WORKERS' COMPENSATION BOARD

Limited Release of Health Information (HIPAA)

State of New York - Workers' Compensation Board

C-3.3

WCB Case No. *(if you know it)*: _____

To Claimant: If you received treatment for a *previous* injury to the same body part or for an illness similar to the one described in your current Claim, fill out this form. This form allows the health care providers you list below to release health care information about your previous injury/illness to your employer's workers' compensation insurer. The federal HIPAA law (Health Insurance Portability and Accountability Act of 1996) says you have a right to get a copy of this form. If you do not understand this form, talk to your legal representative. If you do not have a legal representative, the Advocate for Injured Workers at the Workers' Compensation Board can help you. Call: 800-580-6665.

To Health Care Provider: A copy of this HIPAA-compliant release allows you to disclose health information. If you send records to the employer's workers' compensation insurer in response to this release, also mail copies to the Claimant's legal representative. (If no legal representative is listed below, send copies to the Claimant.) Health care providers who release records must follow New York state law and HIPAA.

This release is:

- **Voluntary.** Your health care provider(s) must give you the same care, payment terms, and benefits, whether you sign this form or not.
- **Limited.** It gives your health care provider(s) permission to release only those health records that are related to the previous illness/condition you describe below.
- **Temporary.** It ends when your current claim for compensation is established or disallowed and all appeals are exhausted.
- **Revocable.** You can cancel this release at any time. To cancel, send a letter to the health care provider(s) listed on this form. Also, send a copy of your letter to your employer's workers' compensation insurer and the Workers' Compensation Board. *Note: You may not cancel this release with respect to medical records already provided.*
- **For records only.** It gives your health care provider(s) listed on this form permission to send copies of your health care records to your employer's workers' compensation insurer.

This form does NOT allow your health care provider(s) to release the following types of information:

- **HIV-related information**
- **Psychotherapy notes**
- **Alcohol/Drug treatment**
- **Mental Health treatment** (unless you check below)
- **Verbal information** (your health care providers may not discuss your health care information with anyone)

Any medical records released will become part of your workers' compensation file and are confidential under the Workers' Compensation Law.

A. YOUR INFORMATION (Claimant)

1. Name: _____ 2. Social Security Number: ___-___-___
3. Mailing Address: _____
4. Date of Birth: ___/___/___ 5. Date of the current injury/illness: ___/___/___
6. Current injury/illness, including all body parts injured: _____
7. Your legal representative's name and address (if any): _____

☐ *Check here if you allow your health care provider(s) to release mental health care information.*

B. YOUR HEALTH CARE PROVIDER(S)

(List all health care providers who treated you for a *previous* injury to the same body part or similar illness. If more than 2 providers attach their contact information to this form.)

1. Provider: _____ 2. Phone Number: (___) _____
3. Mailing Address: _____
4. Other provider (if any): _____ 5. Phone Number: (___) _____
6. Mailing Address: _____

C. READ AND SIGN BELOW.

I hereby request that the health care provider(s) listed above give my employer's workers' compensation insurer copies of all health records related to any previous injury/illness, to all body parts, described above.

_____
Claimant's signature (ink only – use blue ballpoint pen, if possible.) Date

If the claimant is unable to sign, the person signing on his/her behalf must fill out and sign below:

_____
Your name Relationship to Claimant Signature (ink only – use blue ballpoint pen, if possible.) Date

Versión en español al reverso de la forma.

WORKERS' COMPENSATION BOARD

Employee Claim

State of New York - Workers' Compensation Board

C-3

Fill out this form to apply for workers' compensation benefits because of a work injury or work-related illness. Type or print neatly. This form may also be filled out on-line at www.wcb.ny.gov.

WCB Case Number (if you know it): _____

A. YOUR INFORMATION (Employee)

1. Name: _____ (First / MI / Last) 2. Date of Birth: ____/____/____

3. Mailing address: _____ (Number and Street/PO Box / City / State / Zip Code)

4. Social Security Number: ___-___-____ 5. Phone Number: (____)_____ 6. Gender: ☐ Male ☐ Female

7. Will you need a translator if you have to attend a Board hearing? ☐ Yes ☐ No If yes, for what language? _____

B. YOUR EMPLOYER(S)

1. Employer when injured: _____ 2. Phone Number: (____)_____

3. Your work address: _____ (Number and Street / City / State / Zip Code)

4. Date you were hired: ____/____/____ 5. Your supervisor's name: _____

6. List names/addresses of any other employer(s) at the time of your injury/illness: _____

7. Did you lose time from work at the other employment(s) as a result of your injury/illness? ☐ Yes ☐ No

C. YOUR JOB on the date of the injury or illness

1. What was your job title or description? _____

2. What types of activities did you normally perform at work? _____

3. Was your job? (check one) ☐ Full Time ☐ Part Time ☐ Seasonal ☐ Volunteer ☐ Other: _____

4. What was your gross pay (before taxes) per pay period? _____ 5. How often were you paid? _____

6. Did you receive lodging or tips in addition to your pay? ☐ Yes ☐ No If yes, describe: _____

D. YOUR INJURY OR ILLNESS

1. Date of injury or date of onset of illness: ____/____/____ 2. Time of injury: _____ ☐ AM ☐ PM

3. Where did the injury/illness happen? (e.g., 1 Main Street, Pottersville, at the front door) _____

4. Was this your usual work location? ☐ Yes ☐ No If no, why were you at this location? _____

5. What were you doing when you were injured or became ill? (e.g., unloading a truck, typing a report) _____

6. How did the injury/illness happen? (e.g., I tripped over a pipe and fell on the floor) _____

7. Explain fully the nature of your injury/illness; list body parts affected (e.g., twisted left ankle and cut to forehead): _____

YOUR NAME: _____ DATE OF INJURY/ILLNESS: ____/____/____
First MI Last

D. YOUR INJURY OR ILLNESS *continued*

8. Was an object (e.g., forklift, hammer, acid) involved in the injury/illness? ☐ Yes ☐ No If yes, what? _____

9. Was the injury the result of the use or operation of a licensed motor vehicle? ☐ Yes ☐ No
If yes, ☐ your vehicle ☐ employer's vehicle ☐ other vehicle License plate number (if known): _____
If your vehicle was involved, give name and address of your motor vehicle insurance carrier: _____

10. Have you given your employer (or supervisor) notice of injury/illness? ☐ Yes ☐ No
If yes, notice was given to: _____ ☐ orally ☐ in writing Date notice given: ____/____/____

11. Did anyone see your injury happen? ☐ Yes ☐ No ☐ Unknown If yes, list names: _____

E. RETURN TO WORK

1. Did you stop work because of your injury/illness? ☐ Yes, on what date? ____/____/____ ☐ No, skip to Section F.
2. Have you returned to work? ☐ Yes ☐ No If yes, on what date? ____/____/____ ☐ regular duty ☐ limited duty
3. If you have returned to work, who are you working for now? ☐ Same employer ☐ New employer ☐ Self employed
4. What is your gross pay (before taxes) per pay period? _____ How often are you paid? _____

F. MEDICAL TREATMENT FOR THIS INJURY OR ILLNESS

1. What was the date of your first treatment? ____/____/____ ☐ None received (skip to question F-5)
2. Were you treated on site? ☐ Yes ☐ No
3. Where did you receive your first off site medical treatment for your injury/illness? ☐ none received ☐ Emergency Room
☐ Doctor's office ☐ Clinic/Hospital/Urgent Care ☐ Hospital Stay over 24 hours
Name and address where you were first treated: _____
_____ Phone Number: (____)_____
4. Are you still being treated for this injury/illness? ☐ Yes ☐ No
Give the name and address of the doctor(s) treating you for this injury/illness: _____
_____ Phone Number: (____)_____
5. Do you remember having another injury to the same body part or a similar illness? ☐ Yes ☐ No
If yes, were you treated by a doctor? ☐ Yes ☐ No If yes, provide the names and addresses of the doctor(s) who treated you and **COMPLETE AND FILE FORM C-3.3 TOGETHER WITH THIS FORM:**
_____
_____
_____
6. Was the previous injury/illness work related? ☐ Yes ☐ No
If yes, were you working for the same employer that you work for now? ☐ Yes ☐ No

I am hereby making a claim for benefits under the Workers' Compensation Law. My signature affirms that the information I am providing is true and accurate to the best of my knowledge and belief.

Any person who knowingly and with INTENT TO DEFRAUD presents, causes to be presented, or prepares with knowledge or belief that it will be presented to, or by an insurer, or self-insurer, any information containing any FALSE MATERIAL STATEMENT or conceals any material fact, SHALL BE GUILTY OF A CRIME and subject to substantial FINES AND IMPRISONMENT.

Employee's Signature: _____ Print Name: _____ Date: ____/____/____

On behalf of Employee: _____ Print Name: _____ Date: ____/____/____

An individual may sign on behalf of the employee only if he or she is legally authorized to do so and the employee is a minor, mentally incompetent or incapacitated.

I certify to the best of my knowledge, information and belief, formed after an inquiry reasonable under the circumstances, that the allegations and other factual matters asserted above have evidentiary support, or are likely to have evidentiary support after a reasonable opportunity for further investigations or discovery.

Signature of Attorney/Representative (if any): _____ Date: ____/____/____

Print Name: _____ Title: _____

ID No., if any: R _____ If Licensed Representative, License No.: _____ Expiration Date: ____/____/____

Please Complete all Highlighted Sections

CHIROPRACTIC REGISTRATION & HISTORY

Patient Information

Date: _____

SS/HIC/Patient ID # _____

Patient First Name: _____

Patient Middle Initial: _____

Patient Last Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Email: _____

Sex: ☐ Male ☐ Female Age: _____

Birthdate: _____

MARITAL STATUS ☐ Married ☐ Widowed ☐ Signle ☐ Minor

☐ Separated ☐ Divorced ☐ Partnered for _____ Years

Occupation: _____

Patient Employer/School: _____

Employer/School Address: _____

_____

Employer/School Phone: _____

Spouse's Name: _____

Birthdate: _____ SS# _____

Spouse's Employer: _____

Whom may we thank for referring you? _____

Insurance

Who is responsible for this account? _____

Relationship to Patient: _____

Insurance Co.: _____

ID# _____

Is patient covered by additional insurance? ☐ Yes ☐ No

Subscriber's Name: _____

Birthdate: _____ SS# _____

Relationship to Patient: _____

Insurance Co.: _____

Group # _____

ASSIGNMENT AND RELEASE

I certify that I, and/or my dependent(s), have insurance coverage with

_____ (Name of Insurance Company(ies))

and assign directly to Dr. Bicecki

all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named doctor may use my health care information and may disclose such information to the above-named Insurance Companylies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

_____

Signature of Patient, Parent, Guardian or Personal Representative

_____

Please print name of Patient, Parent, Guardian or Personal Representative

_____ _____

Date Relationship to Patient

Phone Numbers

Home Phone: _____ Cell Phone: _____

Best time and place to reach you: _____

IN CASE OF EMERGENCY, CONTACT

Name: _____ Relationship: _____

Home Phone: _____ Work Phone: _____

Accident Information

Is condition due to an accident? ☐ Yes ☐ No Date: _____

Type of accident: ☐ Auto ☐ Work ☐ Home ☐ Other: _____

To whom have you made a report of your accident? ☐ Auto Insurance

☐ Employer ☐ Worker Comp. ☐ Other: _____

Attorney Name (if applicable): _____

Patient Condition

Reason for Visit: _____

When did your symptoms appear? _____

Is this condition getting progressively worse? ☐ Yes ☐ No ☐ Unknown

Mark an X on the picture where you continue to have pain, numbness, or tingling.

Rate the severity of your pain on a scale from I (least pain) to 10 (severe pain) _____

Type of pain: ☐ Sharp ☐ Dull ☐ Throbbing ☐ Numbness ☐ Aching ☐ Shooting

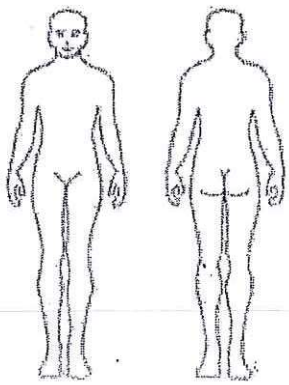
☐ Burning ☐ Tingling ☐ Cramps ☐ Stiffness ☐ Swelling ☐ Other: _____

How often do you have this pain? _____

Is it constant or does it come and go? _____

Does It interfere with your ☐ Work ☐ Sleep ☐ Daily Routine ☐ Recreation

Activities or movements that are painful to perform: ☐ Sitting ☐ Standing ☐ Walking ☐ Bending ☐ Lying Down



Health History

What treatment have you already received for your condition? ☐ Medications ☐ Surgery ☐ Physical Therapy ☐ Chiropractic Services ☐ None

☐ Other: _____

Name and address of other doctor(s) who have treated you for your condition: _____

Date of Last: Physical Exam: _____ Spinal X-Ray: _____ Blood Test : _____

Spinal Exam: _____ Chest X-Ray: _____ Urine Test: _____

Dental X-Ray: _____ MRI, CT-Scan, Bone Scan: _____

Place a mark on Yes" or "No" to indicate if you have had any of the following:

	Y	N		Y	N		Y	N		Y	N
AIDS/HIV	○	○	Diabetes	○	○	Liver Disease	○	○	Rheumatoid Arthritis	○	○
Alcoholism	○	○	Emphysema	○	○	Measles	○	○	Rheumatic Fever	○	○
Allergy Shots	○	○	Epilepsy	○	○	Migraine Headaches	○	○	Scarlet Fever	○	○
Anemia	○	○	Fractures	○	○	Miscarriage	○	○	Sexually Transmitted Disease	○	○
Anorexia	○	○	Glaucoma	○	○	Mononucleosis	○	○	Stroke	○	○
Appendicitis	○	○	Goiter	○	○	Multiple Sclerosis	○	○	Suicide Attempt	○	○
Arthritis	○	○	Gonorrhea	○	○	Mumps	○	○	Thyroid Problems	○	○
Asthma	○	○	Gout	○	○	Osteoporosis	○	○	Tonsillitis	○	○
Bleeding Disorders	○	○	Heart Disease	○	○	Pacemaker	○	○	Tuberculosis	○	○
Breast Lump	○	○	Hepatitis	○	○	Parkinson's Disease	○	○	Tumors, Growths	○	○
Bronchitis	○	○	Hernia	○	○	Pinched Nerve	○	○	Typhoid Fever	○	○
Bulimia	○	○	Herniated Disk	○	○	Pneumonia	○	○	Ulcers	○	○
Cancer	○	○	Herpes	○	○	Polio	○	○	Vaginal Infections	○	○
Cataracts	○	○	High Blood Pressure	○	○	Prostate Problem	○	○	Whooping Cough	○	○
Chemical Dependency	○	○	High Cholesterol	○	○	Prosthesis	○	○	Other: _____	○	○
Chicken Pox	○	○	Kidney Disease	○	○	Psychiatric Care	○	○	Other: _____	○	○

EXERCISE
- ☐ None
- ☐ Moderate
- ☐ Daily
- ☐ Heavy

WORK ACTIVITY
- ☐ Sitting
- ☐ Standing
- ☐ Light Labor
- ☐ Heavy Labor

HABITS
- ☐ Smoking — Packs/Day: _____
- ☐ Alcohol — Drinks/Week: _____
- ☐ Coffee/Caffeine Drinks — Cups/Day: _____
- ☐ High Stress Level — Reason: _____

Are you pregnant? ☐ Yes ☐ No

Injuries/Surgeries you have had	Description	Date
Falls		
Head Injuries		
Broken Bones		
Dislocations		
Surgeries		

Medications	Allergies	Vitamins/Herbs/Minerals
Pharmacy Name:		
Pharmacy Phone:		

Informed Consent to Care

You are the decision maker for your health care. Part of our role is to provide you with information to assist you in making informed choices. This process is often referred to as "informed consent" and involves your understanding and agreement regarding the care we recommend, the benefits and risks associated with the care, alternatives, and the potential effect on your health if you choose not to receive the care.

We may conduct some diagnostic or examination procedures if indicated. Any examinations or tests conducted will be carefully performed but may be uncomfortable.

Chiropractic care centrally involves what is known as a chiropractic adjustment. There may be additional supportive procedures or recommendations as well. When providing an adjustment, we use our hands or an instrument to reposition anatomical structures, such as vertebrae. Potential benefits of an adjustment include restoring normal joint motion, reducing swelling and inflammation in a joint, reducing pain in the joint, and improving neurological functioning and overall well-being.

It is important that you understand, as with all health care approaches, results are not guaranteed, and there is no promise to cure. As with all types of health care interventions, there are some risks to care, including, but not limited to: muscle spasms, aggravating and/or temporary increase in symptoms, lack of improvement of symptoms, burns and/or scarring from electrical stimulation and from hot or cold therapies, including but not limited to hot packs and ice, fractures (broken bones), disc injuries, strokes, dislocations, strains, and sprains. With respect to strokes, there is a rare but serious condition known as an "arterial dissection" that typically is caused by a tear in the inner layer of the artery that may cause the development of a thrombus (clot) with the potential to lead to a stroke. The best available scientific evidence supports the understanding that chiropractic adjustment does not cause a dissection in a normal, healthy artery. Disease processes, genetic disorders, medications, and vessel abnormalities may cause an artery to be more susceptible to dissection. Strokes caused by arterial dissections have been associated with over 72 everyday activities such as sneezing, driving, and playing tennis.

Arterial dissections occur in 3-4 of every 100,000 people whether they are receiving health care or not. Patients who experience this condition often, but not always, present to their medical doctor or chiropractor with neck pain and headache. Unfortunately a percentage of these patients will experience a stroke.

The reported association between chiropractic visits and stroke is exceedingly rare and is estimated to be related in one in one million to one in two million cervical adjustments. For comparison, the incidence of hospital admission attributed to aspirin use from major GI events of the entire (upper and lower) GI tract was 1219 events/ per one million persons/year and risk of death has been estimated as 104 per one million users.

It is also important that you understand there are treatment options available for your condition other than chiropractic procedures. Likely, you have tried many of these approaches already. These options may include, but are not limited to: self-administered care, over-the-counter pain relievers, physical measures and rest, medical care with prescription drugs, physical therapy, bracing, injections, and surgery. Lastly, you have the right to a second opinion and to secure other opinions about your circumstances and health care as you see fit.

I have read, or have had read to me, the above consent. I appreciate that it is not possible to consider every possible complication to care. I have also had an opportunity to ask questions about its content, and by signing below, I agree with the current or future recommendation to receive chiropractic care as is deemed appropriate for my circumstance. I intend this consent to cover the entire course of care from all providers in this office for my present condition and for any future condition(s) for which I seek chiropractic care from this office.

Patient Name: _____ Signature: _____ Date:

Parent or Guardian: _____ Signature: _____ Date:

Witness Name: _____ Signature: _____ Date:

STATEMENT OF ACKNOWLEDGEMENT OF FINANCIAL RESPONSIBILITY DISCLAIMER, RELEASE OF MEDICAL INFORMATION FORM AND DECLARATION

I understand that I may be financially responsible for any charges incurred at this office, including co pays, deductibles, and charges denied or not covered by my insurance company.

I realize my care may be subject to pre-authorization by the insurance company, and I accept any responsibility for charges which may not be approved. The insurance company will review any/all documentation submitted by Dr. John M. Bialecki., for review for medical necessity and base their approval/denial upon this documentation.

I understand that this office agrees to notify me as soon as possible if a service is not covered and will notify me if my care is not approved by the insurance company. If a treatment plan is approved, this office will make me aware of the number of office visits allowed and the time frame of the authorization. Initial visits may be denied and this may be beyond the office's ability to notify the patient prior to rendering acute care, while waiting for insurance coverage approval. These charges will be the patient's responsibility if denied by the insurance company.

This office may seek payment from you for any services your health insurance plan determines to be not medically necessary.

I have read and understood my obligations for payment for care in the absence of insurance coverage.

_____ _____

(Print Patient's Name) Date

_____

Signature (Patient, Parent or Guardian)

* I authorize Dr. John M. Bialecki. to release any medical information pertinent to my treatment plan to my insurance company or an authorized representative for review. This authorization for release of information shall remain valid for the term of my coverage under my current policy/policies. I certify that all insurance information given to this office is correct and complete. I also know that I am entitled to receive a copy of this authorization form.

*I declare under penalty of perjury (under the laws of United States of America) that the foregoing is true and correct: I am not attempting to investigate Bialecki Chiropractic as a representative of any agent or entity, or any insurance company or other organizational entity or person.

_____ _____

(Printed Name) Date

_____ _____

(Signature) Witness signature

John M. Bialecki DC
3140 Sheridan Dr. Suite 140 Amherst New York 14226

BIALECKI CHIROPRACTIC

NO SHOW POLICY/ FINANCIAL POLICY : AS OF 1/1/2023

Our goal is to provide quality care in a timely manner for our patients. We understand unplanned issues can occur. We schedule our appointments with the doctors to ensure the proper amount of time is spent with each patient. It is important that you are on time for the appointment you are given with Dr Bialecki

If your schedule changes, please contact the office and we can arrange a different time for you. We request you give at least **24 hour** notice to cancel or reschedule your appointment. A **"No Show" fee of $35-$70** will be applied and charged directly to you depending on the type of appointment it is. The fee at any point can increase without prior notice. The "No Show" fee is not reimbursable by your insurance company. If you are more than 15 minutes late to an appointment, you may be asked to reschedule (which a fee may be applied) or you may have to wait for the next available time that day or another day.

Our office may decide to terminate its relationship with you if there is consecutive (less than 24 hr notice) cancels and/or no shows.

NO FAULT & WORKERS COMPENSATION PLANS:

You are responsible for providing Bialecki Chiropractic with the information related to your case so we can properly submit for charges. The fees mandated by New York State No fault and Workers Comp will be changed to reflect our contracted fees and you will be responsible for payment. If you have private insurance, it may be possible to charge depending on coverage of chiropractic care plan with your insurance.

NO SHOW POLICY AGREEMENT- EFFECTIVE 1/1/2023

Bialecki Chiropractic has implemented an updated policy. Recent changes in health markets and payment processes have altered insurance coverages to shift the cost of care to our patients. Credit card information can be collected by front office and kept confidential. If no card on file we may request you pay over the phone any balance before scheduling your next appointment. Bialecki Chiropractic may be authorized to charge the account for any appointments missed without the 24 hour notice of cancellation or rescheduling. We want to do our best to service our patients the best way we can.

Print Name: _____ Date: _____

Signature: _____

NECK BOURNEMOUTH QUESTIONNAIRE

Patient Name _____ Date _____

Instructions: The following scales have been designed to find out about your neck pain and how it is affecting you. Please answer ALL the scales, and mark the ONE number on EACH scale that best describes how you feel.

1. Over the past week, on average, how would you rate your neck pain?

No pain Worst pain possible

0 1 2 3 4 5 6 7 8 9 10

2. Over the past week, how much has your neck pain interfered with your daily activities (housework, washing, dressing, lifting, reading, driving)?

No interference Unable to carry out activity

0 1 2 3 4 5 6 7 8 9 10

3. Over the past week, how much has your neck pain interfered with your ability to take part in recreational, social, and family activities?

No interference Unable to carry out activity

0 1 2 3 4 5 6 7 8 9 10

4. Over the past week, how anxious (tense, uptight, irritable, difficulty in concentrating/relaxing) have you been feeling?

Not at all anxious Extremely anxious

0 1 2 3 4 5 6 7 8 9 10

5. Over the past week, how depressed (down-in-the-dumps, sad, in low spirits, pessimistic, unhappy) have you been feeling?

Not at all depressed Extremely depressed

0 1 2 3 4 5 6 7 8 9 10

6. Over the past week, how have you felt your work (both inside and outside the home) has affected (or would affect) your neck pain?

Have made it no worse Have made it much worse

0 1 2 3 4 5 6 7 8 9 10

7. Over the past week, how much have you been able to control (reduce/help) your neck pain on your own?

Completely control it No control whatsoever

0 1 2 3 4 5 6 7 8 9 10

_____
Examiner

OTHER COMMENTS: _____

With Permission from: Bolton JE, Humphreys BK: The Bournemouth Questionnaire: A Short-form Comprehensive Outcome Measure. II. Psychometric Properties in Neck Pain Patients. *JMPT* 2002; 25 (3): 141-148.

BIALECKI CHIROPRACTIC

Headache Disability Index

Patient Name _____

Date _____

Please check the correct response about your headaches:

1. I have a headache: ○ once per month ○ more than once but less than four times per month ○ more than once per week
2. My headache is: ○ mild ○ moderate ○ severe

Please read carefully: The purpose of this scale is to identify difficulties you may be experiencing because of your headaches. Please check Yes, Sometimes or No for each item. Answer each question only as it pertains to your headache.

		Yes	Sometimes	No
1	Do you feel disabled because of your headache?	○	○	○
2	Do you feel restricted in performing your routine daily activities?	○	○	○
3	Do you feel no one understands the effect your headaches have on your life?	○	○	○
4	Do you restrict your recreational activities (for example, sports, hobbies) because of your headaches?	○	○	○
5	Do your headaches make you angry?	○	○	○
6	Do you feel that you are going to lose control because of your headaches?	○	○	○
7	Are you less likely to socialize because of your headaches?	○	○	○
8	Do you feel like your spouse (or significant other), family and friends have no idea what you are going through because of your headaches?	○	○	○
9	Do you feel your headaches are so bad that you will go insane?	○	○	○
10	Is your outlook on the world affected by your headaches?	○	○	○
11	Are you afraid to go outside when you feel a headache is starting?	○	○	○
12	Do you feel desperate because of your headaches?	○	○	○
13	Are you concerned that you are paying penalties at work or at home because of headaches?	○	○	○
14	Do your headaches place stress on your relationships with family or friends?	○	○	○
15	Do you avoid being around people when you have a headache?	○	○	○
16	Do you believe your headaches are making it difficult for you to achieve your goals in life?	○	○	○
17	Are you unable to think clearly because of your headaches?	○	○	○
18	Do you get tense (for example, muscle tension) because of your headaches?	○	○	○
19	Do you not enjoy social gatherings because of your headaches?	○	○	○
20	Do you feel irritable because of your headaches?	○	○	○
21	Do you avoid traveling because of your headaches?	○	○	○
22	Do your headaches make you feel confused?	○	○	○
23	Do your headaches make you feel frustrated?	○	○	○
24	Do you find it difficult to read because of your headaches?	○	○	○
25	Do you find it difficult to focus your attention away from your headaches and on other things?	○	○	○

SCORING INSTRUCTIONS: Yes = 4 points, Sometimes = 2, No = 0.

Using this system, a total score of 10-28 is considered to indicate mild disability; 30-48 is moderate disability; 50-68 is severe disability; 72 or more is complete disability.

BACK BOURNEMOUTH QUESTIONNAIRE

Patient Name _____ Date _____

Instructions: The following scales have been designed to find out about your back pain and how it is affecting you. Please answer ALL the scales, and mark the ONE number on EACH scale that best describes how you feel.

1. Over the past week, on average, how would you rate your back pain?

No pain — Worst pain possible

0 1 2 3 4 5 6 7 8 9 10

2. Over the past week, how much has your back pain interfered with your daily activities (housework, washing, dressing, walking, climbing stairs, getting in/out of bed/chair)?

No interference — Unable to carry out activity

0 1 2 3 4 5 6 7 8 9 10

3. Over the past week, how much has your back pain interfered with your ability to take part in recreational, social, and family activities?

No interference — Unable to carry out activity

0 1 2 3 4 5 6 7 8 9 10

4. Over the past week, how anxious (tense, uptight, irritable, difficulty in concentrating/relaxing) have you been feeling?

Not at all anxious — Extremely anxious

0 1 2 3 4 5 6 7 8 9 10

5. Over the past week, how depressed (down-in-the-dumps, sad, in low spirits, pessimistic, unhappy) have you been feeling?

Not at all depressed — Extremely depressed

0 1 2 3 4 5 6 7 8 9 10

6. Over the past week, how have you felt your work (both inside and outside the home) has affected (or would affect) your back pain?

Have made it no worse — Have made it much worse

0 1 2 3 4 5 6 7 8 9 10

7. Over the past week, how much have you been able to control (reduce/help) your back pain on your own?

Completely control it — No control whatsoever

0 1 2 3 4 5 6 7 8 9 10

_____
Examiner

OTHER COMMENTS: _____

With Permission from: Bolton JE, Breen AC: The Bournemouth Questionnaire: A Short-form Comprehensive Outcome Measure. I. Psychometric Properties in Back Pain Patients. *JMPT* 1999; 22 (9): 503-510.