

Activities of Daily Living Interference Questionnaire

The rating scales used below measure the impact of your pain on your everyday life. The doctor wants to know how much your current condition is preventing you from doing your normal activities. For each of the seven (7) categories listed below, circle the one number between "0" and "10" that best indicates the level of interference you are experiencing in your normal activities. If a category does not apply to you, circle "0". A score of ten (10) indicates that all of the activities that you would normally do have been disrupted by your pain or condition. Your rating should be a reflection of the overall impact of your condition on your life, not just the amount of interference when your condition is at its worst.

Family and/or Home Responsibilities: This category refers to those activities related to your home or family.

0 1 2 3 4 5 6 7 8 9 10
 No disability Mild Moderate Severe Total disability

Recreation: Indicate how much your condition interferes with your recreational activities.

0 1 2 3 4 5 6 7 8 9 10
 No disability Mild Moderate Severe Total disability

Social Activities: Indicate the overall level of interference for this category caused by your condition.

0 1 2 3 4 5 6 7 8 9 10
 No disability Mild Moderate Severe Total disability

Occupation: Indicate the amount of job-related interference you experience due to your present problem.

0 1 2 3 4 5 6 7 8 9 10
 No disability Mild Moderate Severe Total disability

Interpersonal Relationships: Indicate the level to which your condition interferes with the quality of your interpersonal relationships.

0 1 2 3 4 5 6 7 8 9 10
 No disability Mild Moderate Severe Total disability

Self Care: Indicate the amount of interference you experience with personal maintenance and independent daily living activities.

0 1 2 3 4 5 6 7 8 9 10
 No disability Mild Moderate Severe Total disability

Sleeping: Indicate the level of interference with sleeping caused by your condition.

0 1 2 3 4 5 6 7 8 9 10
 No disability Mild Moderate Severe Total disability

Please answer the following questions:

- | | Yes | No |
|---|--------------------------|--------------------------|
| Have you felt keyed up, on edge? | <input type="checkbox"/> | <input type="checkbox"/> |
| Have you been worrying a lot? | <input type="checkbox"/> | <input type="checkbox"/> |
| Have you been irritable? | <input type="checkbox"/> | <input type="checkbox"/> |
| Have you had a difficult time relaxing? | <input type="checkbox"/> | <input type="checkbox"/> |
| Have you been sleeping poorly? | <input type="checkbox"/> | <input type="checkbox"/> |
| Have you had headaches or neck aches? | <input type="checkbox"/> | <input type="checkbox"/> |
| Have you had any of the following: Trembling,
Tingling, dizzy spells, sweating, urinary frequency,
or diarrhea? | <input type="checkbox"/> | <input type="checkbox"/> |
| Have you been worried about your health? | <input type="checkbox"/> | <input type="checkbox"/> |
| Have you had difficulty falling asleep? | <input type="checkbox"/> | <input type="checkbox"/> |
| Have you had low energy? | <input type="checkbox"/> | <input type="checkbox"/> |
| Have you had loss of interests? | <input type="checkbox"/> | <input type="checkbox"/> |
| Have you lost confidence in yourself? | <input type="checkbox"/> | <input type="checkbox"/> |
| Have you felt hopeless? | <input type="checkbox"/> | <input type="checkbox"/> |
| Have you had a difficult time concentrating? | <input type="checkbox"/> | <input type="checkbox"/> |
| Have you lost weight (due to poor appetite)? | <input type="checkbox"/> | <input type="checkbox"/> |
| Have you been waking up early? | <input type="checkbox"/> | <input type="checkbox"/> |
| Have you felt slowed up? | <input type="checkbox"/> | <input type="checkbox"/> |
| Have you tended to feel worse in the morning? | <input type="checkbox"/> | <input type="checkbox"/> |

Please answer the following questions:

- | | Yes | No |
|--|--------------------------|--------------------------|
| Do you get pain in the tip of your tailbone? | <input type="checkbox"/> | <input type="checkbox"/> |
| Does your whole arm/leg ever become painful? | <input type="checkbox"/> | <input type="checkbox"/> |
| Does your whole arm/leg ever become numb? | <input type="checkbox"/> | <input type="checkbox"/> |
| Does your whole leg ever give away? | <input type="checkbox"/> | <input type="checkbox"/> |
| Have you had any pain-free times in the past year? | <input type="checkbox"/> | <input type="checkbox"/> |
| Have you had any intolerance to treatments or
reaction to treatments? | <input type="checkbox"/> | <input type="checkbox"/> |
| Have you ever been to the emergency room
for back pain? | <input type="checkbox"/> | <input type="checkbox"/> |

How did you learn about this office?

- Another patient referred me. Who? _____
- Provider directory
- Yellow pages
- MD Referral. Who? _____

Patient Name _____

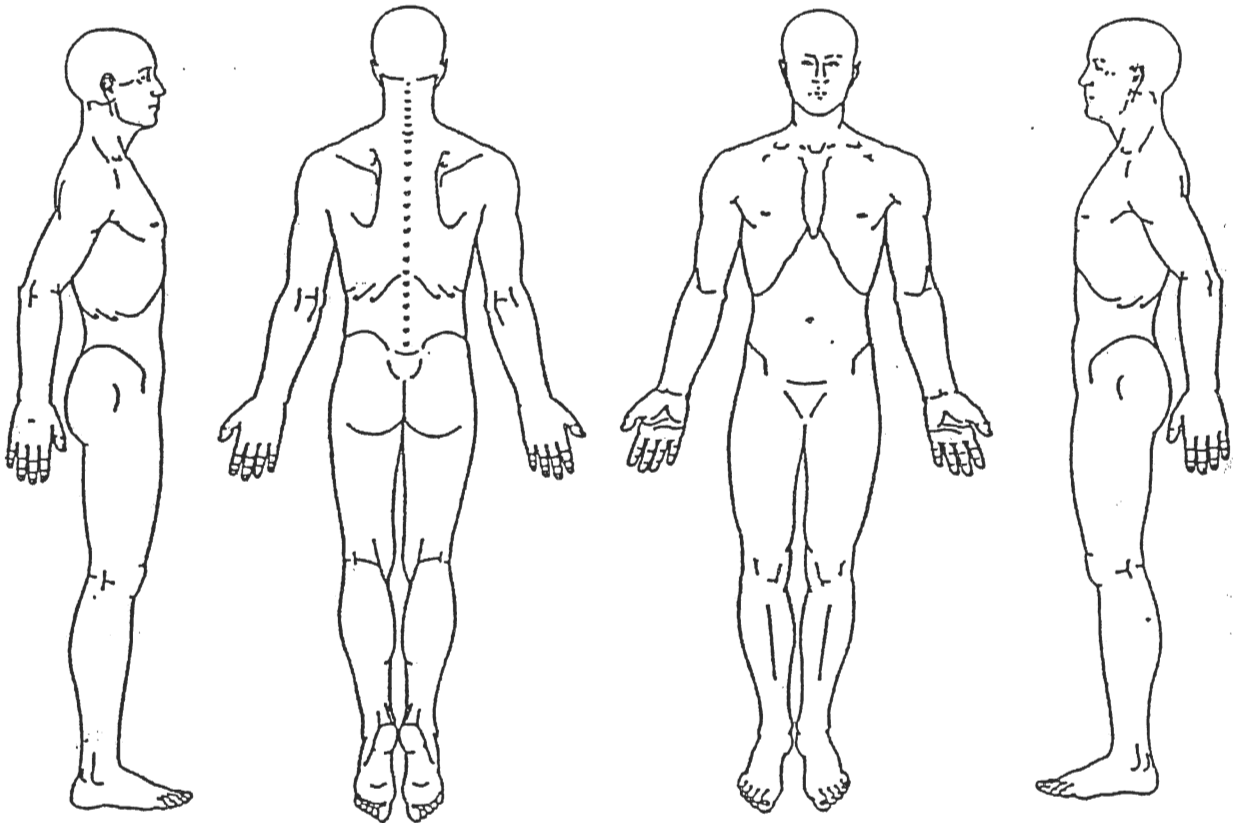
Date _____

Please check the symptoms that you have noticed since your accident or the beginning of your condition:

- | | | | | |
|--|---|--|--|--|
| <input type="checkbox"/> Low back pain | <input type="checkbox"/> Ankle pain | <input type="checkbox"/> Cold/clammy hands | <input type="checkbox"/> Slow heart beat | <input type="checkbox"/> Hay fever |
| <input type="checkbox"/> Neck pain | <input type="checkbox"/> Foot pain or numbness | <input type="checkbox"/> Blurred vision | <input type="checkbox"/> Rapid heart beat | <input type="checkbox"/> Sinusitis |
| <input type="checkbox"/> Pain between shoulders | <input type="checkbox"/> Face pain or numbness | <input type="checkbox"/> Tendency to sweat | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Sore throat |
| <input type="checkbox"/> Swollen joints | <input type="checkbox"/> Loss of feeling | <input type="checkbox"/> Poor appetite | <input type="checkbox"/> Low blood pressure | <input type="checkbox"/> Hoarseness |
| <input type="checkbox"/> Sore muscles | <input type="checkbox"/> Tingling in feet | <input type="checkbox"/> Difficulty swallowing | <input type="checkbox"/> Impatience | <input type="checkbox"/> Dry mouth |
| <input type="checkbox"/> Weak muscles | <input type="checkbox"/> Tingling in hands | <input type="checkbox"/> Upset stomach | <input type="checkbox"/> Insomnia | <input type="checkbox"/> Burning, unpleasant taste |
| <input type="checkbox"/> Walking problems | <input type="checkbox"/> Paralysis | <input type="checkbox"/> Excessive thirst | <input type="checkbox"/> Poor circulation | <input type="checkbox"/> Unsteady voice |
| <input type="checkbox"/> Broken bones | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Nausea | <input type="checkbox"/> Swollen ankles | <input type="checkbox"/> Difficulty in urination |
| <input type="checkbox"/> Shakiness | <input type="checkbox"/> Fainting | <input type="checkbox"/> Vomiting | <input type="checkbox"/> Pressure in chest | <input type="checkbox"/> Frequent urination |
| <input type="checkbox"/> Muscle aches | <input type="checkbox"/> Headache | <input type="checkbox"/> Abdominal pains | <input type="checkbox"/> Choking sensations | <input type="checkbox"/> Fullness in bladder |
| <input type="checkbox"/> Joint stiffness | <input type="checkbox"/> Feeling of tension | <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Sighing | <input type="checkbox"/> Painful urination |
| <input type="checkbox"/> Muscle jerks | <input type="checkbox"/> Sleeping difficulties | <input type="checkbox"/> Constipation | <input type="checkbox"/> Lump in throat | <input type="checkbox"/> Urinary urgency |
| <input type="checkbox"/> Grinding of teeth | <input type="checkbox"/> Convulsions | <input type="checkbox"/> Hemorrhoids | <input type="checkbox"/> Eye pain | <input type="checkbox"/> Menstrual irregularities |
| <input type="checkbox"/> Shoulder pain or numbness | <input type="checkbox"/> Forgetfulness | <input type="checkbox"/> Weight loss | <input type="checkbox"/> Eyelid twitching | <input type="checkbox"/> Painful menstruation |
| <input type="checkbox"/> Arm pain or numbness | <input type="checkbox"/> Confusion | <input type="checkbox"/> Burning in stomach | <input type="checkbox"/> Vision difficulties | <input type="checkbox"/> Decreased sex drive |
| <input type="checkbox"/> Leg pain or numbness | <input type="checkbox"/> Difficulty concentrating | <input type="checkbox"/> Abdominal fullness | <input type="checkbox"/> Light bothers eyes | <input type="checkbox"/> Fatigue |
| <input type="checkbox"/> Elbow pain | <input type="checkbox"/> Irritability | <input type="checkbox"/> Chest pain | <input type="checkbox"/> Ear pain | <input type="checkbox"/> Inability to relax |
| <input type="checkbox"/> Knee pain | <input type="checkbox"/> Restlessness | <input type="checkbox"/> Difficulty breathing | <input type="checkbox"/> Ringing in ears | <input type="checkbox"/> Feel like you have lost control |
| <input type="checkbox"/> Hand pain or numbness | <input type="checkbox"/> Trembling | <input type="checkbox"/> Persistent coughing | | |

Please use the following key to accurately mark the areas in which you feel the described sensations. Use the appropriate symbols and include all affected areas.

Dull **///** Stabbing/Cutting **///** Burning **XXX** Numb **==** Tingling (Pin & needles) **••••** Cramping **SSS**



Using the scale 0-100, with 0 = no pain and 100 = worst possible pain, please write the number indicating your present pain level in the box at the right:

Place one mark on the line below to indicate your present pain level:

No pain _____ Worst pain

**ACKNOWLEDGEMENT OF RECEIPT OF
NOTICE OF PRIVACY PRACTICES**

I, _____, [patient's name] acknowledge that I have received, reviewed, understand and agree to the the Notice of Privacy Practices of NASA Bay Area Chiropractic, which describes the Practice's policies and procedures regarding the use and disclosure of any of my Protected Health Information created, received or maintained by the Practice.

Date

Signature

Print Name

FOR OFFICE USE ONLY IF NOTICE NOT PROVIDED TO PATIENT

The Practice has made a good-faith effort to obtain an acknowledgement of _____ [patient's name]'s receipt of our Notice of Privacy Practices. In spite of these efforts, the Practice has been unable to obtain a signed acknowledgement of receipt for the following reasons (check all that apply):

- Patient Unavailable
- Patient Physically Unable
- Patient Unwilling

In an effort to obtain the patients acknowledgement, the Practice has attempted to provide patient with a Notice of Privacy Practices in the following manner (check all that apply) :

- Personally
- Mail
- Phone Follow Up
- Other: _____

Date

Signature

Print Name of Physician

NASA Bay Area Chiropractic
Name of Practice