



421 Barony St. Suite 1, Moncks Corner, Sc 29461 ~ 843.761.1790 ~ Fax: 843.761.1786

**ABOUT YOU:**

Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Age: \_\_\_\_\_ Date: \_\_\_\_\_

SSN: \_\_\_\_\_

Mailing Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Contact Number: \_\_\_\_\_ Email: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Phone Number: \_\_\_\_\_

**PAST MEDICAL HISTORY:**

Circle all that apply: Heart Problem Kidney Problem Liver Problem Tuberculosis  
Thyroid Problem Respiratory Problem Sinus Problem Digestive Problem  
Rheumatic/Scarlet Fever Venereal Disease TMJ/TMD Cancer/Tumors  
Hepatitis HIV/AIDS Arthritis/Rheumatism Lupis Shingles Anemia  
Leukemia Diabetes/Hypoglycemia High/Low BP Chemotherapy  
Fainting/Seizures Epilepsy Artificial Joint/Implants

List any surgeries, procedures, or medical conditions: \_\_\_\_\_

**SOCIAL AND PREVENTATIVE HISTORY:**

Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_

Marital Status: Single Married Divorced Widowed

Children: Yes No How Many: \_\_\_\_\_

Do you use tobacco products? Yes No How Long: \_\_\_\_\_ How Often: \_\_\_\_\_

Do you drink alcohol? Yes No How many drinks per month? \_\_\_\_\_

Do you exercise? Yes No How Often: \_\_\_\_\_

Do you have any allergies (Latex, Foods, Etc.)? \_\_\_\_\_

Women, please circle any that apply: Taking Birth Control Pregnant Nursing

Do you currently take any supplements? Yes No List: \_\_\_\_\_



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**REASON FOR YOUR VISIT:**

**(Please include ALL issues and complaints experienced within the last six (6) months for insurance purposes; our office can provide additional paper if needed.)**

What is the patient's **PRIMARY** complaint? \_\_\_\_\_ Intensity of pain 0-10: \_\_\_\_

Onset (when did it begin?): \_\_\_\_\_ How did it begin? \_\_\_\_\_

Character (circle): Dull Ache Sharp Stabbing Burning Throbbing Stiffness Pounding Other: \_\_\_\_\_

Duration: Intermittent Occasional Frequent Constant

Aggravating Factors: Cough/sneeze Lifting Sitting Standing Pushing Pulling Driving Walking  
Bending Lying Sleeping Bright lights Noise Other: \_\_\_\_\_

Relieving Factors: Rest NSAIDS Pain Meds Ice/Heat Sitting Standing Lying Sleeping Exercise

What is the patient's **SECONDARY** complaint? \_\_\_\_\_ Intensity of pain 0-10: \_\_\_\_

Onset (when did it begin?): \_\_\_\_\_ How did it begin? \_\_\_\_\_

Character (circle): Dull Ache Sharp Stabbing Burning Throbbing Stiffness Pounding Other: \_\_\_\_\_

Duration: Intermittent Occasional Frequent Constant

Aggravating Factors: Cough/sneeze Lifting Sitting Standing Pushing Pulling Driving Walking  
Bending Lying Sleeping Bright lights Noise Other: \_\_\_\_\_

Relieving Factors: Rest NSAIDS Pain Meds Ice/Heat Sitting Standing Lying Sleeping Exercise

**OFFICE USE ONLY.**

Patient: \_\_\_\_\_

Date: \_\_\_\_\_

X-Rays: \_\_\_\_\_

Acct # \_\_\_\_\_

DOB: \_\_\_\_\_

Orthos: \_\_\_\_\_

Functional Leg Length Difference: \_\_\_\_\_

Neurological: \_\_\_\_\_

Muscle Testing: \_\_\_\_\_

Subluxations: \_\_\_\_\_

Grip Strength: R    = \_\_\_\_

L    = \_\_\_\_

ROM: Cerv \_\_\_\_\_

Thor-Lumb:

Flex: \_\_\_\_/60 P S R

Flex: \_\_\_\_/90 P S R

Ext: \_\_\_\_/55 P S R

Ext: \_\_\_\_/30 P S R

LT Lat Flex: \_\_\_\_/40 P S R

LT Lat Flex: \_\_\_\_/35 P S R

RT Lat Flex: \_\_\_\_/40 P S R

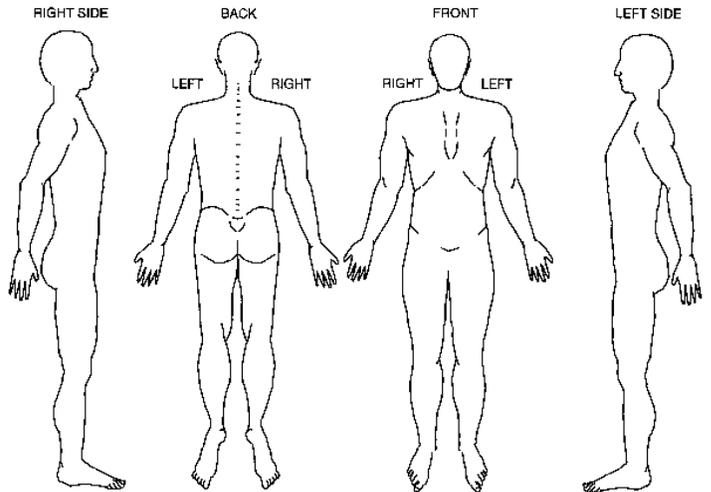
RT Lat Flex: \_\_\_\_/35 P S R

Lt Rot: \_\_\_\_/80 P S R

Lt Rot: \_\_\_\_/30 P S R

Rt Rot: \_\_\_\_/80 P S R

Rt Rot: \_\_\_\_/30 P S R



\*Disclaimer: This written exam form may not contain all detailed information about this patient's exam findings. Detailed information is available upon request after our physician has completed his documentation in our digital records.



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# Electronic Health Records Intake Form

*In Compliance with requirements for the government EHR incentive program*

First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_

Email Address: \_\_\_\_\_@\_\_\_\_\_

Preferred method of communication for patient reminders (circle one): Email / Phone / Mail

DOB: \_\_\_/\_\_\_/\_\_\_ Gender (Circle One): Male / Female Preferred Language: \_\_\_\_\_

Smoking Status (Circle One): Every Day Smoker / Occasional Smoker / Former Smoker / Never Smoked

CMS requires providers to report both race and ethnicity

Race (Circle One): American Indian or Alaska Native / Asian / Black or African American /  
White (Caucasian) / Native Hawaiian or Pacific Islander / Other / I Decline to Answer

Ethnicity (Circle One): Hispanic or Latino / Not Hispanic or Latino / I Decline to Answer

Are you currently taking any medications? (Please include regularly used over the counter medications)

Medication Name	Dosage and Frequency (i.e. 5mg once a day, etc.)

Do you have any medication allergies?

Medication Name	Reaction	Onset Date	Additional Comments

I choose to decline receipt of my clinical summary after every visit (These summaries are often blank as a result of the nature and frequency of chiropractic care.)

Patient Signature: \_\_\_\_\_

Date: \_\_\_\_\_



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### HIPPA Notice of Privacy Practices

Authorization for Use or Disclosure of Protected Health Information (PHI)

(Required by the Health Insurance Portability and Accountability Act-45CFR Parts 160 and 164)

I hereby authorize all medical service sources and health care providers to use and/ or disclose the protected health information described below to my agent identified in my durable POA for health care Named

Milo Chiropractic, LLC

Authorization for release of PHI covering the period of health care (check one)

all past, present and future treatment periods

from (date) \_\_\_\_\_ to (date) \_\_\_\_\_

I, hereby authorize the release of PHI as follows (check one);

My complete health record (including relating to mental health care, communicable diseases, HIV, or AIDS, and treatment of alcohol / drug abuse) OR

my complete health record **except** for the following information (Check as appropriate):

Mental Health Records

Communicable diseases (including HIV / AIDS)

Alcohol / drug abuse treatment

Other (please specify): \_\_\_\_\_

In addition to the authorization for release of my PHI as described above, I authorize disclosure of information regarding my billing, condition, treatment and prognosis to the following individual(s):

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

This medical information may be used by the persons I authorize to receive this information for medical treatment or consultation, billing or claims payment, or other purposes as I may direct.



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***In accordance to Part 2 of the NPP some information including substance use disorder (SUD) is protected by Part 2 and may have extra privacy protections and may have different rules than the standard HIPPA disclosures. Part 2 limits how SUD Records and testimony can be used in civil, criminal, administrative proceedings without consent or a court order.***

The NPP information disclosed may be redisclosed by the recipient and may not remain protected by HIPPA, except where other laws apply.

I understand that I have the right to revoke this authorization, in writing, at any time. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

I understand that my treatment, payment, enrollment, or eligibility for benefits will not be conditioned on whether I sign this authorization.

I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

**MEDICARE AND MEDICAID CONSENT TO RELEASE:**

I certify that the information given by me, in applying for payment under the Social Security Act, is correct. I authorize any holder of medical or other information about me to be released to the Social Security Administration or it's intermediary earners.

**CONSENT TO TREAT**

I voluntarily consent to the care and any diagnostics being recommended by my treating physician here at Milo Chiropractic, LLC. Of course, and and all treatment / diagnostics will be explained prior to treatment.

**HIPPA COMPLIANCE**

Our office is required by law to maintain the HIPPA Notice of Privacy Practices (NPP). This notice explains our legal duties and privacy practices with respect to your protected health information (PHI). Signature below acknowledges that I have read this Notice of Privacy Practices. A copy will be provided to me upon request.

**Verification of NON-PREGNANCY (female patients only)**

I do hereby certify that to the best of knowledge, I am not pregnant currently and if become pregnant that I will notify this office before treatment. Please initial. \_\_\_\_\_

**By signing below, I acknowledge that I consent to treatment and have read and understand ALL of the above information**

Print Patients Name \_\_\_\_\_ Date: \_\_\_\_\_

Signature of Patient or Guardian: \_\_\_\_\_



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### **PATIENT FINANCIAL POLICY**

Thank you for choosing Milo Chiropractic as your health care provider. We are committed to building a successful physician-patient relationship with you and your family. Your clear understanding of our Patient Financial Policy is important to our professional relationship, and payment for services is part of that relationship. Please ask if you have any questions or concerns about our fees, policies, or your responsibilities. It is your responsibility to notify our office with any information changes such as address, phone, name, and insurance coverage prior to receiving services.

**Insurance:** We participate with most insurance plans, including Medicare and Medicaid. We ask you give us the most up-to-date insurance card this way claims can be processed accurately. If you have changed insurance since seeing us, please provide the most current information to the front desk staff. Also, provide us with any address or phone number changes.

**Co-pays, deductibles & non-covered services:** All co-pays and deductibles must be paid at the time of service. This arrangement is part of your contract with the insurance company. With that, please be aware that some services you may receive may NOT be covered by your insurance plan. We do our best to give an estimate for the services you receive, but anything denied by insurance will be patient responsibility.

**Self-pay Accounts:** Self-pay accounts are usually patients with no health insurance. We are partnered with a discounted medical program to help with out-of-pocket costs. We can sign you up right here in the office.

**Minors:** Parents and/or guardians are responsible for payments on minor's accounts and will receive the billing statements. Parent/guardian must sign paperwork for minor and consent to treat.

**Nonpayment/Collections:** Starting September 1, 2024 our office will be sending unpaid accounts to collections. We will send five statements for the balance owed after insurance pays on all claims, but please note; If we **DO NOT** receive a payment on your account after those five statements have been sent, your balance will be handed off to a collection's agency.

**Automobile Accidents: Our office WILL NOT bill health insurance or an adjuster for any cases related to a motor vehicle accident. If you have been involved in an accident, please talk to the front desk about our office policy on this matter.**

**Please understand payment is due at time of service and the payment collected is an estimate. The final amount will be determined by your insurance plan coverage you have at the time of service.**

For your convenience, our office accepts cash, checks, all major credit/debit cards, and Care Credit. Should payment be refused by your bank for any written check, there will be a charge of \$35 to offset the charge incurred as a result of the returned check.

By signing below, you are acknowledging you have a clear understanding of our office policy.

---

Signature

Date



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## MASSAGE POLICY

Due to an increase in patients not attending scheduled massage appointments, we feel it necessary to strictly enforce our **No-Show Policy**.

You are required to contact our office **twenty-four (24)** hours in advance to cancel or reschedule. In the event that you contact the office the day of, or more than **twenty (20)** minutes late for a scheduled massage, you will be charged a \$75 **No Show Fee**.

**FIRST OFFENSE** No Show Fee May be waived as a courtesy

**SECOND OFFENSE** You will be required to prepay for massage appointment at time of scheduling.

**EXCEPTIONS:** Medical or legal documentation excusing a **No Show**.

I have read and understand the above policy and agree to the terms.

Print Name: \_\_\_\_\_ Date: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_



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**PLEASE ADVISE THIS IS FOR: Lumbar/Low Back Pain Scale**

Please rate the severity of your pain by circling a number below:

No pain 0 1 2 3 4 5 6 7 8 9 10 Unbearable Pain

Name: \_\_\_\_\_ Date: \_\_\_\_\_

**Instructions:** Please circle only **ONE NUMBER** in each section which mostly describes your problem.

**Section 1 – Pain Intensity**

- 0. The pain comes and goes and is very mild.
- 1. The pain is mild and does not vary much.
- 2. The pain comes and goes and is moderate.
- 3. The pain is moderate and does not vary much.
- 4. The pain comes and goes and is severe.
- 5. The pain is severe and does not vary much.

**Section 2 – Personal Care (Washing, dressing, etc.)**

- 0. I 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.
- 4. 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.

**Section 3 – Lifting**

- 0. I can lift heavy weights without extra pain.
- 1. I can lift heavy weights but it gives 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, ie: on a table.
- 4. Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
- 5. I can only lift very light weights at most.

**Section 4 – Walking**

- 0. I have no pain when walking.
- 1. I have some pain when walking, but it does not 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.
- 4. I cannot walk more than 1/4 mile without increasing pain.
- 5. I cannot walk at all without increasing pain.

**Section 5 - Sitting**

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

**Section 6 - Standing**

- 0. I can stand as long as I want without pain.
- 1. I have some pain on 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.
- 4. I cannot stand for longer than 10 minutes without increasing pain.
- 5. I avoid standing because it increases the pain immediately.

**Section 7 – Sleeping**

- 0. I have no pain in bed.
- 1. I have pain in bed, but it does not prevent me from sleeping well.
- 2. Because of my pain my normal night’s sleep is reduced by less than 1/4.
- 3. Because of my pain my normal night’s sleep is reduced by less than 1/2.
- 4. Because of my pain my normal night’s sleep is reduced by less than 3/4 .
- 5. Pain prevents me from sleeping at all.

**Section 8 – Social Life**

- 0. My social life is normal and gives me no pain.
- 1. My social life is normal but it increases the degree of pain.
- 2. Pain has no significant effect on my social life apart from limiting my more energetic interests, ie: dancing, etc.
- 3. Pain has restricted my social life and I do not go out very often.
- 4. Pain has restricted my social life to my home.
- 5. I have hardly any social life because of the pain.

**Section 9 - Traveling**

- 0. I get no pain when traveling.
- 1. I get some pain when traveling but none of my usual forms of travel make it worse.
- 2. I get extra pain while traveling, but it does not compel me to seek alternative forms of travel.
- 3. I get extra pain while traveling which compels me to seek alternative forms of travel.
- 4. Pain restricts me to short necessary journeys under 1/2 hour.
- 5. Pain restricts all forms of travel.

**Section 10 – Changing Degree of Pain**

- 0. My pain is rapidly getting better.
- 1. My pain fluctuates, but is definitely getting better.
- 2. My pain seems to be getting better, but improvement is slow.
- 3. My pain is neither getting better or worse.
- 4. My pain is gradually worsening.
- 5. My pain is rapidly worsening



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**PLEASE ADVISE THIS IS FOR: Thoracic/Mid-Back Pain Scale**

Please rate the severity of your pain by circling a number below:

No pain 0 1 2 3 4 5 6 7 8 9 10 Unbearable Pain

Name: \_\_\_\_\_ Date: \_\_\_\_\_

**Instructions:** Please circle the **ONE NUMBER** in each section that most closely describes your problem.

**Section 1 – Pain Intensity**

- 0 I have no pain at the moment.
- 1 The pain is very mild at the moment
- 2 The pain is moderate at the moment
- 3 The pain is fairly severe at the moment
- 4 The pain is very severe at the moment
- 5 The pain is the worst imaginable at the moment

**Section 2 – Personal Care (washing, dressing, etc.)**

- 0 I can look after myself normally without causing extra pain
- 1 I can look after myself but it causes extra pain
- 2 It is painful to look after myself if I am slow and careful
- 3 I need some help but can manage most of my personal care
- 4 I need help every day in most aspects of self-care
- 5 I do not get dressed, wash with difficulty and stay in bed

**Section 3 – Lifting**

- 0 I can lift heavy weights without extra pain
- 1 I can lift heavy weights but it gives me extra pain
- 2 Pain prevents me from lifting heavy weights off the floor but I can manage if they are conveniently placed
- 3 Pain prevents me from lifting heavy weights but I can manage light to medium weights if they are conveniently placed
- 4 I can only lift very light weights
- 5 I cannot lift or carry anything

**Section 4 - Reading**

- 0 I can read as much as I want with no neck pain
- 1 I can read as much as I want to with only a slight increase in neck pain
- 2 I can read as much as I want to with moderate increase in my neck pain
- 3 Pain prevents me from reading as much as I want to
- 4 I can hardly read at all because of neck pain
- 5 I cannot read at all because of neck pain

**Section 5 – Headaches**

- 0 I have no headaches at all
- 1 I have mild headaches that come infrequently
- 2 I have moderate but infrequent headaches
- 3 I have moderate and frequent headaches
- 4 I have severe and frequent headaches

- 5 I have a headache almost all the time

**Section 6 – Concentration**

- 0 I can concentrate fully and with no difficulty
- 1 I can concentrate fully but with slight difficulty
- 2 I can concentrate fully but only for short periods of time
- 3 I have a fair degree of difficulty concentrating
- 4 I have a lot of difficulty concentrating
- 5 I cannot concentrate at all

**Section 7 – Sleeping**

- 0 My sleep is never disturbed by pain
- 1 My sleep is occasionally disturbed by pain
- 2 Because of pain I have less than 6 hours sleep at night
- 3 Because of pain I have less than 4 hours sleep at night
- 4 Because of pain I have less than 2 hours sleep at night
- 5 I can't sleep at all because of the pain

**Section 8 – Work**

- 0 I can do as much work as I want to
- 1 I can only do my usual work but no more
- 2 I can do most of my usual work but with difficulty
- 3 I cannot do my usual work
- 4 I can hardly work
- 5 I cannot work at all

**Section 9 – Social Life**

- 0 My social life is normal and gives me no extra pain
- 1 My social life is normal but increases my pain
- 2 Pain limits only my more energetic interests, ie: sports
- 3 Pain has restricted my social life and I do not go out as often
- 4 Pain has restricted my social life to home
- 5 I have no social life because of pain

**Section 10 – Traveling**

- 0 I can travel anywhere without pain
- 1 I can travel anywhere but it gives me extra pain
- 2 Pain is bad but I manage trips longer than 2 hours
- 3 Pain restricts me to trips of less than 1 hour
- 4 Pain restricts me to trips of less than 30 minutes
- 5 Pain prevents me from traveling



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**PLEASE ADVISE THIS IS FOR: Cervical/Neck Pain Scale**

Please rate the severity of your pain by circling a number below:

No pain 0 1 2 3 4 5 6 7 8 9 10 Unbearable Pain

Name: \_\_\_\_\_ Date: \_\_\_\_\_

**Instructions:** Please circle the **ONE NUMBER** in each section that most closely describes your problem.

**Section 1 – Pain Intensity**

- 0 I have no pain at the moment.
- 1 The pain is very mild at the moment
- 2 The pain is moderate at the moment
- 3 The pain is fairly severe at the moment
- 4 The pain is very severe at the moment
- 5 The pain is the worst imaginable at the moment

**Section 2 – Personal Care (washing, dressing, etc.)**

- 0 I can look after myself normally without causing extra pain
- 1 I can look after myself but it causes extra pain
- 2 It is painful to look after myself if I am slow and careful
- 3 I need some help but can manage most of my personal care
- 4 I need help every day in most aspects of self care
- 5 I do not get dressed, wash with difficulty and stay in bed

**Section 3 – Lifting**

- 0 I can lift heavy weights without extra pain
- 1 I can lift heavy weights but it gives me extra pain
- 2 Pain prevents me from lifting heavy weights off the floor but I can manage if they are conveniently placed
- 3 Pain prevents me from lifting heavy weights but I can manage light to medium weights if they are conveniently placed
- 4 I can only lift very light weights
- 5 I cannot lift or carry anything

**Section 4 - Reading**

- 0 I can read as much as I want with no neck pain
- 1 I can read as much as I want to with only a slight increase in neck pain
- 2 I can read as much as I want to with moderate increase in my neck pain
- 3 Pain prevents me from reading as much as I want to
- 4 I can hardly read at all because of neck pain
- 5 I cannot read at all because of neck pain

**Section 5 – Headaches**

- 0 I have no headaches at all
- 1 I have mild headaches that come infrequently
- 2 I have moderate but infrequent headaches
- 3 I have moderate and frequent headaches
- 4 I have severe and frequent headaches
- 5 I have a headache almost all the time

**Section 6 – Concentration**

- 0 I can concentrate fully and with no difficulty
- 1 I can concentrate fully but with slight difficulty
- 2 I can concentrate fully but only for short periods of time
- 3 I have a fair degree of difficulty concentrating
- 4 I have a lot of difficulty concentrating
- 5 I cannot concentrate at all

**Section 7 – Sleeping**

- 0 My sleep is never disturbed by pain
- 1 My sleep is occasionally disturbed by pain
- 2 Because of pain I have less than 6 hours sleep at night
- 3 Because of pain I have less than 4 hours sleep at night
- 4 Because of pain I have less than 2 hours sleep at night
- 5 I can't sleep at all because of the pain

**Section 8 – Work**

- 0 I can do as much work as I want to
- 1 I can only do my usual work but no more
- 2 I can do most of my usual work but with difficulty
- 3 I cannot do my usual work
- 4 I can hardly work
- 5 I cannot work at all

**Section 9 – Social Life**

- 0 My social life is normal and gives me no extra pain
- 1 My social life is normal but increases my pain
- 2 Pain limits only my more energetic interests, ie: sports
- 3 Pain has restricted my social life and I do not go out as often
- 4 Pain has restricted my social life to home
- 5 I have no social life because of pain

**Section 10 – Traveling**

- 0 I can travel anywhere without pain
- 1 I can travel anywhere but it gives me extra pain
- 2 Pain is bad but I manage trips longer than 2 hours
- 3 Pain restricts me to trips of less than 1 hour
- 4 Pain restricts me to trips of less than 30 minutes
- 5 Pain prevents me from traveling

