Abhishiek Sharma, MD
Erik Curtis, MD

Atlas Neurosurgery & Spine

Personal information

Date: _____

Prefix: ___First name: _____ MI: _____ Last name: _____
Date of birth:_____ Age: _____ Social Security #: _____
Driver's license #: _____ Email: _____
Current mailing address: _____
City: _____ State: _____ ZIP code: _____
Home phone #: _____ Cellphone #: _____
Secondary address _____
City: _____ State: _____ ZIP code: _____
Sex: Male Female Prefer to self-describe or not to say _____
Marital status: Single Married Partnered Divorced Widowed
If you are married or otherwise partnered, what is the person's name?
_____

Race:	Black/African-American	American Indian	Asian
	White	Hispanic or Latino	Alaska Native
	Native Hawaiian/Pacific Islander	Decline to answer	Other _____

Emergency contact information

I authorize Atlas Neurosurgery and Spine Center to discuss my selected information with the following people:

Contact name 1: _____ Relationship: _____
Home phone #: _____ Cellphone #: _____
Street address: _____
City: _____ State: _____ ZIP code: _____

Contact name 2: _____ Relationship: _____
Home phone #: _____ Cellphone #: _____
Street address: _____
City: _____ State: _____ ZIP code: _____

Patient/guardian signature: _____

Printed name: _____ Date: _____

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Insurance

Primary insurance: _____ Insurance company's phone #: _____
Policyholder's name (as on card): _____ Policyholder's relationship: _____
Insurance claims address: _____
Policyholder's DOB: _____ Policyholder's SSN: _____
Member ID/policy #: _____ Group #: _____

Secondary insurance: _____ Insurance company's phone #: _____
Policyholder's name (as on card): _____ Policyholder's relationship: _____
Insurance claims address: _____
Policyholder's DOB: _____ Policyholder's SSN: _____
Member ID/policy #: _____ Group #: _____

Pharmacy information

Name: _____
Address: _____
Phone _____

Attorney information

If your condition is the result of an accident or other injury for which you are represented by an attorney, please provide the following information about your attorney:

Name: _____ Phone #: _____
Street address: _____
City: _____ State: _____ ZIP code: _____

Auto insurance

If your condition or injury is the result of an automobile accident, please provide the following:

Company name: _____ Claim #: _____
Phone #: _____ Date of accident: _____
Name of policyholder: _____ Relationship: _____
State accident occurred in: _____ Adjuster name: _____
Have auto benefits been exhausted? Yes No

Workers' compensation

Company name: _____ Claim #: _____
Phone #: _____ Date of accident: _____
Name of insurance adjuster:_____

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HISTORY

Chief complaint

What is your primary concern?

_____

_____

How long have you been bothered by your current symptoms?

_____

How did your symptoms begin? (For auto accident or workers' compensation, please complete the necessary section on page 2.)

_____

_____

Current problem began: ❒Suddenly ❒Gradually ❒Lifting ❒Twisting ❒Fall ❒Bending ❒Pulling

Do your symptoms interfere with your activities of daily living (self-care, meal prep, home maintenance)? ❒ Yes ❒ No If yes, please explain:

_____

Are you able to stand for long periods of time? ❒Yes ❒No

Are you able to sit for long periods of time? ❒Yes ❒No

Does your pain interfere with your daily job functions? ❒Yes ❒No If yes, please explain:

_____

_____

What makes your symptoms worse?

❒During Exercise	❒After Exercise	❒Prolonged Sitting	❒Prolonged Standing
❒Walking	❒Bending Forward	❒Bending Backward	❒Pushing
❒Pulling	❒Squatting	❒Night Pain	❒Other

What makes your symptoms better?

❒Nothing	❒Lying down	❒Sitting	❒Standing	❒Walking
❒Medication	❒Shifting/Changing positions		❒Other	

Have you been diagnosed previously with a spine condition such as spinal stenosis, arthritis, scoliosis, herniated disc or fracture? ❒Yes ❒No
If yes, please explain:

_____

What treatments have you had for this problem? (Check all that apply)

PHYSICAL THERAPY ❒Stretching ❒Strengthening ❒Traction
❒Iontophoresis/Topical Steroid ❒Massage
❒Ultrasound ❒Heat/Ice ❒Therapeutic Ball

MEDICATIONS ❒Muscle Relaxants ❒Pain Medication ❒Anti-Inflammatory
❒Anti-Inflammatory OTC ❒Chiropractic Care
❒Acupuncture ❒Injections ❒Other

What tests have you had for this problem?

❒X-ray ❒MRI ❒Discography ❒CT ❒EMG
❒CT/Myelogram ❒Bone Scan ❒Other

Physician information

Primary care physician: _____ Phone #: _____ Fax #: _____
Street address: _____
City: _____ State: _____ ZIP: _____

Specialist name: _____Type: _____ Phone #: _____ Fax #: _____

Medical History

DATE	SURGERY	SURGEON NAME	Complication (if present)

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Current or Past Medical Conditions

DATE	Diagnosis and/or Hospitalization

Allergies: Please list any allergies, medical or non-medical.

Allergen (medication/food/medical tape exc.)	Reaction

Medications: Please list any prescribed and over-the-counter medications you are taking.

Name	Dose (mg)	# of pills per day
1.		
2.		
3.		
4.		
5.		

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Social History

Age: _____Occupation: _____
Handedness: ❒Right-handed ❒Left-handed
Employment Status: ❒Full Time ❒Part-Time ❒Disabled ❒Retired ❒Not working
Education Level: ❒High School ❒College ❒Graduate Work
Exercise: ❒Daily ❒Weekly ❒Monthly ❒Rarely ❒Never
Children: ❒Yes ❒No How many?
Do you live alone? ❒Yes ❒No
Do you have stairs at your place of residence? ❒Yes ❒No
Do you smoke (including e-cigarettes)? ❒Yes ❒No _____ Packs per day for _____ years.
Do you use other forms of tobacco? ❒Yes ❒No
❒Chew ❒Gum ❒Patch ❒Cigars ❒Other
Do you drink alcohol? ❒Daily ❒1-2x/week ❒1-2x/monthly ❒1-2x/year ❒Never

Family History

Do you have a family history of any of the following:

Condition	If yes, please list relative
Cancer ❒Yes ❒No	
Heart disease ❒Yes ❒No	
Diabetes ❒Yes ❒No	
Neuromuscular disease ❒Yes ❒No	
Osteoporosis ❒Yes ❒No	
Stroke ❒Yes ❒No	
Brain tumor ❒Yes ❒No	

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REVIEW OF SYSTEMS: Please check any current symptoms you are having.

Constitutional
- ☐ Recent fevers/sweats
- ☐ Unexplained weight loss/gain
- ☐ Fatigue/weakness

Eyes
- ☐ Change in vision
- ☐ Drainage/crusting
- ☐ Pain/redness

Ears/Nose/Throat
- ☐ Change in hearing
- ☐ Hay fever/allergies
- ☐ Trouble swallowing

Cardiovascular
- ☐ Chest pain
- ☐ Palpitations
- ☐ Ankle swelling

Respiratory
- ☐ Cough/Wheeze
- ☐ Coughing up blood
- ☐ Shortness of breath

Gastrointestinal
- ☐ Heartburn/reflux
- ☐ Nausea/vomiting/diarrhea
- ☐ Blood in stool
- ☐ Pain in abdomen

Genito-urinary
- ☐ Pain/Blood with urinating
- ☐ Leaking/night urination
- ☐ Change in sexual function

Musculoskeletal
- ☐ Muscle/joint pain
- ☐ Swelling

Skin
- ☐ Rash
- ☐ Changing Mole

Neurological
- ☐ Headaches
- ☐ Numbness/tingling

Psychiatric
- ☐ Anxiety/stress
- ☐ Depression/suicide
- ☐ Problem sleeping
- ☐ ADHD
- ☐ Bipolar

Blood/lymphatics
- ☐ Unusual bruising/bleeding
- ☐ Pain/swelling

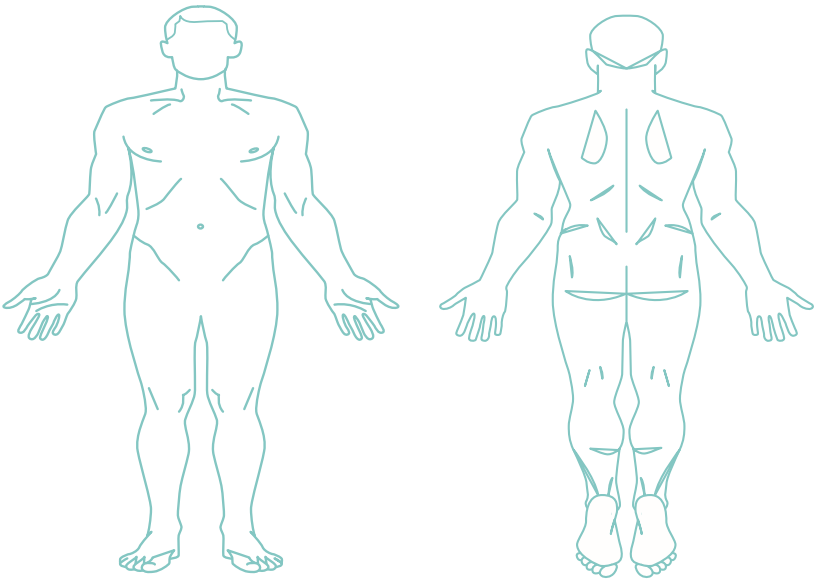
Other:_____

VISUAL ANALOG SCALE (VAS)

USE THE BODY DIAGRAM TO SHOW WHERE YOU FEEL THE FOLLOWING SENSATIONS

PAIN: Δ
NUMBNESS: O
BURNING: X
STABBING: /
PINS & NEEDLES: =

LEG PAIN	**%**
ARM PAIN	**%**
NECK PAIN	**%**
BACK PAIN	**%**
TOTAL	**100 %**



PLEASE PLACE AN X ON THE HASH MARK THAT MOST ACCURATELY DESCRIBES YOUR OVERALL DEGREE OF PAIN NOW.

None | Mild | Moderate | Severe | Very Severe | Worst Possible

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Erik Curtis, MD

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Authorization to Discuss, Release and/or Obtain Medical Information

Patient Name:_____ Date of Birth: _____ Email: _____
Address:_____Preferred Phone: _____

I hereby authorize Atlas Neurosurgery and Spine Center to call and/or leave messages on my home phone, cell phone and/or email. I understand that each of these communications are NOT considered completely secure since someone else could access the information.

- I hereby authorize Atlas Neurosurgery and Spine Center to discuss my medical care with the following individuals (i.e. relatives/caregiver):

Name: _____Relationship:_____
Name: _____Relationship:_____

- I hereby authorize Atlas Neurosurgery and Spine Center to contact the following individual in case of an emergency:

Name: _____ Relationship:_____ Contact Number: (___)____-_____

- I hereby authorize Atlas Neurosurgery and Spine Center to RELEASE copies of the following medical records: ❒all my medical records ❒other records: _____

Release my medical records to this Individual/Institution/Physician: _____
Relationship: _____ Phone: (___)___-_____ Fax: (___)____-_____
Address: _____ City: _____ ST:_____ ZIP: _____

- I hereby authorize Atlas Neurosurgery and Spine Center to OBTAIN copies of the following medical records: ❒all my medical records ❒other records: _____

Obtain my medical records from this Individual/Institution/Physician: _____
Relationship: _____ Phone: (___)___-_____ Fax: (___)____-_____
Address: _____ City: _____ ST:_____ ZIP: _____

I authorize Atlas Neurosurgery and Spine Center to send/receive confidential information as the term is defined by HIPAA (Health Insurance Portability and Accountability Act of 1996) to healthcare providers, hospitals, laboratories, and other medical caregivers in the necessary coordination of care and as authorized above. "The covered entity may not condition treatment, payment, enrollment, or eligibility for benefits on whether the individual signs the authorization when the prohibition on conditioning or authorizations in paragraph (b)(4) of [45 C.F.R. § 164.508] applies." 45 C.F.R. § 164.508(c)(2)(ii)(A). I understand a potential for information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer protected by the Privacy Rule. 45 C.F.R. § 164.508(c)(2)(iii). I may revoke this authorization in writing, except to the extent that we have already used/ disclosed your information. When your medical information is used/disclosed pursuant to this authorization it may be subject to re-disclosure by a person who received your information. This re-disclosure may not be protected by the applicable privacy laws. You have the right to submit a written request to inspect and copy your medical records. In certain limited circumstances this request may be denied. By signing below, I hereby release Atlas Neurosurgery and Spine Center from all legal responsibility/liability that may arise from the act I have authorized above.

_____ _____ _____
Name of Patient/Legal Representative Signature Date

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Erik Curtis, MD

Pain Management Agreement

Patient Name:_____ Date of Birth: _____

Atlas Neurosurgery and Spine Center and I understand that the primary goal of care is to improve my neurological function and/or prevent further deterioration. Therefore, I agree to practice habits to improve my Neurological and spine health including but not limited to smoking cessation, maintaining a healthy body weight and exercise. I understand and acknowledge that Atlas Neurosurgery and Spine Center is not a pain management clinic and is is not responsible for treating my pain. However, pain medications i.e. narcotics, barbiturates, muscle relaxants, etc are prescribed for post-operative pain control for a period of up to 4 weeks post-operatively in accordance with the following:

- Opioids are used to treat acute and chronic pain with a goal to improve one's quality of life. The goal should be to not take the medication at all, or to stop taking it after no more than three days. One the pain is tolerable and you no longer need the opioid, you should dispose of them in a secure location as found on the AZ Department of Health Services safe. It should be understood that sharing or selling left over opioids is against the law. You should not operate a motor vehicle or heavy machinery while taking these medications. Instead of opioids, other over the counter agents such as acetaminophen or ibuprofen as advised by me physician could be used to control pain.
- A prescription for a controlled substance may not be provided if another active prescription is identified in AZPMP.
- Chronic pain patients will discuss their post-operative pain regimen with their primary pain management physician to avoid multiple prescriptions for controlled substances. They will obtain a regimen for post-operative pain control from their primary pain physician.
- I agree not to request, accept or solicit a prescription for a controlled substance while an active prescription exists from a healthcare practitioner at Atlas Neurosurgery and Spine Center.
- I understand that a refill of controlled prescriptions may be requested through clinic during hours of 8am to 5pm during a routine weekday in the immediate post-operative period only. The prescription will be provided electronically to the pharmacy on file in 72 hours' time.
- I understand that a violation of any of the above conditions may result in an immediate termination of the controlled substances prescription and potential treatment with Atlas Neurosurgery and Spine Center.

- I also give Atlas Neurosurgery and Spine Center permission to obtain a list of medications and controlled substances that I am currently taking.
- By signing this, I understand the potential for significant side effects or risks including but not limited to withdrawal symptoms of severe pain, abdominal cramps, muscle aches, joint aches, nausea, diarrhea, sweating, headaches, restlessness, irritability, discontent and cravings for more opioids. In addition, tolerance is state of adaptation in which using a drug routinely may lead to a reduction in ability to control pain over time and need for higher doses to deliver same pain control. Furthermore, addiction can occur in 5-10% of patients taking pain medications, even if they have never previously experienced an addictive disorder. Lastly, drinking alcohol and/or combining opioids with other medications (including but not limited to sedatives such as benzodiazepines, sleeping aides such as Ambien or Lunesta, and certain other psychiatric medications) increase the likelihood of death by overdose markedly.
- Other side effects include constipation, sedation, slowed or cessation of breathing, impaired judgment, impaired ability to drive, decreased libido and function. Taking opioid medications while pregnant (or if one becomes pregnant while taking opioids) may lead to a condition known as neonatal abstinence syndrome, where the newborn is dependent on opioids and go through life threatening withdrawal upon birth.

_____	_____	_____
Name of Patient/Legal Representative	Signature	Date

Abhishiek Sharma, MD
Erik Curtis, MD

Atlas Neurosurgery & Spine

Financial Policy

Atlas Neurosurgery and Spine Center is committed to serving our patients with professionalism and care. Your responsibility is to provide us with accurate and complete information concerning your primary and secondary insurance medical benefits, including referral documents from other providers. Current identification and insurance benefit cards are to be presented at each office visit. As a courtesy, Atlas Neurosurgery and Spine Center will file your insurance claim for you. If you are a Medicare patient, we will bill Medicare and your secondary insurance for you. For services performed outside of our clinic, i.e. radiology, laboratory, referrals, surgery centers, physical therapy, hospitals and rehabilitation centers, please consult your insurance prior to scheduling.

Please read, initial each blank and sign where indicated – this document describes your financial responsibilities. This is a legally binding contract between Atlas Neurosurgery and Spine Center and you. The words, I, me, my, you and your refer to the patient.

_____ (initial) I agree to be financially responsible for payment of Atlas Neurosurgery and Spine Center services. Cash, check or credit cards are acceptable forms of payment for these services.

_____ (initial) Current insurance cards must be presented at every office visit. Atlas Neurosurgery and Spine Center is not responsible for filing your insurance claim, but we will do so as a courtesy. Upon payment from my insurance carrier, I agree to pay the remaining balance immediately.

_____ (initial) I agree to give Atlas Neurosurgery and Spine Center my complete and accurate insurance information for primary and secondary insurance benefits including referral documents from other providers, if needed. I understand that a failure to provide complete and accurate information about my insurance benefits may result in a denial of my claim or a delay in payment. I agree to pay the balance on my account after my insurance claim has been processed.

_____ (initial) I agree that if my insurance benefit requires me to provide a referral and if the referral is not in place before my appointment, that I will have to pay the estimated charges for my office visit in advance.

_____ (initial) I understand that I will be responsible for any missed appointments or any cancelled appointments where a 48-hour notice was not provided. There will be a fee of $50 for any missed office visits and $250 for any missed surgical procedures.

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_____ (initial) I understand that all services provided to me by Atlas Neurosurgery and Spine Center are considered medically necessary. If I fail to have a procedure performed or do not comply with my provider's instructions, it may be against medical advice and may void my insurance benefits. Should this occur, I agree to pay the balance remaining on my account after my insurance payment has been processed.

_____ (initial) I understand that my insurance may or may not agree to the usual, customary or reasonable charges for my local area. I understand that my benefits may not cover all services or might deny payment for services that have been approved in advance. In such a scenario, I agree to pay the balance remaining on my account.

_____ (initial) If I have a high deductible policy or do not currently have insurance benefits, I agree to pay an estimate of charges for my office visit in advance and understand that other charges may apply.

_____ (initial) Atlas Neurosurgery and Spine Center will receive payment from my insurance company for covered services provided by my insurance benefits. I agree to pay co-payments and deductibles at the time of service. If co-payments are not made at the time of service, I understand that my appointment may be rescheduled.

_____ (initial) I understand and agree that if my account becomes delinquent, it may be forwarded to an outside collection agency without notice. If this happens, I will be responsible for all costs of collection, including but not limited to interest, rebilling fees, court costs, attorney fees, and collection agency costs.

I have read and understand these financial policies and I accept responsibility for the payment of any fees associated with my care.

_____ _____

Patient Signature Date

Abhishiek Sharma, MD
Erik Curtis, MD

Atlas Neurosurgery & Spine

ASSIGNMENT OF BENEFITS

I hereby authorize direct payment of medical benefits, including medical benefits to which I am entitled to Atlas Neurosurgery and Spine Center. This is a DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS. This authorization will remain in effect until cancelled by me in writing. A copy of this authorization is as valid as the original document.

I authorize the release of any medical information necessary in order to obtain payment. I understand that I am financially responsible for all charges, late fees, interest, attorney fees and collection charges incurred during the process of settling my account. I understand that I am solely responsible for all charges during a lapse in insurance or lack thereof. I authorize Atlas Neurosurgery and Spine Center to deposit checks received on my account when made out in my name.

I have read and I understand these financial policies and I accept responsibility for the payment of any fees associated with my care.

_____ _____

Patient Signature Date

_____ _____

Witness Signature Date

Abhishiek Sharma, MD
Erik Curtis, MD

Atlas Neurosurgery & Spine

Out-of-Network Disclosure

Patient Name:_____ Date of Birth: _____ Email: _____
Address:_____Preferred Phone: _____

Doctors who are not contracted with a patient's health plan are referred to as out-of-network providers. Atlas Neurosurgery and Spine cannot ensure that the providers who treat you during your visit will have a contract with your health plan. Insurance plans place the burden on you, the member, to ensure that you are receiving services from a provider that has a contract with your health plan. If a provider is not contracted with your health plan (i.e. is not an in-network provider), you may receive an additional written notification from that provider.

By signing this document, I and the patient for whom I am signing understand that certain services provided may be billed out-of-network. If it is important to you, you should ask about the network status for your provider prior to your appointment.

All services at Atlas Neurosurgery and Spine are provided to you with the understanding that you are responsible for services rendered and applicable cost-sharing according to your insurance coverage.

I and the patient for whom I am signing understand and agree that all my questions have been answered to my satisfaction regarding this Out-of-Network Disclosure.

Patient Signature _____ Date _____

Witness Signature _____Date _____

Relationship to patient _____

8402 E. Shea Blvd, Suite 100, Scottsdale, AZ 85260
Phone: (602) 975-0123 Fax: (623) 900-7937 www.AtlasNeurosurgery.com

Atlas
Neurosurgery & Spine

Abhishiek Sharma, MD
Erik Curtis, MD

Consent for Text, Voice and Email Reminders

Patients in our practice may be contacted via email and/or text messaging to remind you of an appointment, to obtain feedback on your experience with our healthcare team, and to provide general health reminders/information. If at any time I provide an email or text address at which I may be contacted, I consent to receiving appointment reminders and other healthcare communications/information at that email or text address from the Practice.

_____ (Patient initials) I consent to receive text messages from the practice on my cell phone and any number forwarded or transferred to that number or emails to receive communication as stated above. I understand that this request to receive emails and text messages will apply to all future appointment reminders/feedback/health information unless I request a change in writing. I authorize to receive text messages for appointment reminders, feedback, and general health reminders/information to the following Cell Phone number:

Cell Phone Number:	( ) -

I authorize to receive email/text messages for appointment reminders and general health reminders/feedback/ information in the Patient Portal to the following Email Address:
_____

Signature	
Printed Name	
Date	

The practice does not charge for this service, but standard text messaging rates may apply as provided in your wireless plan (contact your carrier for pricing plans and details.

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NOTICE TO PATIENTS

A physician must notify a patient that the physician has a direct interest in the non-routine goods or services being prescribed by the physician, and whether these are available elsewhere on a competitive basis. A.R.S. §32-1401(27)(ff). We support this law because it helps patients make reasoned financial decisions concerning their medical care. In compliance with the requirements of this law, you are being advised we have a direct interest in the diagnostic or treatment agency or in the non-routine goods or services named below:

Dr. Sharma has medical consulting agreements with Medtronic, A-tec and Johnson & Johnson. He also has a direct financial interest with Banner Health and Scottsdale Healthcare Hospitals D/B/A HonorHealth whereby the hospital shares with the physicians a portion of the savings attributed to quality enhancement and cost savings arrangement. These arrangements include spine implants, biologics and spine ancillary products.

Dr. Curtis has a direct financial interest with Banner Health and Scottsdale Healthcare Hospitals D/B/A HonorHealth whereby the hospital shares with the physicians a portion of the savings attributed to quality enhancement and cost savings. These arrangements include spine implants, biologics and spine ancillary products.

Multiple other health care companies offer the same equipment that may accomplish the goals of the equipment provided by the above health care companies listed. You are encouraged to ask any of our physicians their reasons for choosing instruments from the above listed companies, or any other instrument, in your treatment. The law provides for the acknowledgement of your having read and understood these disclosures by dating and signing this form in the spaces provided below. We will keep the signed original in your patient file and you may request a copy.

I hereby give my consent for photography, filming, videotaping and/or audio recording or other means of capturing my image, radiographic or otherwise, or voice and/or being quoted in the media or printed materials (including social media websites) at Atlas Neurosurgery and Spine Center. I hereby waive any right to compensation for such uses by reason of the foregoing authorization. I and my successors or assigns hereby hold Atlas Neurosurgery and Spine Center and its personnel and affiliated programs harmless from any and all liability which may or could arise from activities authorized by this agreement. I may request cessation of such use or rescind this Authorization up until a reasonable time before use, but I must do so in writing. I have a right to receive a copy of this Authorization.

_____ _____

Patient Signature Date

Atlas Neurosurgery & Spine

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Erik Curtis, MD

Oswestry Disability Index

section 1 - pain intensity
- ❑ I can tolerate the pain I have without having to use pain killers
- ❑ the pain is bad but I manage without taking pain killers
- ❑ pain killers give complete relief from pain
- ❑ pain killers give moderate relief from pain
- ❑ pain killers give very little relief from pain
- ❑ pain killers have no effect on the pain and I do not use them

section 2 - personal care (washing, dressing, etc)
- ❑ I can look after myself normally without causing extra pain
- ❑ I can look after myself normally but it causes extra pain
- ❑ it is painful to look after myself and I am slow and careful
- ❑ I need some help but manage most of my personal care
- ❑ I need help every day in most aspects of self care
- ❑ I do not get dressed, wash with difficulty and stay in bed

section 3 - lifting
- ❑ I can lift heavy weights without extra pain
- ❑ I can lift heavy weights but it gives extra pain
- ❑ pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned, eg on a table
- ❑ pain prevents me from lifting heavy weights but I can manage light to medium weights if they are conveniently positioned
- ❑ I can lift only very light weights
- ❑ I cannot lift or carry anything at all

section 4 - walking
- ❑ pain does not prevent me walking any distance
- ❑ pain prevents me walking more than 1 mile
- ❑ pain prevents me walking more than 1/2 mile
- ❑ pain prevents me walking more than 1/4 mile
- ❑ I can only walk using a stick or crutches
- ❑ I am in bed most of the time and have to crawl to the toilet

section 5 - sitting
- ❑ I can sit in any chair as long as i like
- ❑ I can only sit in my favorite chair as long as i like
- ❑ pain prevents me from sitting more than 1 hour
- ❑ pain prevents me from sitting more than 1/2 hour
- ❑ pain prevents me from sitting more than 10 minutes
- ❑ pain prevents me from sitting at all

section 6 - standing
- ❑ I can stand as long as I want without extra pain
- ❑ I can stand as long as I want but it gives me extra pain
- ❑ pain prevents me from standing for more than 1 hour
- ❑ pain prevents me from standing for more than 1/2 hour
- ❑ pain prevents me from standing for more than 10 minutes
- ❑ pain prevents me from standing at all

section 7 - sleeping
- ❑ pain does not prevent me from sleeping well
- ❑ I can sleep well only by using tablets
- ❑ even when I take tablets I have less than six hours sleep
- ❑ even when I take tablets I have less than four hours sleep
- ❑ even when I take tablets I have less than two hours sleep
- ❑ pain prevents me from sleeping at all

section 8 - sex life
- ❑ my sex life is normal and causes no extra pain
- ❑ my sex life is normal but causes some extra pain
- ❑ my sex life is nearly normal but is very painful
- ❑ my sex life is severely restricted by pain
- ❑ my sex life is nearly absent because of pain
- ❑ pain prevents any sex life at all

section 9 - social life
- ❑ my social life is normal and gives me no extra pain
- ❑ my social life is normal but increases the degree of pain
- ❑ pain has no significant effect on my social life apart from limiting my more energetic interests, eg dancing etc
- ❑ pain has restricted social life and I do not go out as often
- ❑ pain has restricted my social life to my home
- ❑ I have no social life because of pain

section 10 - travelling
- ❑ I can travel anywhere without extra pain
- ❑ I can travel anywhere but it gives me extra pain
- ❑ pain is bad but I manage journeys over two hours
- ❑ pain restricts me to journeys of less than one hour
- ❑ pain restricts me to short necessary journeys of less than 1/2 hour
- ❑ pain prevents me from travelling except to the doctor or hospital