THE SPINE CENTER
• Life Begins when Pain Ends •
CHARLES S. THEOFILOS, M.D.
Board Certified Neurosurgeon and Founder

Patient Name: _____ Today's Date: _____ DOB: _____

Why are you here today? _____

Review of Systems: Please check (√) off any symptoms you **currently** have.

Constitutional	Gastrointestinal	Psychiatric	Hematologic	Cardiovascular
☐ Chills ☐ Fatigue ☐ Fever ☐ Malaise ☐ Night sweats ☐ Weakness ☐ Weight loss ☐ Weight gain	☐ Abdominal pain ☐ Constipation ☐ Black tarry stools ☐ Diarrhea ☐ Heartburn ☐ Yellowing of skin ☐ Loss of appetite ☐ Nausea ☐ Vomiting	☐ Anxiety ☐ Depression ☐ Insomnia	☐ Easy bleeding ☐ Easy bruising	☐ Chest pain ☐ Bluing ☐ Heart murmur ☐ Leg swelling ☐ Fainting ☐ Irregular heart beat/ Palpitations
HEENT	**Genitourinary**	**Integumentary**	**Immunologic**	**Neurological**
☐ Blurred vision ☐ Double vision ☐ Difficulty swallowing ☐ Ear drainage ☐ Headache ☐ Hearing loss ☐ Hoarseness ☐ Ringing in ears ☐ Vertigo ☐ Vision loss	☐ Painful urination ☐ Frequent urination ☐ Blood in urine ☐ Urge incontinence ☐ Urinary incontinence	☐ Contact allergy ☐ Itchy skin ☐ Rash ☐ Skin infections ☐ Skin lesion	☐ Asthma ☐ Contact dermatitis ☐ Environmental allergies ☐ Food allergies	☐ Difficulty walking ☐ Dizziness ☐ Poor coordination ☐ Memory loss ☐ Muscle weakness ☐ Numbness ☐ Seizures ☐ Tremors
Respiratory	**Metabolic**	**Other**		
☐ Chest pain (in lungs) ☐ Cough ☐ Difficulty breathing ☐ Recent infection ☐ Known TB Exposure ☐ Wheezing	☐ Cold intolerance ☐ Hair loss ☐ Heat intolerance			

Medications: List all medications you are taking (prescribed and over the counter)

Medication Name	Dosage	How often?

Allergies: List all known allergens including medications, food, and other.

Allergen description	Severity (Mild, Moderate, Severe)	Reaction
(circle): Sulfites/Red Wine or Eggs, Contrast or Shellfish		

Medical History: Please check (√) off any symptoms you **have or have had in the past.**

☐ Aids	☐ Alzheimer's disease	☐ Anemia
☐ Angina	☐ Arthritis	☐ Asthma
☐ Bleeding Disorder	☐ Cancer	☐ Chicken Pox
☐ Congestive heart failure	☐ COPD	☐ Coronary artery disease
☐Deep Vein Thrombosis (DVT)	☐ Degenerative Joint Disease	☐ Depression
☐ Diabetes; Non-insulin dependent	☐ Diabetes – Insulin dependent	☐ Drug abuse
☐ Elevated lipids	☐ Emphysema	☐ Fibromyalgia
☐ Gout	☐ Headache, migraine	☐ Heart attack
☐ Heart Disease	☐ Heart Valve Disease	☐ Hepatitis, liver disease
☐ Herpes	☐ HIV Positive	☐ Hypertension
☐ Inflammatory bowel disease	☐ Kidney disease	☐ Lupus

THE SPINE CENTER
• Life Begins when Pain Ends •
CHARLES S. THEOFILOS, M.D.
Board Certified Neurosurgeon and Founder

☐ Lyme disease	☐ Osteoporosis	☐ Pace Maker
☐ Parkinson disease	☐ Psoriasis	☐ Rheumatic Fever
☐ Scoliosis	☐ Seizure disorder/epilepsy	☐ Shingles
☐ Sleep apnea	☐ Stroke	☐ Thyroid disease
☐ Tuberculosis	☐ Ulcers	☐ Vaginal Infection
☐ Venereal Disease	☐ Other:	☐ Other:

Surgical History: Please list any surgical interventions and procedures you have had.

Surgery or procedure	Description, Side, or Note	Date	Outcome

Family History: Please fill in any known health information about your relatives.

Relationship	Condition/diagnosis	Age of Onset	Was this the cause of death? (if applicable)
Mother ☐ Alive ☐ Deceased			☐ Yes Age? _____
Father ☐ Alive ☐ Deceased			☐ Yes Age? _____
Other_____ ☐ Alive ☐ Deceased			☐ Yes Age? _____
Other_____ ☐ Alive ☐ Deceased			☐ Yes Age? _____
Other_____ ☐ Alive ☐ Deceased			☐ Yes Age? _____

Social History: Please Complete.

Have you **ever** used tobacco? ☐ Yes ☐ No	If you answered yes: What type: _____ Daily ☐ Yes ☐ No How Much per Day: _____ For How Long: _____ Age Started: _____ Age Stopped: _____ (if applicable)
Do you drink alcohol ☐ Yes ☐ No	If you answered yes: What type: _____ How Often: _____ How Much?: _____ When was your last drink?_____
Do you drink/consume caffeine? ☐ Yes ☐ No	If you answered yes: What type: _____ How Much?: _____

THE SPINE CENTER
• Life Begins when Pain Ends •
CHARLES S. THEOFILOS, M.D.
Board Certified Neurosurgeon and Founder

Therapeutic History: Please place a check (√) by any therapy you are undergoing or have undergone for your neck and/or back complaints.

Treatment/Therapy	**Description of treatment (duration of treatment, location of treatment, dose, outcome, etc.)**
☐ Anti-inflammatory medications	
☐ Activity modification	
☐ Chiropractic care	
☐ Exercises	
☐ Ice/heat	
☐ Injections	
☐ Pain medications	
☐ Physical therapy	
☐ Other	

Spinal History: (Office Use Only)

☐ Neck pain	☐ Mid-back pain	☐ Low back pain

I certify that the above information is correct to the best of my knowledge. I will not hold my doctor or any members of his/her staff responsible for any errors or omission that I may have made in the completion of these forms.

Patient Signature: _____ Patient Name (Print): _____ Date _____

THE SPINE CENTER
• Life Begins when Pain Ends •
CHARLES S. THEOFILOS, M.D.
Board Certified Neurosurgeon and Founder

Name: _____ **DOB**: _____

The Spine Center will need to call you regarding your healthcare and account. By completing the information below you are giving us authorization to contact you and to leave a message or send a text reminder of your appointment.

□ Home Phone: _____

□ Cell Phone: _____

□ Work Phone: _____

□ Email: _____

□ Fax: _____

□ Other: **By checking this box I choose to opt out of The Spine Center's Email correspondences.**

I hereby authorize the continuous release of all my medical records/films/x-rays, and billing statements to the following persons. This authorization is in full force and effect unless and until revoked by me in writing. (Examples: Spouse, Children, Attorney, Employer etc.)

NAME	PHONE/FAX/EMAIL	RELATIONSHIP
_____	_____	_____
_____	_____	_____
_____	_____	_____

Who should we contact in case of an emergency?

NAME: _____
RELATIONSHIP: _____
PHONE: _____

ACKNOWLEDGMENT OF RECEIPT OF PRIVACY NOTICE

I acknowledge that I am entitled to the Spine Center's Privacy Notice upon my request.

_____ _____ _____
Patient Signature: Patient Name (Print): Date

THE SPINE CENTER
• Life Begins when Pain Ends •
CHARLES S. THEOFILOS, M.D.
Board Certified Neurosurgeon and Founder

Name: _____ **DOB**: _____

NOTICE TO OUR PATIENTS:

"Under Florida law, physicians are generally required to carry medical malpractice insurance or otherwise demonstrate financial responsibility to cover potential claims for medical malpractice. **YOUR DOCTOR HAS DECIDED NOT TO CARRY MEDICAL MALPRACTICE INSURANCE.** This is permitted under Florida law subject to certain conditions. Florida law imposes penalties against non-insured physicians who fail to satisfy adverse judgments arising from claims of medical malpractice. This is provided pursuant to Florida law."

_____ _____
Patient Signature **Print Name**

_____ _____
Witness Signature **Date**

I understand Charles S. Theofilos, MD, PA owns and operates the following located within The Spine Center in all locations:

Spine Pack
X-ray
North Palm MRI
In-office Procedure Suite

_____ _____
Patient Signature **Print Name**

_____ _____
Witness Signature **Date**

THE SPINE CENTER
• Life Begins when Pain Ends •
CHARLES S. THEOFILOS, M.D.
Board Certified Neurosurgeon and Founder

Name: _____ **DOB:** _____

CONSENT FOR THE RELEASE OF MEDICAL RECORDS
By signing below, I agree that Charles S. Theofilos, M.D., P.A. has the right to request any and all previous medical records. I understand that my health or medical information may be used or released for purposes of treatment, payment or health care operations.

I authorize Charles S. Theofilos, M.D., P.A., to release copies of my records as necessary to process claims, obtain reimbursement or payment from an insurance company, HMO, or other third party payer or attorney. I further authorize Charles S. Theofilos, M.D., P.A. to furnish information from my medical records to other treating physicians, other medical care facilities, hospitals, home health agencies, ancillary service providers or other health care providers for my continued care and treatment. I understand that my health information and medical records may be transmitted to me, my insurers or other health care providers by telephone, regular mail, email or facsimile.

ASSIGNMENT OF BENEFITS, INSURANCE AUTHORIZATION, AND PAYMENT
I, the patient herby authorize any and all of my insurance company to make medical benefit payments otherwise payable to me for services rendered by Charles S. Theofilos, MD, PA but not to exceed the charges of those services payable to and mailed directly to: Charles S. Theofilos, MD, PA. Furthermore I hereby IRREVOCABLY ASSIGN to Charles S. Theofilos, MD, PA the rights and benefits under any insurance, indemnity agreement, or any other collateral source as defined in Florida Statutes for any service and or charges provided by Charles S. Theofilos, MD, PA.

I direct payment of the benefits I am entitled to under the provision of my insurance policy directly to Charles S. Theofilos, MD, PA. I understand that I am fully responsible for any balance not paid by my insurance including co-payments, deductibles, and out of pocket network disallowments.

I agree that if my insurance company pays me for any services provided by Charles S. Theofilos, MD, PA; I will forward any payments in full within 5 days of the explanation of benefits to Charles S. Theofilos, MD, PA. I understand that failure to forward any payments made for services rendered by Charles S. Theofilos, MD, PA will be considered insurance fraud and I will be responsible for the cost to recover these payments including collection fees, attorney fees, and all legal free involved in collecting this debt.

I understand that I am fully responsible for any balance not paid by my insurance, and I agree to pay any outstanding balance including co-payments and deductible amounts. If my account has to be referred to a collection agency or an attorney, I will pay all costs of the collection, including reasonable attorney's fees and costs.

I will also be financially responsible for any scheduled appointments not cancelled 24 hours prior to appointment time. There is a 24-hour cancellation policy for all office visits. If any appointment is not cancelled or if I fail to show, I understand that my account will be charged as follows: Follow up, New Patient, and X-Ray appointments will be charged the full fee of the visit. MRI appointments will be charged $750.00.

LIMITED POWER OF ATTORNEY
I hereby appoint Charles S. Theofilos ,M.D., P.A. and any of its duly authorized agents to be my agent and attorney-in-fact for the limited purpose of endorsing and depositing, for the benefit of Charles S. Theofilos ,M.D., P.A., any and all checks and/or paperwork received for payment of services rendered up to the amount of my bill. This appointment means that Charles S. Theofilos, M.D., P.A., or its authorized agents may deposit any and all checks or other financial instruments received from my insurer or any person as payment for my treatment services without my endorsement.

I have read and fully understand the conditions listed above with respect to the release of information, assignment of benefits, and financial responsibility. I understand that this form will remain in effect for so long as I am being treated by Charles S. Theofilos, M.D., P.A., unless it is revoked by me in writing.

_____ _____
Signature of Patient **Print Name**

_____ _____
Witness signature REV 11/03/15 **Date**

THE SPINE CENTER
• Life Begins when Pain Ends •
CHARLES S. THEOFILOS, M.D.
Board Certified Neurosurgeon and Founder

BY SIGNING THIS AGREEMENT, YOU ARE WAIVING YOUR RIGHT TO A JURY TRIAL AND YOU ARE AGREEING TO ARBITRATE ALL CLAIMS ARISING OUT OF OR RELATED TO YOUR MEDICAL CARE AND TREATMENT

CHARLES S. THEOFILOS, MD PA
VOLUNTARY ARBITRATION AGREEMENT FOR CLAIMS ARISING OUT OF OR RELATED TO MEDICAL CARE AND TREATMENT

1. AGREEMENT TO ARBITRATE CLAIMS REGARDING FUTURE CARE & TREATMENT.
The patient agrees that any controversy, including without limitation, claims for medical malpractice, personal injury, loss of consortium, or wrongful death, arising out of or in any way relating to the diagnosis, treatment, or care of the patient by the undersigned provider of medical services, including any partners, agents, or employees of the provider of medical services, shall be submitted to binding arbitration.

2. AGREEMENT TO ARBITRATE CLAIMS REGARDING PAST CARE & TREATMENT. The patient further agrees that any controversy, including without limitation, claims for medical malpractice, personal injury, loss of consortium, or wrongful death, arising out of or in any way relating to the past diagnosis, treatment, or care of the patient by the undersigned provider of medical services or the provider's partners, agents or employees, shall be submitted to binding arbitration.

3. WAIVER OF RIGHT TO JURY TRIAL. BOTH PARTIES TO THIS AGREEMENT, BY ENTERING INTO IT, ARE GIVING UP THEIR CONSTITUTIONAL RIGHT TO HAVE ANY SUCH DISPUTE DECIDED IN A COURT OF LAW BEFORE A JURY, AND INSTEAD ARE ACCEPTING THE USE OF BINDING ARBITRATION.

4. ALL CLAIMS MUST BE ARBITRATED BY ALL CLAIMANTS. All claims based upon the same occurrence, incident, or care shall be arbitrated in one proceeding. It is the intention of the parties that this Agreement bind all parties whose claims may arise out of or relate to treatment or services provided by the provider of medical services, including the patient, the patient's estate, any spouse or heirs of the patient, and any children of the patient, whether born or unborn, at the time of the occurrence giving rise to the claim. In the case of any pregnant mother, the term "patient" herein shall mean both the mother and the mother's expected child or children. By signing this Agreement, the parties consent to the participation in this arbitration of any person or entity that would otherwise be a proper additional party in a court action.

5. ARBITRATION PROCEDURES. The parties agree and recognize that the substantive provisions of Florida
Statutes, Chapter 766, governing medical malpractice claims shall apply to the parties and/or claimant(s) in all respects, except that at the conclusion of the pre-suit screening period and provided there is no mutual agreement to arbitrate under Florida Statutes, 766.106 or 766.207, et seq. (which remain available if elected by the parties), the parties and/or claimant(s) shall resolve any claim through arbitration pursuant to this Agreement. Within fifteen (15) days after a party to this Agreement has given written notice to the other of a demand for arbitration of said dispute or controversy under this Agreement, the parties to the dispute or controversy shall each appoint an arbitrator and give notice of such appointment to the other. Within a reasonable time after such notices have been given the two arbitrators so selected shall select a neutral arbitrator, who shall be an administrative law judge, and give notice of the selection thereof to the parties.

BY SIGNING THIS AGREEMENT, YOU ARE WAIVING YOUR RIGHT TO A JURY TRIAL AND YOU ARE AGREEING TO ARBITRATE ALL CLAIMS ARISING OUT OF OR RELATED TO YOUR MEDICAL CARE AND TREATMENT

The arbitrators shall hold a hearing within a reasonable time from the date of notice of selection of the neutral arbitrator. The parties agree that the arbitration proceedings are private, not public,
and the privacy of the parties and of the arbitration proceedings shall be preserved. By agreeing to arbitrate defendant will have conceded liability for purposes of the arbitration.

6. ARBITRATION EXPENSES. The defendant in the arbitration shall pay all the costs of the arbitration proceeding and the fees of all arbitrators other than the administrative law judge.

7. APPLICABLE LAW. Except as herein provided, the arbitration shall be conducted and governed by the provisions of the Florida Arbitration Code, Florida Statutes, Section 682.01 et seq. In conducting the arbitration under Florida Statutes, Section 682.01 et seq., all substantive provisions of Florida law governing medical malpractice claims and damages related thereto, including but not limited to, Florida's Wrongful Death Act, the standard of care for medical providers, the applicable statute of limitations and the application of collateral sources and setoffs shall be applied. Except as otherwise provided by law, interest shall only accrue after an award by the arbitration panel. Post-decision interest shall be computed in a manner consistent with other civil claims. Each defendant who submits to arbitration shall be jointly and severally liable for all damages assessed in the arbitration in accordance with Florida Statutes, Section 768.81.

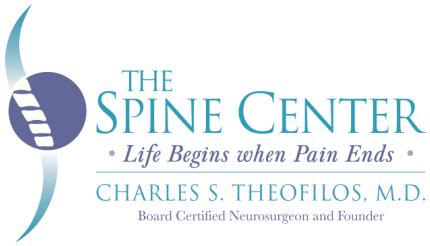
8. EFFECT OF REFUSAL TO PROCEED WITH ARBITRATION. ln the event that any party to this Agreement refuses to go forward with arbitration, the party compelling arbitration reserves the right to proceed with arbitration, the appointment of an arbitrator, and hearings to resolve the dispute, despite the refusal to participate or absence of the opposing party. Submission of any dispute under this agreement to arbitration may only be avoided by a valid court order, indicating that the dispute is beyond the scope of this arbitration Agreement or contains an illegal aspect precluding the resolution of the dispute by arbitration. Any party to this Agreement who refuses to go forward with arbitration hereby acknowledges that the arbitrator will go forward with the arbitration hearing and render a binding decision without the participation of the party opposing arbitration or despite that party's absence at the arbitration hearing.

9. SEVERABILITY. If any provision of this Agreement is held invalid or unenforceable, the remaining provisions shall remain in full force and shall not be affected by the invalidity of any other provision.

10. ACKNOWLEDGEMENTS BY PATIENT. The patient, by signing this agreement, also acknowledges that he or she has been informed that:

a. NO DURESS. The Agreement may not be submitted to a patient for approval when the patient's condition prevents the patient from making a rational decision whether or not to agree.

b. AGREEMENT BASED UPON OWN FREE WILL. The decision whether or not to sign the agreement is solely a matter for the patient's determination without any influence by the physician or hospital.



BY SIGNING THIS AGREEMENT, YOU ARE WAIVING YOUR RIGHT TO A JURY TRIAL AND YOU ARE AGREEING TO ARBITRATE ALL CLAIMS ARISING OUT OF OR RELATED TO YOUR MEDICAL CARE AND TREATMENT

c. BINDING ARBITRATION AND EFFECT ON RIGHT OF APPEAL. Binding arbitration means that the parties give up their right to go to court to assert or defend a claim covered by this Agreement. The resolution of claims covered by this Agreement will be determined by a neutral panel of arbitrators and not a judge or jury. Each party is entitled to a fair hearing, but the arbitration procedures are simpler and more limited than rules applicable in court. Arbitration decisions are as enforceable as any court order. The decision of an arbitration panel is final and there will generally be no right to appeal an adverse decision except as provided for in Fla. Stat. § 766.212(1).

d. READ AGREEMENT AND UNDERSTOOD. I have read and understand the above Agreement. I understand that I have the right to have my questions about arbitration or this Agreement answered and I do not have any unanswered questions. I execute this Agreement of my own free will and not under any duress.

e. SIGNATURE OF AGREEMENT. This Agreement shall be effective upon the patient's and/or the patient's representative's signature below. Upon such signature, this Agreement shall be deemed to be fully executed and binding upon all parties.

CHARLES S. THEOFILOS, M.D., P.A. d/b/a
THE SPINE CENTER

Date:

Patient:

Print Name

Date

Patient Signature

Parent or Guardian [if patient is a minor]

Print Name

Date

Parent or Guardian Signature

THE SPINE CENTER
• Life Begins when Pain Ends •
CHARLES S. THEOFILOS, M.D.
Board Certified Neurosurgeon and Founder

Patient: _____ Date: _____

Please answer the questions below by choosing the ONE answer that describes your typical **NECK PAIN**, and/or limitations within the last week or two.

Section 1 - Pain intensity
__I have no pain at the moment.
__The pain is mild at the moment.
__The pain comes and goes and is moderate.
__The pain is moderate and does not vary.
__The pain is severe but comes and goes.
__The pain is severe and does not vary.

Section 2 - Personal Care
(Washing, Dressing etc.)
__I can look after myself 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 manager most of my personal care.
__I need help every day in most aspects of self-care.
__I cannot get dressed or wash without assistance, and am bedridden.

Section 3 - Lifting
__I can lift heavy weights without extra pain.
__I can lift heavy weights, but it causes extra pain.
__Pain prevents me from lifting heavy weights off the floor but I can if they are conveniently positioned, for example 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 very light weights.
__I cannot lift or carry anything at all.

Section 4 - Reading
__I can read as much as I want with no pain in my neck.
__I can read as much as I want with slight pain in my neck.
__I can read as much as I want with moderate pain in my neck.
__I cannot read as much as I want because of moderate pain in my neck.
__I cannot read as much as I want because of severe pain in my neck.
__I cannot read at all.

Section 5 - Headache
__I have no headaches at all.
__I have slight headaches which come in-frequently.
__I have moderate headaches which come frequently.
__I have severe headaches which come frequently.
__I have headaches almost all the time.

Section 6 - Concentration
__I can concentrate fully when I want to with no difficulty.
__I can concentrate fully when I want to with slight difficulty.
__I have a fair degree of difficulty in concentrating with I want to.
__I have a lot of difficulty in concentrating when I want to.
__I have a great deal of difficulty in concentration when I want to.
__I cannot concentration at all.

Section 7 - Work
__I can do as much work as I want to.
__I can only do my usual work, but no more.
__I can do most of my usualy work, but no more.
__I cannot do my usual work.
__I can hardly do any work at all.
__I cannot do any work at all.

Section 8 - Driving
__I can drive my car without neck pain.
__I can drive my care as long as I want with slight pain in my neck.
__I can drive my car as long as I want with moderate pain in my neck.
__I cannot drive my car as long as I want because of moderate pain in my neck.

Section 9 - Sleeping
__I have no trouble sleeping.
__My sleep is slightly disturbed (less than 1 hour sleepless).
__My sleep is mildly disturbed (1-2 hours sleepless).
__My sleep is moderately disturbed (2-3 hours sleepless)
__My sleep is greatly disturbed (3-5 hours sleepless)
__My sleep is completely diturbed (5-7 hours sleepless).

Section 10 - Recreation
__I am able to engage in all recreational activities with no pain in my neck at all.
__I am able to engage in all recreational activities with some pain in my neck.
__I am able to engage in most, but not all recreational activities because of pain in my neck.
__I am able to engage in only a few of my usual recreational activities because of pain in my neck .
__I can hardly do any recreational activities because of pain in my neck.
__I cannot do any recreational activities at all.

THE SPINE CENTER
• Life Begins when Pain Ends •
CHARLES S. THEOFILOS, M.D.
Board Certified Neurosurgeon and Founder

Patient: _____ Date: _____

Please answer the questions below by choosing the ONE answer that describes your typical **LOW BACK** PAIN, and/or limitations within the last week or two.

Section 1 - Pain intensity
__I have no pain at the moment.
__The pain is mild at the moment.
__The pain comes and goes and is moderate.
__The pain is moderate and does not vary.
__The pain is severe but comes and goes.
__The pain is severe and does not vary.

Section 2 - Personal Care
(Washing, Dressing etc.)
__I can look after myself 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 manager most of my personal care.
__I need help every day in most aspects of self-care.
__I cannot get dressed or wash without assistance, and am bedridden.

Section 3 - Lifting
__I can lift heavy weights without extra pain.
__I can lift heavy weights, but it causes extra pain.
__Pain prevents me from lifting heavy weights off the floor but I can if they are conveniently positioned, for example 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 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 ¼ of a mile.
__Pain prevents me walking more than 100 yards.
__I can only walk using a stick or crutches.
__I am in bed most of time and must use a wheelchair to go to the bathroom.

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 for more than 1 hour.
__Pain prevents me from sitting for more than ½ hour.
__Pain prevents me from sitting for 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 ½ hour.
__Pain prevents me from standing for more than 10 minutes.
__Pain prevents me from standing at all.

Section 7 - Sleeping
__My sleep is never disturbed by pain.
__My sleep is occasionally disturbed by pain.
__Because of pain, I have less than 6 hours sleep.
__Because of pain, I have less than 4 hours sleep.
__Because of pain, I have less than 2 hours sleep.
__Pain prevents me from sleeping at all.

Section 8 - Sex Life (if applicable)
__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 painfull.
__My sex life is severly 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 causes no extra pain.
__My social life is normal but increases the degree of pain.
__Pain has no signifigant effect on my social life apart from limiting my more energetic interests, i.e. sports
__Pain has restricted my social life and I do not go out as often.
__Pain has restricted my social life to my home, and/or social media only.
__I have no social life because of pain.

Section 10 - Traveling
__I can travel anywhere without pain.
__I can travel anywhere but it gives extra pain.
__Pain is bad but I manage journeys of over two hours.
__Pain restricts me to short necessary journeys less than 30 minutes.
__Pain prevents me from traveling except to receive treatment.