceased please list their age at death and cause:

______________________________________________________________________________________________

______________________________________________________________________________________________

______________________________________________________________________________________________

______

**Patient, Parent, Guardian or Personal Representative's Signature** _____________________________________________________

**Please Print Name of Patient, Parent, Guardian, or Personal Representative** _____________________________________________

**Date** __________________________________ **Relationship to Patient** _______________________________________________

# *LIGHTHOUSE CHIROPRACTIC HEALTH CENTER, INC.*
## Assessment Questionnaire

| Patient Last Name | Patient First Name | Date of Birth (MM/DD/YYYY |
|---|---|---|
| | | _______/_______/__________ |

**Instructions:** This questionnaire will help us understand how much your pain has affected your ability to manage everyday activities. Please answer each Section by circling the **ONE CHOICE** that most applies to you. We realize you may feel that more than one statement may relate to you, but please ***just circle the one choice which closely describes your problem right now.***

### SECTION 1—PAIN INTENSITY

A.I have no pain at the moment
B. The pain is mild at the moment.
C. The pain comes and goes and is moderate.
D. The pain is moderate and does not vary much.
E. The pain is severe but comes and goes.
F. The pain is severe and does not vary much.
G. Does not apply

### SECTION 2—PERSONAL CARE (Washing, Dressing, etc.)

A. I can look after myself without causing pain.
B. I can look after myself normally but it causes pain.
C. It is painful to look after myself and I am slow and careful.
D. I need some help, but manage most of my personal care.
E. I need help every day in most aspects of self-care.
F. I do not get dressed; I wash with difficulty and stay in bed.
G. Does not apply

### SECTION 3—LIFTING

A. I can lift heavy weights without extra pain.
B. I can lift heavy weights, but it causes extra pain.
C. Pain prevents me from lifting heavy weights off the floor but I can if they are conveniently positioned, for example on a table.
D. Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
E. I can lift very light weights.
F. I cannot lift or carry anything at all.
G. Does not apply

### SECTION 4—READING

A. I can read as much as I want to with no pain in my neck.
B. I can read as much as I want with slight pain in my neck.
C. I can read as much as I want with moderate pain in my neck.
D. I cannot read as much as I want because of moderate pain in in my neck
E. I cannot read as much as I want because severe pain in my neck.
F. I cannot read at all.
G. Does not apply.

### SECTION 5—HEADACHE

A. I have no headache at all.
B. I have slight headaches which come infrequently.
C. I have moderate headaches which come infrequently.
D. I have moderate headaches which come frequently.
E. I have severe headaches which come frequently.
F. I have headaches almost all the time.
G. Does not apply.

### SECTION 6—CONCENTRATION

A. I can concentrate fully when I want to with no difficulty.
B. I can concentrate fully when I want to with slight difficulty.
C. I have a fair degree of difficulty in concentrating when I want.
D I have a lot of difficulty in concentrating when I want to.
E. I have a great deal of difficulty in concentrating when I want.
F. I cannot concentrate at all.
G. Does not apply.

### SECTION 7—WORK

A. I can do as much work as I want to.
B. I can only do my usual work, but no more.
C. I can do most of my usual work but no more.
D. I cannot do my usual work.
E. I can hardly do any work at all.
F. I cannot do any work at all.
G. Does not apply.

### SECTION 8—SITTING

A. I can sit in any chair as long as I like without pain.
B. I can only sit in my favorite chair as long as I like.
C. Pain prevents me from sitting more than 1 hour.
D. Pain prevents me from sitting more than ½ hour.
E. Pain prevents me from sitting more than 10 min.
F. Pain prevents me from sitting at all.
G. Does not apply.

### SECTION 9—STANDING

A. I can stand as long as I want without pain.
B. I have some pain on standing but it does not increase with time.
C. I cannot stand for longer than one hour without increasing pain.
D. I cannot stand for longer than ½ hour without increasing pain.
E. I cannot stand for longer than 10 minutes without increasing pain.
F. Pain prevents me from standing at all.
G. Does not apply.

### SECTION 10 - WALKING

A. Pain does not prevent me from walking any distance.
B. Pain prevents me from walking more than 1 mile.
C. Pain prevents me from walking more than ½ mile.
D. Pain prevents me from walking more than ¼ mile.
E. I can only walk using a stick or crutches.
F. I am in bed most of the time and have to crawl to the toilet
G. Does not apply.

# Assessment Questionnaire
# Continued

## SECTION 11—DRIVING

A. I can drive my car without neck pain.
B. I can drive my car as long as I want with slight pain in my neck.
C. I can drive my car as long as I want with moderate pain in my neck.
D. I cannot drive my car as long as I want because of moderate pain in my neck.
E. I can hardly drive my car at all because of severe pain in my neck.
F. I cannot drive my car at all.
G. Does not apply

## SECTION 12—TRAVELING

A. I get no pain while traveling.
B. I get some pain while traveling but none of my usual forms of travel make it any worse.
C. I get extra pain while traveling but it does not compel me to seek alternative forms of travel.
D. I get extra pain while traveling which compels me to seek alternative forms of travel.
E. Pain restricts all forms of travel.
F. Pain restricts all forms of travel except that done lying down.
G. Does not apply

## SECTION 13 – RECREATION

A. I am able to engage in all recreational activities with no pain In my neck at all.
B. I am able to engage in all recreational activities with some pain in my neck.
C. I am able to engage in most, but not all recreational activities because of pain in my neck.
D. I am able to engage in a few of my usual recreational activities because of pain in my neck.
E. I can hardly do any recreational activities because of pain in my neck.
F. I cannot do any recreational activities at all.
G. Does not apply

## SECTION 14— SOCIAL LIFE

A. My social life is normal and gives me no pain.
B. My social life is normal but increases the degree of my pain.
C. Pain has no significant effect on my social life apart from limiting my more energetic interests, (e.g. dancing, etc.).
D. Pain has restricted my social life and I do not go out very often.
E. Pain has restricted my social life to my home.
F. I have hardly any social life because of the pain.
G. Does not apply.

## SECTION 15 - SLEEPING

A. I have trouble sleeping.
B. My sleep is slightly disturbed (Less than 1 hour sleepless).
C. My sleep is mildly disturbed (1-2 hours sleepless).
D. My sleep is moderately disturbed (2-3 hours sleepless).
E. My sleep is greatly disturbed (3-5 hours sleepless).
F. My sleep is completely disturbed (5-7 hours sleepless).
G. Does not apply.

## SECTION 15 - SLEEPING

A. My pain is rapidly getter better.
B. My pain fluctuates, but overall is definitely getting better.
C. My pain seems to be getting better but improvement is slow at present.
D. My pain is neither getting better nor worse.
E. My pain is gradually worsening.
F. My pain is rapidly worsening.
G. Does not apply.

I understand that the information I have provided above is current and correct to the best of my knowledge.

SIGNATURE ____________________________________________ DATE __________________________

# Upper Extremity Assessment Questionnaire

| Patient Last Name | Patient First Name | Date of Birth (MM/DD/YYYY |
|---|---|---|
| | | |

**Instructions:** This questionnaire will help us understand how much your pain has affected your ability to manage everyday activities. Please answer each section by checking the **ONE CHOICE** that most applies to you. We realize you may feel that more than one may relate to you, but please ***just mark the one choice which closely describes your problem right now.***

| | **None** | **Mild** | **Moderate** | **Severe** | **Extreme** |
|---|---|---|---|---|---|
| **Arm, Shoulder or hand pain.** | | | | | |
| **Tingling (pins and needles) in arm, shoulder, or hand.** | | | | | |
| **Weakness or stiffness in your arm, shoulder or hand.** | | | | | |
| | **No Difficulty** | **Mild Difficulty** | **Moderate Difficulty** | **Severe Difficulty** | **Unable** |
| **Open a tight or new jar.** | | | | | |
| **Write** | | | | | |
| **Turn a key.** | | | | | |
| **Push open a heavy door.** | | | | | |
| **Place an object on a shelf above your head.** | | | | | |
| **Garden or do yard work.** | | | | | |
| **Carry a shopping bad or briefcase.** | | | | | |
| **Carry a heavy object over 10 lbs.** | | | | | |
| **Care for myself (e.g. bathing, dressing).** | | | | | |
| **Use a knife to cut food.** | | | | | |
| **Doing usual work because of arm, shoulder or hand pain?** | | | | | |
| **Spending your usual amount of time doing your work?** | | | | | |
| **Recreational activities in which require little effort (e.g. cardplaying, knitting, etc).** | | | | | |
| **Recreational activities in which you take some force or impact through your arm, shoulder or hand(e.g. golf, hammering, tennis, etc.).** | | | | | |

I understand that the information I have provided above is current and correct to the best of my knowledge.

SIGNATURE ______________________________ DATE ______________

# Lower Extremity Assessment Questionaire

| Patient Last Name | Patient First Name | Date of Birth (MM/DD/YYYY |
|---|---|---|
| | | |

**Instructions:** This questionnaire will help us understand how much your pain has affected your ability to manage everyday activities. Please answer each section by checking the **ONE CHOICE** that most applies to you. We realize you may feel that more than one may relate to you, but please ***just mark the one choice which closely describes your*** **problem right now.**

| | None | Mild | Moderate | Severe | Extreme |
|---|---|---|---|---|---|
| **Hip, thigh, knee or ankle pain.** | | | | | |
| **Tingling (pins and needles) in hip, thigh, knee or ankle.** | | | | | |
| **Weakness or stiffness in your hip, thigh, knee or ankle.** | | | | | |

| | No Difficulty | Mild Difficulty | Moderate Difficulty | Severe Difficulty | Unable |
|---|---|---|---|---|---|
| **Any of your usual work, housework, or school activities.** | | | | | |
| **Your usual hobbies, recreational or sporting activities.** | | | | | |
| **Getting into or out of the bath.** | | | | | |
| **Walking between rooms.** | | | | | |
| **Putting on your shoes or socks.** | | | | | |
| **Squatting.** | | | | | |
| **Lifting an object, like a bag of groceries from the floor.** | | | | | |
| **Performing light activities around your home.** | | | | | |
| **Getting into or out of a car.** | | | | | |
| **Walking 2 blocks.** | | | | | |
| **Walking a mile.** | | | | | |
| **Going up or down 10 stairs (about 1 flight of stairs).** | | | | | |
| **Standing for 1 hour.** | | | | | |
| **Sitting for 1 hour.** | | | | | |
| **Running on even or uneven ground.** | | | | | |
| **Rolling over in bed.** | | | | | |

I understand that the information I have provided above is current and correct to the best of my knowledge.

SIGNATURE ______________________________ DATE ____________