WHAT TO BRING TO YOUR APPOINTMENT

Please bring the following items to your appointment:

- ☐ Insurance card(s) or copies
- ☐ Referrals from your primary care physician (if necessary)
- ☐ Completed paperwork including registration, medical history information, medication list and any other relevant paperwork
- ☐ Any related test results and reports

X-RAYS

Our x-ray facilities are located inside our offices. If you are insured by a managed care plan and have a capitated radiology site, you must get x-rays done at that site (example: Keystone Health Plan). If you are bringing x-rays (actual films or a disk) to your appointment, **x-rays must be current (no older than 3 to 4 months)** to be of use to the doctor. Exception: If you are being seen for neck or back problems, x-rays can be no older than 6 months.

Please bring a copy of the written report. In addition, if you have older x-rays, please bring them for comparison.

- ☐ **X-rays** - See below for required views

For Knee: Three views should be taken: (1) AP (front) standing of both knees; (2) Lateral (side) view of problem knee; (3) Front view of problem patell (kneecap)

For Hips: Two views should be taken: (1) AP both hips, (2) Lateral (side) of the problem hip.

If you are bringing MRI films, please bring a copy of the written report as well.

INSURANCE

Booth, Bartolozzi, Balderston Orthopaedics participates with many insurance companies. Please check with your insurance carrier regarding our participation and your responsibility for referrals and co-payments or contact our billing office at 215-829-2499. If it is determined that Booth, Bartolozzi, Balderston Orthopaedics does not participate with your insurance company, payment is required at the time of your visit.

PARKING

The Delancey Parking Garage is located at 8th and Delancey St. Delancey St. is the first street on the left once you pass the 8th St. (main) entrance of the hospital. We offer discounted parking for office visits and Pre-Admission Testing visits prior to your surgery. Discounted parking is not given for your surgery date, other physician's offices or visits to the blood bank. When you check-out from your appointment, the staff will give you a sticker that entitles you to the discounted parking rate.

BOOTH BARTOLOZZI BALDERSTON
PENN Orthopaedics

PATIENT REGISTRATION

PLEASE PRINT

DATE: PHYSICIAN: MRN #

Patient Name: _____ Social Security #: _____
Street Address: _____ Date of Birth: _____
City, State, Zip: _____ Age: _____ Sex: ☐ Male ☐ Female
Home Phone #: _____ Allergies: _____
Work Phone #: _____ Email Address: _____
Cell Phone #: _____ Marital Status: ☐ Single ☐ Married
Occupation: _____ ☐ Widowed ☐ Divorced ☐ Separated
Employer: _____ Emergency Contact: _____
Employer Address: _____ Relationship: _____
City, State, Zip: _____ Emergency Contact Phone #: _____
Mother's First Name: _____ Father's First Name: _____

Who referred you (either physician or friend)

Name: _____ Phone #: _____
Address: _____ City, State, Zip: _____

Primary Care or Family Doctor

Physician Name: _____ Phone #: _____
Address: _____ City, State, Zip: _____

INSURANCE INFORMATION

Primary Insurance: _____ ***Secondary Insurance:*** _____
Insurance Address: _____ Insurance Address: _____
Phone #: _____ Phone #: _____
Identification #: _____ Identification #: _____
Group #: _____ Effective Date: _____ Group #: _____ Effective Date: _____
Policyholder Name: _____ Policyholder Name: _____
Relationship to Patient: _____ Relationship to Patient: _____
Policyholder Date of Birth: _____ Policyholder Date of Birth: _____
Policyholder Employer: _____ Policyholder Employer: _____
Policyholder Employer Address: _____ Policyholder Employer Address: _____
_____ _____

If visit is related to an auto accident or worker's compensation claim, please complete:

Name of Insurance: _____ Accident Date: _____
Address of Insurance Co.: _____ State in which accident occurred: _____
City, State, Zip: _____ Claims Adjuster Phone #: _____
Claims Adjuster #: _____ Claim #: _____

LEGAL CASES AND TESTIMONY

We want to acquaint you with our policy related to cases with legal involvement or those requiring testimony. Because of our commitment to clinical care, research and teaching and the ongoing requirements of good patient care, we find it impossible to accept any new patients with legal involvement or cases requiring testimony. It is frequently impossible to predict which case with legal involvement will require testimony and which will not. Therefore, we do not accept any case of this nature and refer patients who need this type of advice and assistance to other physicians for their care.

Our principal reason for declining participation in any case with legal involvement is it would ultimately mean that we would have to deny medical care to other parties. We feel our primary obligation is to render medical care and treatment, rather than testimony and assistance in lawsuits.

I have read and fully understand the above statement. I agree not to require your participation in legal proceedings.

_____ _____
Patient's Signature Date

_____ _____
Witness' Signature Date

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

By signing below I,_____ acknowledge that 3B Orthopaedics, PC has
(please print name)
provided me with a copy of its Notice of Privacy Practices, as required under the Health Insurance Portability and Accountability Act of 1996.

_____ _____
Patient Signature Date

PATIENT NOTICE OF RELATIONSHIPS WITH INDUSTRY

Some of our physicians participate in the research, design, development or improvement of implants, and some physicians receive compensation for their research and development efforts from the manufacturers of the implants. These implants could be used if it is determined that you need surgery. If so, prior to surgery, you can take the opportunity to ask your physician whether he has any such financial agreements with a prosthetic manufacturer, and, if so, to ask any questions you might have regarding those agreements.

_____
Patient Name (print)

_____ _____
Patient Signature Date

3B ORTHOPAEDICS, P.C.

FINANCIAL RESPONSIBILITY, ASSIGNMENT OF BENEFITS AND PATIENT AUTHORIZATION

Charges for Items or Services

I am financially responsible, to the extent permitted by applicable law, to pay to 3B Orthopaedics, P.C. (hereafter known as "3B") all charges for items or services rendered to Patient. This expressly includes any insurance deductibles, co-insurance, co-payments and non-covered services. I acknowledge that the information provided is accurate and complete. If there are any changes to this information in the future, I will provide any such change at my next scheduled visit.

Assignment of Benefits

I hereby authorize and assign payment directly to 3B for medical insurance benefits, including any major medical benefits otherwise payable to me under the terms of my policy, but not to exceed the balance due to 3B and its physicians for items rendered to Patient.

Release of Health Information

I authorize 3B to disclose any or all parts of Patient's medical record to Patient's insurance company(s) or employer(s) for the purposes of satisfying charges billed by 3B and it's physicians for items or services provided by to the Patient. I further understand that it may be necessary for 3B to contact my past or present employer(s) in regard to this claim. This authorization does not cover third party liability claims.

I hereby release and forever discharge 3B and its respective employees, directors, officers, shareholders, agents, assigns and legal representatives (collectively, "3B Parties") from any and all obligations, claims, liabilities, damages, debts, liens and deficiencies arising out of or in connection with 3B's use or disclosure of my health information in accordance with this Financial Responsibility, Assignment of Benefits and Patient Authorization ("Authorization"). I hereby agree to indemnify and hold harmless the 3B Parties from and against any liability, loss, cost or expense (including reasonable attorneys' fees) incurred by the 3B Parties in reliance upon this Authorization.

I permit a copy of this Authorization to be used in place of the original. I certify that this information is true complete to the best of my knowledge.

_____ _____
Print Patient Name Date

_____ _____
Patient Signature Date

_____ _____
Responsible Party Name (if applicable) Date

_____ _____
Responsible Party Signature (if applicable) Date

Please describe Responsible Party's relationship to Patient and a description of Responsible Party's authority to act on behalf of the Patient _____

3B Orthopaedics, PC, is an independent medical group affiliated with, but not employed by, Pennsylvania Hospital or the University of Pennsylvania Health System.

(Medicare Patients only Complete Opposite Side)

MEDICARE PATIENTS MUST COMPLETE

Medicare Beneficiary Number:_____

Effective Date Part A:_____ Effective Date Part B:_____

I request that payment of authorized Medicare benefits be made either to me or on my behalf to 3B to the individual attending physician to for any items or services furnished to me by that physician. I authorize 3B and its physicians to release to the Health Care Financing Administration and its agent any medical information needed to determine these benefits or the benefits for related services.

1) Are you receiving Black Lung Benefits? Yes or No (Please circle one)
   If yes, Date Benefits Began: _____

2) Are the services to be paid by Government Program? Yes or No (Please circle one)

3) Are the services to be paid by Veterans Affairs? Yes or No (Please circle one)

4) Are the services to be paid by Research Grants? Yes or No (Please circle one)

5) Was the illness/injury due to an accident? Yes or No (Please circle one)
   If yes, Work related injury/illness? Date: _____
   Automobile Accident? Date: _____
   Other type of accident? _____ Date: _____

6) Are you entitled to Medicare based on Age? Yes or No (Please circle one)
   If yes, are you or your spouse currently employed and receiving health benefits through your employer? Yes or No (Please circle one)
   Does the patient's employer employ 20 or more employees? Yes or No (Please circle one)
   Give approximate number of employees: ____
   Does the spouse's employer employ 20 or more employees? Yes or No (Please circle one)
   Give approximate number of employees: ____

7) Are you entitled to Medicare based on Disability? Yes or No (Please circle one)
   If yes, is the patient the dependent of an employed family member? Yes or No (Please circle one)
   Are you or your spouse currently employed? Yes or No (Please circle one)
   Does the employer employ 100 or more employees? Yes or No (Please circle one)
   Give approximate number of employees: ____
   Does the employer provide a Group Health Plan? Yes or No (Please circle one.
   If yes, please provide copy of Insurance card.

8) Are you entitled to Medicare based on End Stage Renal Disease? Yes or No (Please circle one)
   If yes, did you receive a kidney transplant? Yes or No (Please circle one)
   Date of transplant: _____ Date of first dialysis treatment: _____
   Did you participate in a self dialysis-training program? Yes or No (Please circle one)
   Date training began: _____
   Is the patient within 30-month coordination period? Yes or No (Office Use Only)
9) Do you have a secondary insurance to your Medicare plan? Yes or No (Please circle one)

Patient Signature: _____ Date: _____

WHY WE USE A BINDING ARBITRATION AGREEMENT

- At 3B Orthopaedics, our goal is provide quality care to our patients. Unfortunately, once in a while in the course of our care, disputes arise between our providers and our valued patients. If this occurs, we work with our patients to resolve matters as quickly as possible and with a minimum amount of upset to the patient or the patient's family.

- If the dispute remains unresolved, we have found that using a binding arbitration process outside the normal civil court system has been beneficial to our patients and to our providers. Arbitration is encouraged by the United States and Pennsylvania governments as a way to resolve matters more quickly and less expensively for both sides. Lawsuits filed in the Philadelphia & Tri-State areas are expensive for both sides to litigate and take much longer to resolve than Arbitration. For this reason we ask our patients to review the attached Binding Arbitration Agreement and execute it for treatment by 3B Orthopaedics.

- Binding arbitration is a procedure which uses three trained individuals (arbitrators) to decide a dispute, rather than a jury of twelve citizens and follows the same laws as the court system. Each side chooses an attorney arbitrator, and then the two attorney arbitrators choose a neutral arbitrator to complete the panel. The neutral arbitrator would be an orthopaedic surgeon chosen by both attorney arbitrators.

- Please also note that even after you do sign the Agreement, you have 30 days to talk the matter over with family or others. If you choose to withdraw your agreement, you may do so. If that becomes the case, we will discuss further treatment options with you.

- 3B Orthopaedics is primarily an "elective" practice, meaning that the vast number of our patients choose to treat with us. We are aware you have other choices for orthopaedic care, and we sincerely hope you understand that our decision to employ binding arbitration is taken very seriously.

- If you have any questions regarding the Arbitration Agreement, please call our office at 1-888-ORTHO3B or (215)-829-2222, and ask to speak with the Practice Manager prior to your first visit.

Initial _____

BINDING ARBITRATION AGREEMENT

I, _____ (printed patient name) hereby agree that any future claim for medical malpractice against any physician or other employee of 3B Orthopaedics, P.C., or any dispute regarding the quality of medical treatment rendered by a 3B Orthopaedics, P.C. employee shall be resolved by binding arbitration as described in this Agreement.

I understand and agree that this Agreement to arbitrate shall also include all claims against any other medical providers which are related to my claims and disputes with any 3B Orthopaedics, P.C. employee and all claims involving the same injuries I claim were caused by any 3B Orthopaedics, P.C. employee. Further, if I bring suit against an entity that sues 3B Orthopaedics, PC, its agents, servants and/or employees, I agree that the lawsuit will be transferred to arbitration in accordance with this Agreement.

I have had a chance to review a handout entitled – "WHY WE USE A BINDING ARBITRATION AGREEMENT" which summarizes the arbitration process; and I freely and voluntarily choose arbitration as a means to resolve my dispute with 3B Orthopaedics and its employees. I understand that my treatment with 3B Orthopaedics is voluntary and that I have other options for care. However, I choose 3B for my care, and hereby agree to the provisions of this document.

I understand arbitration is a procedure by which a panel of three arbitrators will decide the facts and the law of my claim, rather than my claim being decided by a judge or jury. The arbitrators will be selected as follows: one arbitrator selected by each party ("party arbitrators"), and the third (neutral) arbitrator will be selected by the two party arbitrators. The Arbitration shall be held in Philadelphia County, Pennsylvania before two party arbitrators who are members of the Bar of Pennsylvania; and one neutral arbitrator who is an orthopaedic surgeon licensed to practice in Pennsylvania and is selected by the party arbitrators. If this venue is unavailable to the parties at the time of a dispute, this Agreement shall be flexible enough to allow the Court or the parties to appoint another venue.

The arbitration shall be held in accordance with the Pennsylvania Uniform Arbitration Act and in accordance with that Act, a court may enforce any award. I further acknowledge that the medical treatment being provided involves interstate commerce and that this Agreement is valid and enforceable under provisions of the Federal Arbitration Act. I further acknowledge that this agreement is supported by good consideration in the form of medical treatment provided to me, and also acknowledges that I intend to be legally bound by this Agreement.

I understand that this Agreement will be deemed to have been made and to be construed in accordance with the laws of the Commonwealth of Pennsylvania. This Agreement encompasses claims for any and all type of liability, including alleged claims for liability for negligent and careless acts by my medical providers. This Agreement also encompasses all claims for loss of consortium brought by my spouse or children. It is specifically agreed that the laws of the Commonwealth of Pennsylvania relating to the statute of limitations, statute of repose and certificate of merit applicable to medical malpractice actions shall govern this Arbitration process.

I understand that receipt of a request to arbitrate by 3B Orthopaedics, PC, its agents, servants and/or employees will serve to toll the statute of limitations and/or the statute of repose. The arbitrators shall hear and decide questions relating to arbitrability of the dispute and validity of this Arbitration Agreement.

I understand that I am entitled to a fair arbitration hearing but that arbitration procedures are often more limited than procedures in court. During the process, the parties may establish the particular rules for this Arbitration by agreement. I also understand that arbitration decisions are subject to limited review by a court and are enforceable as any court order.

As a requirement for asserting my claim, I agree to furnish to all providers involved in my claim with a written authorization permitting representatives of those providers to obtain my medical records of any treatment related to my injuries. As a further requirement for asserting my claim, I agree to be examined by medical, dental, psychological, and vocational examiners selected by the providers involved in my claims.

Each party to the arbitration will promptly provide, upon the written request of the other party, copies of documents legitimately relevant to the claims and defenses raised. Parties to the arbitration will also make themselves available for depositions of reasonable duration. At the request of any party to arbitration, the arbitrators shall have the discretion to order examination by deposition or any additional witnesses to the extent the arbitrators deem such discovery relevant and/or necessary. The arbitrators shall determine any dispute regarding discovery.

Except as may be required by law, neither party nor an arbitrator may disclose the existence, content, or results of any arbitration without the prior written consent of all parties to the arbitration. Each party shall bear its own costs regarding the arbitration, to include their own arbitrator fees. The neutral arbitrator's fees and any administrative fees of arbitration shall be borne equally by the parties, with all claimants assuming one-half of these costs and all respondents assuming one-half of these costs divided equally between them.

However, if I challenge the validity of this Agreement and the Agreement is upheld I specifically agree to pay all attorney fees and costs of any 3B Orthopaedics, P.C. employee, or any such employee's insurance carrier, which are incurred to defend the validity of application of this Arbitration Agreement, whether contested in arbitration or court.

I understand and agree that this Agreement is binding on me and on my minor or incompetent for whom I am guardian, as well as on all of my agents, representatives, administrators of my estate, heirs and assigns. If any provision of this Agreement is held to be invalid, illegal, unenforceable, or in conflict with the laws of the Commonwealth of Pennsylvania, the validity, legality and enforceability of the remaining provisions shall not be in any way affected or impaired.

Finally, I acknowledge that I may revoke or rescind this agreement within 30 days of signature, thereby allowing me the opportunity to discuss the matter further.

NOTICE: THIS AGREEMENT SHALL HAVE ANY CLAIM OF MEDICAL MALPRACTICE DECIDED BY A PANEL OF THREE ARBITRATORS.

I certify that I have read and fully understand this two-page Agreement. I will take the opportunity to discuss it with my doctor if I feel it is necessary. I also understand that I may discuss this document with an attorney, and execute this Agreement voluntarily and by my own free will by signing below. I will also initial the first page as further evidence of my review of this document.

Witness – Printed	Patient Name – Printed
Witness –Signature	Patient Signature
Date	Parent or Guardian – printed and signed

Patient Spine Problem **Date of Visit _____**

Please circle or fill in completely

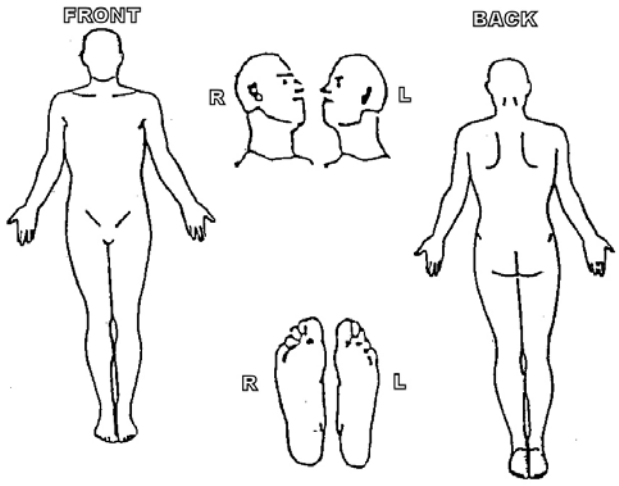
Name:			**Date of Birth:**		
Pain	Neck	Back	Arms	Legs	
Pain on which side	Left	Right	Both		
If all your pain = 100%, assign each area a percentage: Arm Leg Back Neck					
Worse when:	Standing	Sitting	Walking	All	
How far can you walk?					
Better when: Lying Down	Standing	Sitting	Walking	No Different	
What position gives least amount of pain?					
Pain aggravated by: Coughing	Sneezing	Straining	Bending forward	Bending backward	
How long have you had present pain?					
What do you think started your pain?					
Have you had the following:	***Body Part***	***Date***		***Body Part***	***Date***
Myelogram			MRI		
Discogram			CT Scan		
Plain X-Rays			EMG		
Is this a 2nd opinion?	Yes	No			

On diagram, please shade in the location of your pain.

Please CIRCLE the one most painful area:

Check all that describes your pain:

- ☐ Sharp
- ☐ Shooting
- ☐ Throbbing
- ☐ Stabbing
- ☐ Burning
- ☐ Aching
- ☐ Sickening
- ☐ Punishing



Place an "X" to indicate the level of your pain of the following:

Average level of pain you have every day

No Pain |_____| Worst Possible Pain

Level of pain you have now

No Pain |_____| Worst Possible Pain

Please turn over

List all surgeries with date & surgeon's names:

Previous hospitalizations:

List all medications Dose Times per day

Previous Treatments	Effective	Non-effective
Acupuncture		
Chiropractor		
Biofeedback		
Anti-inflammatories		
Injections		
Anti-depressants		
Sedatives/Narcotics		
Physical therapy		

List allergies:

List other medical conditions:

Family history of:
Rheumatoid arthritis Yes No Cancer Yes No
Heart disease Yes No Diabetes Yes No

Social History:

Do you drink alcohol?	Yes	No
If yes, # drinks per day		
Do you smoke cigarettes?	Yes	No
If yes, # packs per day		

Occupation:
If not employed, most recent occupation:
Disabled? Yes No
Any litigation in progress? Yes No

Date of Birth: Age:
Social Security #: Sex M F

Do you have significant problems with these other areas?

Weight loss	Yes	No	Blood in stool	Yes	No
Loss of appetite	Yes	No	Constipation/Diarrhea	Yes	No
Fever/Chills	Yes	No	Blood in urine	Yes	No
Double/Blurred vision	Yes	No	Abdominal pain	Yes	No
Ringing in ears	Yes	No	Change in bladder habits	Yes	No
Bloody nose/gums	Yes	No			
Sore throat	Yes	No	Rashes	Yes	No
Chest pain	Yes	No	Bruises	Yes	No
Palpitations	Yes	No	Headache	Yes	No
Shortness of breath	Yes	No	Dizziness	Yes	No
Cough	Yes	No	Blackouts	Yes	No
Speech	Yes	No	Numbness/tingling	Yes	No
Leg/Arm weakness	Yes	No	Seizures	Yes	No

Pain in other joints?

Past medical history includes:

High blood pressure	Yes	No	Cardiac disease	Yes	No
Peptic ulcer	Yes	No	Angina	Yes	No
Frequent infections	Yes	No	Thyroid	Yes	No
Bleeding problems	Yes	No	Diabetes	Yes	No
Stroke	Yes	No	Cancer	Yes	No
Anesthesia problems	Yes	No	Emphysema	Yes	No
Liver disease	Yes	No	Depression/anxiety	Yes	No

I acknowledge that the information provided related to my family and medical history is accurate and complete. If there are any changes to this information in the future, I will provide any such changes at my next scheduled visit.

Patient's signature/date:

NEW PATIENT MEDICATION LIST

Name:	DOB:

Source of medication list:	Drug Allergies/Describe Reaction:
☐ Patient wallet card ☐ Patient/ family recall ☐ Pharmacy_____ ☐ Primary care physician list ☐ Other_____	_____ _____ _____ _____ _____ _____

Have you had a flu shot?	☐	YES	If yes, when_____	☐	NO
Have you had a pneumonia vaccine?	☐	YES	If yes, when_____	☐	NO

CURRENT MEDICATION LIST

List below your current medications including over the counter and herbal medications.

NAME OF MEDICATION	DOSE	FREQUENCY	ROUTE

Medication Disclaimer: This list represents the medicines you are taking based on the information you have given us. If you have any questions or concerns about medicines we did not prescribe in this practice please contact that prescribing physician.

Reviewed:
Date:_____ By_____

_____
PATIENT SIGNATURE DATE

Physician / Allied Health Professional

5/09jbf

BOOTH
BARTOLOZZI
BALDERSTON
ORTHOPAEDICS

+

800 Spruce St
Phila., PA 19107
215-829-2222

Dear _____,

Please complete the enclosed questionnaire.

Your answers will allow us to better understand your pain and assist us in caring for you.

Please answer **every** question.

Thank you for your assistance.

PLEASE READ:

This questionnaire is designed to enable us to understand how much your low back has affected your ability to manage everyday activities. Please answer each Section by circling the **ONE CHOICE** that most applies to you. We realize that 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. The pain comes and goes and is very mild
B. The pain is mild and does not vary much.
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 and is severe.
F. The pain is severe and does not vary much.

Section 2 – Personal Care

A. I would not have to change my way of washing or dressing in order to avoid pain.
B. I do not normally change my way of washing or dressing even though it causes some pain.
C. Washing and dressing increase the pain, but I manage not to change my way of doing it.
D. Washing and dressing increase the pain and I find it necessary to change my way of doing it.
E. Because of the pain, I am unable to do any washing and dressing without help.
F. Because of the pain, I am unable to do any washing or dressing without help.

Section 3 – Lifting

A. I can lift heavy weights without extra pain.
B. I can lift heavy weights, but is causes extra pain.
C. Pain prevents me from lifting heavy weights off the floor.
D. Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned, e.g. on the table.
E. Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
F. I can only lift very light weights, at most.

Section 4 – Walking

A. Pain does not prevent me from walking any distance.
B. Pain prevents me from walking more than one 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 while using a cane or on crutches.
F. I am in bed most of the time and have to crawl to the toilet.

Section 5 – 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 m e from sitting more than one hour.
D. Pain prevents me from sitting more than ½ hour.
E. Pain prevents me from sitting more than ten (10) minutes.
F. Pain prevents me from sitting at all.

Section 6 – Standing

A. I can stand as long as I want without pain.
B. I have some pain while 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 more than ten (10) minutes without increasing pain.
F. I avoid standing because it increases the pain right away.

Section 7 – Sleeping

A. I get no pain in bed.
B. I get pain in bed, but it does not prevent me from sleeping.
C. Because of pain, my normal night's sleep is reduced by less than one-quarter.
D. Because of pain, my normal night's sleep is reduced by less than one-half.
E. Because of pain, my normal night's sleep is reduced by less than three-quarters.
F. Pain prevents me from sleeping at all.

Section 8 – 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 may more energetic interests, e.g., dancing, etc.
D. Pain has restricted my social life and I do not go our very often.
E. Pain has restricted my social life to my home.
F. I have hardly any social life because of the pain.

Section 9 – 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 prevents all forms of travel except when done lying down.

Section 10 – Changing Degree of Pain

A. My pain is rapidly getting 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.

_____ _____ _____

Patient Signature Date of Birth Date