Voluntary Prior Approval Process

- You sign this Voluntary Prior Approval Agreement Form upon your initial visit to indicate that you are
 opting to obtain prior approval for non-participating physical therapy or occupational therapy services
 that you understand the process, that you agree to the procedures described here and that you
 authorize your non-participating provider to submit information on your behalf.
- You ask your non-participating provider to submit a completed one page <u>Patient Summary Form</u> along with this signed <u>Voluntary Prior Approval Agreement Form</u> directly to OptumHealth (fax to 1-866-695-6923). You or your non-participating provider can obtain a copy of the Patient Summary Form by calling OptumHealth at 1-877-369-7564 or by visiting OptumHealth's Web site at www.myoptumhealthphysicalhealth.com.
- OptumHealth will respond to both you and your provider for each Patient Summary Form received, indicating the time frame and services that have been approved or that the services have not been approved.
 - a. If the services are approved, you are responsible only for out-of-network cost shares (e.g., deductible and coinsurance amounts).
 - b. If the services are not approved and you choose to receive care, you will be responsible for the cost in full. You may appeal that decision by following the procedures attached with the response or as described in your Certificate of Coverage.
- 4. If your treating provider believes that you need care beyond the approved number of services and/or time frame provided, he/she should submit a new updated Patient Summary Form, including asking you to complete the Patient Section of the Patient Summary Form to assess your progress. If the new forms are not submitted, the claims will be reviewed retrospectively as described.
- 5. If you change non-participating therapy providers and wish to continue to use the Voluntary Prior Approval process, the new provider should submit your new **Voluntary Prior Approval Agreement Form** along with a newly completed Patient Summary Form.

Submission of this form indicates that you understand the Voluntary Prior Approval process; you agree to the procedures outlined in this letter and that you authorize your non-participating provider to submit a Patient Summary Form on your behalf.

Treating Practitioner's Name	
Clinic Name (if available):	
Treating Practitioner's Street Address:	
Treating Practitioner's City, State, ZIP:	
Treating Practitioner's Tax Identification Number:	
Treating Practitioner's Phone Number:	
Member's Name:	Member's DOB:
Member's ID Number:	
Member/Guardian Signature:	

Turresent Cas Schools - Theods communicates Coloresenth Cas and Dobres on Theods and Schools Preside New Roll and Automotive and Casteria and Caster

Patient Information First Bill Male Female	Patient Summary Form			Pleas	tructions se complete this form within the specified timeframe.
Patient Junes Patient Junes Patient Design Patient				All Ps	SF submissions should be completed online at myoptumhealthphysicalhealth.com unless other-
**Processor of the billing periodic or facility in stud appear on the class hours September Septem	Dations as an	O Mala		1 11	se review the Plan Summary for more information.
Patient Insurance By Health plan Group number	radurit marine Last Pirst	MI 5	Patient date	of birth	
Referred number (if applicables) Debt referred leased (if applicables) Debt referred leased (if applicables) Referred number (if applicable	Patient address	City			State Zip code
Referred number (if applicables) Debt referred leased (if applicables) Debt referred leased (if applicables) Referred number (if applicable					
Name of the billing provider or facility is n use spease on the date forms 1 MDDO 2 DC 2 PT 4 DOT 8 Both PT and OT 8 Home Care 7 ATC 8 NT 2 Other 1 MDDO 2 DC 2 PT 4 DOT 8 Both PT and OT 8 Home Care 7 ATC 8 NT 2 Other 1 MDDO 2 DC 2 PT 4 DOT 8 Both PT and OT 8 Home Care 7 ATC 8 NT 2 Other 1 MDDO 2 DC 2 PT 4 DOT 8 Both PT and OT 8 Home Care 7 ATC 8 NT 2 Other 1 MDDO 2 DC 2 PT 4 DOT 8 Both PT and OT 8 Home Care 7 ATC 8 NT 2 Other 1 MDDO 2 DC 2 PT 4 DOT 8 Both PT and OT 8 Home Care 7 ATC 8 NT 2 Other 1 MDDO 2 DC 2 PT 4 DOT 8 Both PT and OT 8 Home Care 7 ATC 8 NT 2 DOT 8 NT 1 MDDO 2 DC 2 PT 4 DOT 8 Both PT and OT 8 Home Care 7 ATC 8 NT 2 DOT 8 NT 1 MDDO 2 DC 2 PT 4 DOT 8 Both PT and OT 8 Home Care 7 ATC 8 NT 2 DOT 8 NT 1 MDDO 2 DC 2 PT 4 DOT 8 Both PT and OT 8 Home Care 7 ATC 8 NT 2 DOT 8 NT 1 MDDO 2 DC 2 PT 4 DOT 8 Both PT and OT 8 Home Care 7 ATC 8 NT 2 DOT 8 NT 1 MDDO 2 DC 2 PT 4 DOT 8 Both PT and OT 8 Home Care 7 ATC 8 NT 2 DOT 8 NT 1 MDDO 2 DC 2 PT 4 DOT 8 Both PT and OT 8 Home Care 7 ATC 8 NT 2 DOT 8 NT 1 MDDO 2 DC 2 PT 4 DOT 8 Both PT and OT 8 Home Care 7 ATC 8 NT 2 DOT 8 NT 1 MDDO 2 DC 2 PT 4 DOT 8 Both PT and OT 8 Home Care 7 ATC 8 NT 1 PT 2 DOT 8 NT 1 MDDO 2 DC 2 PT 4 DOT 8 Both PT and OT 8 Home Care 7 ATC 8 NT 1 PT 2 DOT	Patient insurance ID#	Health plan		Group number	
Name of the billing provider or ficility is the season on the case of the billing provider or ficility is the season of the billing provider or ficility in box #1 MD/DO DC PT OT Both PT and OT Home Care ATC MT Other	Referring physician (if applicable)	Date referral issued (if applicable)		Referral number /// appli	(cable)
MODO 2 DC 2 PT 4 OT 8 Both PT and OT 8 Home Care 7 ATC 8 MT 8 Other	Provider information			Total Indiana (II appl	CADIE)
MODO 2 DC 2 PT 4 OT 8 Both PT and OT 8 Home Care 7 ATC 8 MT 8 Other	1. Name of the billing provider or facility (as it will appear on the claim	(orm)	2 Sederal tow ID:		
A. Alternate rane (if any) of smitty in box #1 6. NPI of entity in box #1 7. NPI of Surreery 7. Address of the billing provider or facility indicated in box #1 6. NPI of entity in box #1 7. NPI of Surreery 7. Address of the billing provider or facility indicated in box #1 6. NPI of entity in box #1 7. Address of the billing provider or facility indicated in box #1 6. NPI of entity in box #1 7. Address of the billing provider or facility indicated in box #1 6. NPI of entity in box #1 7. Address of the billing provider or facility indicated in box #1 6. NPI of entity in box #1 7. Address of the billing provider or facility indicated in box #1 6. NPI of entity in box #1 7. In general, would you say your overall health right now is					- ATC AMT A Other
7. Address of the billing provider or facility indicated in box #1 8. City 8. State 10. Zip code Provider Compiletes Files Section Date you want 7HS submission to begin: 7. Traumatic 2 Unspecified 9 Post-surpcial 10 ACL Reconstruction 9 Cause of Current Episode 10 ACL Reconstruction 9 Cause of Current Episode 9 Est'd, new injury 9 Est'd, new episode 9 Est'd, new injury 9 Est'd, new episode 9 Est'd, new episode 9 Est'd, new injury 9 Est'd, new episode 9 Est'd, new injury 10 Initial cross twithin last 3 months) 9 Recurrent (multiple episodes of < 3 months) 9 Recurrent (multiple episodes of < 3 months) 9 Recurrent (multiple episodes of < 3 months) 9 Rest in selections completely) 1 Briefly describe your symptoms 1 Briefly describe your symptoms: 2 How did your symptoms start? 3 Average pain intensity: Last 24 hours: no pain 9 1	3. Name and credentials of the individual performing the service(10.[0]20011 111	o la voue care	7 ATC [8] MT [8] Other ——
7. Address of the billing provider or facility indicated in box #1 8. City 8. State 10. Zip code Provider Compiletes Files Section Date you want 7HS submission to begin: 7. Traumatic 2 Unspecified 9 Post-surpcial 10 ACL Reconstruction 9 Cause of Current Episode 10 ACL Reconstruction 9 Cause of Current Episode 9 Est'd, new injury 9 Est'd, new episode 9 Est'd, new injury 9 Est'd, new episode 9 Est'd, new episode 9 Est'd, new injury 9 Est'd, new episode 9 Est'd, new injury 10 Initial cross twithin last 3 months) 9 Recurrent (multiple episodes of < 3 months) 9 Recurrent (multiple episodes of < 3 months) 9 Recurrent (multiple episodes of < 3 months) 9 Rest in selections completely) 1 Briefly describe your symptoms 1 Briefly describe your symptoms: 2 How did your symptoms start? 3 Average pain intensity: Last 24 hours: no pain 9 1					
Date of Surgery Date of Su	4. Alternate name (if any) of entity in box #1	5. NPI of entity in bo	x #1		6. Phone number
Date of Surgery Date of Su					
Date you want THS submission to begin: Cause of Current Epleode Traumatic Post-surgical Surgery	7. Address of the billing provider or facility indicated in box #1		i. City		
Submission to begin: Cause of Current Epleade A Post-surgical A Post-surgical			Date of Sur	<u>iery</u>	Please ensure all digits are
Patient Type (2) Unspecified (3) Work related (3) Repetitive (3) Repetitive (4) Motor vehicle (5) Motor vehicle (6) Motor vehicle (7) Redution Cuffit abrai Repair (8) Spinal Fusion (9) Joint Replacement (9) Joint Replac	aubmiceles to bester	Current Episode		10	entered accurately
Patient Type (a) New to your office (b) Est'd, new injury (c) Est'd, new injury (d) Est'd, new episode (e) Est'd, new episode (e) Est'd, cortinuing care Nature of Condition (c) Initial onset (within last 3 months) (c) Recurrent (multiple episodes of < 3 months) (d) Securrent (multiple episodes of < 3 months) (e) Recurrent (multiple episodes of < 3 months) (e) Recurrent (multiple episodes of < 3 months) (f) Symptoms began on: Patient Completes This Section: (r) Last 24 hours: no pain (f) Pass week: no pain (f) C) (f) (f) (f) (f) (f) (f) (f) (f) (f) (f		× 1	\sim	<u> </u>	
New to your office Est'd, new injury Spinal Fusion Spin	X `	X	×	: 2°	
Est'd, new injury 3	<u> </u>	(i) Midtor Verlide	X		
3 Est'd, new episode (a) Est'd, continuing care Stature of Condition	X '		×	3°	
Nature of Condition ① Initial onset (within last 3 months) ② Recurrent (multiple episodes of < 3 months) ③ Chronic (continuous duration > 3 months) ③ Patient Completes This Section: Symptoms began on: Patient Completes This Section: Symptoms began on: Indicate where you have pain or other symptoms			5 Joint Replacemen	n 4°	
Anticipated CMT Level (initial onset (within last 3 months) (i) Recurrent (multiple episodes of < 3 months) (ii) Recurrent (multiple episodes of < 3 months) (iii) 98940 98942 (iiii) 98941 98943 (iiii) 98941 Passet (including between the time) (iii) 98941 Passet (iiii) Passet (iiii) Passet (iiiii) Passet (iiiiii) Passet (iiiiiiiiiiiiiiiiiiiiiiiiiiiiiiiiiiii	(4) Est'd, continuing care		6 Other		
1 Initial onset (within last 3 months) 2 Recurrent (multiple episodes of < 3 months) 3 Chronic (continuous duration > 3 months) 98940 98941 98943 Back Index LEFS Indicate where you have pain or other symptoms Patient Completes This Section: (Please fill in selections completely) 1. Briefly describe your symptoms: 2. How did your symptoms start? 3. Average pain intensity: Last 24 hours: no pain ① ① ② ② ④ ⑤ ⑦ ⑧ ② ① worst pain Past week: no pain ① ① ② ② ④ ⑤ ⑦ ⑧ ② ① worst pain Past week: no pain ① ① ② ③ ④ ⑤ ⑦ ⑧ ② ① worst pain 4. How often do you experience your symptoms? 1) Constantly (76%-100% of the time) 2) Frequently (51%-75% of the time) 3) Occasionally (26% - 50% of the time) 4) Intermittently (0%-25% of the time) 5. How much have your symptoms interfered with your usual daily activities? (including both work outside the home and housework) 1) Not at all 2) A little bit 3) Moderately 4) Quite a bit 5) Extremely 6. How is your condition changing, since care began at this facility? (a) N/A — This is the initial visit 1) Much worse (2) Worse (3) A little worse (4) No change (5) A little better (6) Better 7. In general, would you say your overall health right now is	Nature of Condition	1		Current Functio	nal Measure Score
2) Recurrent (multiple episodes of < 3 months) 3) Chronic (continuous duration > 3 months) 4) 98941 98943 Back Index LEFS Indicate where you have pain or other symptoms I	1 Initial onset (within last 3 months)		Neck Inde		
Patient Completes This Section: (Please fill in selections completely) 1. Briefly describe your symptoms: 2. How did your symptoms start? 3. Average pain intensity: Last 24 hours: no pain 0 1 2 3 4 5 6 7 8 9 10 worst pain Past week: no pain 0 1 2 3 4 5 6 7 8 9 10 worst pain Past week: no pain 0 1 2 3 4 5 6 7 8 9 10 worst pain 4. How often do you experience your symptoms? 1) Constantly (76%-100% of the time) 2 Frequently (51%-75% of the time) 3 Occasionally (26% - 50% of the time) 4 Intermittently (0%-25% of the time) 5. How much have your symptoms interfered with your usual daily activities? (including both work outside the home and housework) 1) Not at all 2) A little bit 3 Moderately 4 Quite a bit 5 Extremely 6. How is your condition changing, since care began at this facility? (a) N/A — This is the initial visit 1 Much worse 2 Worse 3 A little worse 4 No change 5 A little better 6 Better 7 Much better 7. In general, would you say your overall health right now is	×				·
(Please fill in selections completely) 1. Briefly describe your symptoms: 2. How did your symptoms start? 3. Average pain intensity: Last 24 hours: no pain ① ① ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ② ① worst pain Past week: no pain ① ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ② ① worst pain 4. How often do you experience your symptoms? ① Constantly (76%-100% of the time) ② Frequently (51%-75% of the time) ③ Occasionally (26% - 50% of the time) ④ Intermittently (0%-25% of the time) 5. How much have your symptoms interfered with your usual daily activities? (including both work outside the home and housework) ① Not at all ② A little bit ③ Moderately ④ Quite a bit ⑤ Extremely 6. How is your condition changing, since care began at this facility? ② N/A — This is the initial visit ① Much worse ② Worse ③ A little worse ④ No change ⑤ A little better ⑥ Better ⑦ Much better 7. In general, would you say your overall health right now is	(3) Chronic (continuous duration > 3 months)	98941 0 98943	Back Inde	× L LEF	FS
1. Briefly describe your symptoms: 2. How did your symptoms start? 3. Average pain intensity: Last 24 hours: no pain ① ① ② ② ④ ⑤ ⑥ ⑦ ⑧ ⑨ ① worst pain Past week: no pain ② ① ② ③ ④ ⑥ ⑥ ⑦ ⑧ ⑨ ① worst pain Past week: no pain ② ① ② ③ ④ ⑥ ⑥ ⑦ ⑧ ⑨ ① worst pain 4. How often do you experience your symptoms? ① Constantly (76%-100% of the time) ② Frequently (51%-75% of the time) ③ Occasionally (26% - 50% of the time) ④ Intermittently (0%-25% of the time) 5. How much have your symptoms interfered with your usual daily activities? (including both work outside the home and housework) ① Not at all ② A little bit ③ Moderately ④ Quite a bit ⑤ Extremely 6. How is your condition changing, since care began at this facility? ② N/A — This is the initial visit ① Much worse ② Worse ③ A little worse ④ No change ⑤ A little better ⑥ Better ⑦ Much better 7. In general, would you say your overall health right now is	Patient Completes This Section:	ne hegan on:		Indicate where	you have pain or other symptoms
2. How did your symptoms start? 3. Average pain intensity: Last 24 hours: no pain ① ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ① worst pain Past week: no pain ① ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ① worst pain 4. How often do you experience your symptoms? ① Constantly (76%-100% of the time) ② Frequently (51%-75% of the time) ③ Occasionally (26% - 50% of the time) ④ Intermittently (0%-25% of the time) 5. How much have your symptoms interfered with your usual daily activities? (including both work outside the home and housework) ① Not at all ② A little bit ③ Moderately ④ Quite a bit ⑤ Extremely 6. How is your condition changing, since care began at this facility? ② N/A — This is the initial visit ① Much worse ② Worse ③ A little worse ④ No change ⑤ A little better ⑥ Better ⑦ Much better 7. In general, would you say your overall health right now is	(Please fill in selections completely)	ina began on.		\Box	(#.)
3. Average pain intensity: Last 24 hours: no pain ① ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ① worst pain Past week: no pain ① ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ① worst pain 4. How often do you experience your symptoms? ① Constantly (76%-100% of the time) ② Frequently (51%-75% of the time) ③ Occasionally (26% - 50% of the time) ④ Intermittently (0%-25% of the time) 5. How much have your symptoms interfered with your usual daily activities? (including both work outside the home and housework) ① Not at all ② A little bit ③ Moderately ④ Quite a bit ⑤ Extremely 6. How is your condition changing, since care began at this facility? ② N/A — This is the initial visit ① Much worse ② Worse ③ A little worse ④ No change ⑤ A little better ⑥ Better ⑦ Much better 7. In general, would you say your overall health right now is	1. Briefly describe your symptoms:				
3. Average pain intensity: Last 24 hours: no pain ① ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ① worst pain Past week: no pain ① ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ① worst pain 4. How often do you experience your symptoms? ① Constantly (76%-100% of the time) ② Frequently (51%-75% of the time) ③ Occasionally (26% - 50% of the time) ④ Intermittently (0%-25% of the time) 5. How much have your symptoms interfered with your usual daily activities? (including both work outside the home and housework) ① Not at all ② A little bit ③ Moderately ④ Quite a bit ⑤ Extremely 6. How is your condition changing, since care began at this facility? ② N/A — This is the initial visit ① Much worse ② Worse ③ A little worse ④ No change ⑤ A little better ⑥ Better ⑦ Much better 7. In general, would you say your overall health right now is					
Last 24 hours: no pain 0 1 2 3 4 5 6 7 8 9 10 worst pain Past week: no pain 0 1 2 3 4 5 6 7 8 9 10 worst pain 4. How often do you experience your symptoms? 1) Constantly (76%-100% of the time) 2 Frequently (51%-75% of the time) 3 Occasionally (26% - 50% of the time) 4 Intermittently (0%-25% of the time) 5. How much have your symptoms interfered with your usual daily activities? (including both work outside the home and housework) 1) Not at all 2 A little bit 3 Moderately 4 Quite a bit 5 Extremely 6. How is your condition changing, since care began at this facility? 0) N/A — This is the initial visit 1 Much worse 2 Worse 3 A little worse 4 No change 5 A little better 6 Better 7 Much better 7. In general, would you say your overall health right now is	2. How did your symptoms start?			1/19	11/ 21/5/11
Last 24 hours: no pain 0 1 2 3 4 5 6 7 8 9 10 worst pain Past week: no pain 0 1 2 3 4 5 6 7 8 9 10 worst pain 4. How often do you experience your symptoms? 1) Constantly (76%-100% of the time) 2 Frequently (51%-75% of the time) 3 Occasionally (26% - 50% of the time) 4 Intermittently (0%-25% of the time) 5. How much have your symptoms interfered with your usual daily activities? (including both work outside the home and housework) 1) Not at all 2 A little bit 3 Moderately 4 Quite a bit 5 Extremely 6. How is your condition changing, since care began at this facility? 0) N/A — This is the initial visit 1 Much worse 2 Worse 3 A little worse 4 No change 5 A little better 6 Better 7 Much better 7. In general, would you say your overall health right now is	3. Average pain intensity:			السائد	May Jan () May
Past week: no pain 0 1 2 3 4 5 6 7 8 9 10 worst pain 4. How often do you experience your symptoms? 1 Constantly (76%-100% of the time) 2 Frequently (51%-75% of the time) 3 Occasionally (26% - 50% of the time) 4 Intermittently (0%-25% of the time) 5. How much have your symptoms interfered with your usual daily activities? (including both work outside the home and housework) 1 Not at all 2 A little bit 3 Moderately 4 Quite a bit 5 Extremely 6. How is your condition changing, since care began at this facility? 0 N/A — This is the initial visit 1 Much worse 2 Worse 3 A little worse 4 No change 5 A little better 6 Better 7 Much better 7. In general, would you say your overall health right now is		4 (5) (6) (7) (8) (9) (1	0) worst pain	HALL I	7-(1-1
(1) Constantly (76%-100% of the time) (2) Frequently (51%-75% of the time) (3) Occasionally (26% - 50% of the time) (4) Intermittently (0%-25% of the time) 5. How much have your symptoms interfered with your usual daily activities? (including both work outside the home and housework) (1) Not at all (2) A little bit (3) Moderately (4) Quite a bit (5) Extremely 6. How is your condition changing, since care began at this facility? (0) N/A — This is the initial visit (1) Much worse (2) Worse (3) A little worse (4) No change (5) A little better (6) Better (7) Much better 7. In general, would you say your overall health right now is					
5. How much have your symptoms interfered with your usual daily activities? (including both work outside the home and housework) 1) Not at all 2) A little bit 3) Moderately 4) Quite a bit 5) Extremely 6. How is your condition changing, since care began at this facility? 0) N/A — This is the initial visit 1) Much worse 2) Worse 3) A little worse 4) No change 5) A little better 6) Better 7) Much better 7. In general, would you say your overall health right now is	4. How often do you experience your symptoms?				
(1) Not at all (2) A little bit (3) Moderately (4) Quite a bit (5) Extremely 6. How is your condition changing, since care began at this facility? (0) N/A — This is the initial visit (1) Much worse (2) Worse (3) A little worse (4) No change (5) A little better (6) Better (7) Much better 7. In general, would you say your overall health right now is	•	•			•
6. How is your condition changing, since care began at this facility? (1) N/A — This is the initial visit (2) Worse (3) A little worse (4) No change (5) A little better (6) Better (7) Much better (7) In general, would you say your overall health right now is	1) Not at all (2) A little bit (3) Modes			ooth work outside the h	nome and housework)
0) N/A — This is the initial visit 1 Much worse 2 Worse 3 A little worse 4 No change 5 A little better 6 Better 7 Much better 7. In general, would you say your overall health right now is		. 0	-AudinGly		
7. In general, would you say your overall health right now is					
○			oor .		
Patient Signature: X Date:	0 1 0			Date	



Patient	Name
---------	------

Date	

This questionnaire will give your provider information about how your back condition affects your everyday life. Please answer every section by marking the one statement that applies to you. If two or more statements in one section apply, please mark the one statement that most closely describes your problem.

Pain Intensity

- ① The pain comes and goes and is very mild.
- ① The pain is mild and does not vary much.
- The pain comes and goes and is moderate.
- 3 The pain is moderate and does not vary much.
- The pain comes and goes and is very severe.
- (5) The pain is very severe and does not vary much.

Sleeping

- 1 get no pain in bed.
- ① I get pain in bed but it does not prevent me from sleeping well.
- ② Because of pain my normal sleep is reduced by less than 25%.
- 3 Because of pain my normal sleep is reduced by less than 50%.
- Because of pain my normal sleep is reduced by less than 75%.
- ⑤ Pain prevents me from sleeping at all.

Sitting

- 1 can sit in any chair as long as I like.
- 1 can only sit in my favorite chair as long as I like.
- Pain prevents me from sitting more than 1 hour.
- 3 Pain prevents me from sitting more than 1/2 hour.
- Pain prevents me from sitting more than 10 minutes.
- ⑤ I avoid sitting because it increases pain immediately.

Standing

- ① I can stand as long as I want without pain.
- ① I have some pain while standing but it does not increase with time.
- ② I cannot stand for longer than 1 hour without increasing pain.
- (3) I cannot stand for longer than 1/2 hour without increasing pain.
- I cannot stand for longer than 10 minutes without increasing pain.
- (5) I avoid standing because it increases pain immediately.

Walking

- ① I have no pain while walking.
- ① I have some pain while walking but it doesn't increase with distance.
- 2 I cannot walk more than 1 mile without increasing pain.
- ③ I cannot walk more than 1/2 mile without increasing pain.
- I cannot walk more than 1/4 mile without increasing pain.
- (5) I cannot walk at all without increasing pain.

Personal Care

- 1 do not have to change my way of washing or dressing in order to avoid pain.
- ① I do not normally change my way of washing or dressing even though it causes some pain.
- ② Washing and dressing increases the pain but I manage not to change my way of doing it.
- 3 Washing and dressing increases the pain and I find it necessary to change my way of doing it.
- Because of the pain I am unable to do some washing and dressing without help.
- (5) Because of the pain I am unable to do any washing and dressing without help.

Lifting

- (1) I can lift heavy weights without extra pain.
- 1 can lift heavy weights but it causes extra pain.
- 2 Pain prevents me from lifting heavy weights off the floor.
- ③ Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned (e.g., on a table).
- Pain prevents me from lifting heavy weights off the floor, but I can manage light to medium weights if they are conveniently positioned.
- ⑤ I can only lift very light weights.

Traveling

- ① I get no pain while traveling.
- ① I get some pain while traveling but none of my usual forms of travel make it worse.
- ② I get extra pain while traveling but it does not cause me to seek alternate forms of travel.
- 3 I get extra pain while traveling which causes me to seek alternate forms of travel.
- Pain restricts all forms of travel except that done while lying down.
- ⑤ Pain restricts all forms of travel.

Social Life

- My social life is normal and gives me no extra pain.
- ① My social life is normal but increases the degree of pain.
- Pain has no significant affect on my social life apart from limiting my more energetic interests (e.g., dancing, etc).
- ③ Pain has restricted my social life and I do not go out very often.
- Pain has restricted my social life to my home.
- ⑤ I have hardly any social life because of the pain.

Changing degree of pain

- My pain is rapidly getting better.
- My pain fluctuates but overall is definitely getting better.
- My pain seems to be getting better but improvement is slow.
- 3 My pain is neither getting better or worse.
- My pain is gradually worsening.
- My pain is rapidly worsening.

Back	
Index	
Score	

Index Score = [Sum of all statements selected / (# of sections with a statement selected x 5)] x 100