MID VALLEY CLINIC
CHIROPRACTIC

Dr. Woodmansee, DC **Dr. Bryan Gordon DC**

Clinic and Financial Policy (Please Read Very Carefully)

The following is an explanation of our clinic's policies. We believe that a clear definition will allow us both to concentrate on the most important issue: Regaining and maintaining your health. We will be happy to answer any questions you may have regarding our policies, your account, or insurance coverage.

No Charge Consultation

Midvalley Clinic will do a special "No Charge" consultation or brief conference with anyone interested in finding out if chiropractic care can help with their individual health problem. There is no charge or obligation in connection with this service. (Consultation is a discussion which can consist of: Current and Past Medical History, and Current Complains only, this does not include advice, examination, or other "treatment" recommendations.)

Patient Payment Policy

We feel that the patient's health needs are paramount; therefore, the following payment policy is an attempt to allow you, the patient, to receive the care you need along with clear account balances.

New Patient Services

All payments towards deductible and cash are required at the time of service. Properly documented Worker's Compensations and Auto Accident claims are not required to pay at this time if appropriate forms and liens are signed.

Established Patient Care Services

Patients under care are required to make regular payments on all unpaid balances, except for properly documented Worker's Compensation and Auto Accident claims. Payments need to be paid on time according to your arrangements. In the event your account becomes over 60 days late, you agree to the following terms: ***The undersigned specifically agrees to pay all reasonable attorney's fees and court costs in the event legal action is taken to collect on the account. The undersigned further agrees to pay an additional amount representing fifty (50%) of the principle balance if the account is referred to a collection agency or attorney for collection. There will be an additional interest accrued on your account in the amount of 1.5% of the original balance per month. This additional amount is in recognition of the costs associated with said collection action processing.***

Our Policy on Health Insurance

Today, not all insurance companies will cover chiropractic care. We will be happy to file your insurance claim for you and do everything we can to make sure you receive proper reimbursement; however, we cannot take responsibility for what your health insurance will or will not cover. In the event your insurance deems your visit or procedure "not medically necessary" you agree to waive the portion of your agreement with your HMO/PPO and pay for the office visit(s) that day in full or make payment arrangements. In the event you begin a treatment plan in which all visits are not covered, you agree to accept financial arrangements.

Appointments

It is essential that you keep your appointments, failure to do so results in poor results, and a lost opportunity we have to treat someone else. We understand that emergencies and accidents happen; however, we charge for missed appointments in the amount of $15.00 per missed appointment. You are responsible for this fee if you do not give 24 hour notice of missed appointment.

Release of Information

I authorize the release of any information concerning my health and health care services to my insurance companies, pre-paid health plan or Medicare.

Assignment of Insurance Benefits and Payment Agreement

I authorize and direct that payment be made directly to: Dr. Dirk Woodmansee, DC @ Comprehensive Chiropractic Clinic, and/or Dr. Bryan Gordon, DC or other designated corporation located at 2618 West 7800 South Suite #200, West Jordan, UT 84088 (801) 562-1531; for any and all insurance benefits or reimbursement for services rendered by him/them which amounts would otherwise be payable to me under any insurance or pre-paid health care plan. I understand that there is no guarantee that my insurance company or pre-paid health plan will cover or pay for all of my charges. Notwithstanding denial, reduction of benefits or failure to pay for any reason, I understand that I am responsible for all remaining charges.

Privacy Policy

At MidValley Clinic we care about your privacy, and we have taken steps to ensure that your personal information is protected. We will only provide information to those whom you have given authorization in writing to do so. If you would like to review in detail our policies on HIPPA we will provide you one at your request.

Questions and Answers

Your questions about any aspect of your care or account are invited. Please feel free to ask your doctor or any available staff member. We will make every effort to answer your inquiries.

We look forward to serving you.

Name (Printed) Signature Date

MidValley Chiropractic Clinic

Patient Information

Patient Name: _____

Insurance Information

Is your condition related to any of the following: [ ] Auto Crash Date of Injury: _____
[ ] Health Insurance [ ] Self Pay: _____

(Please provide the necessary Information to the Front Desk Staff)

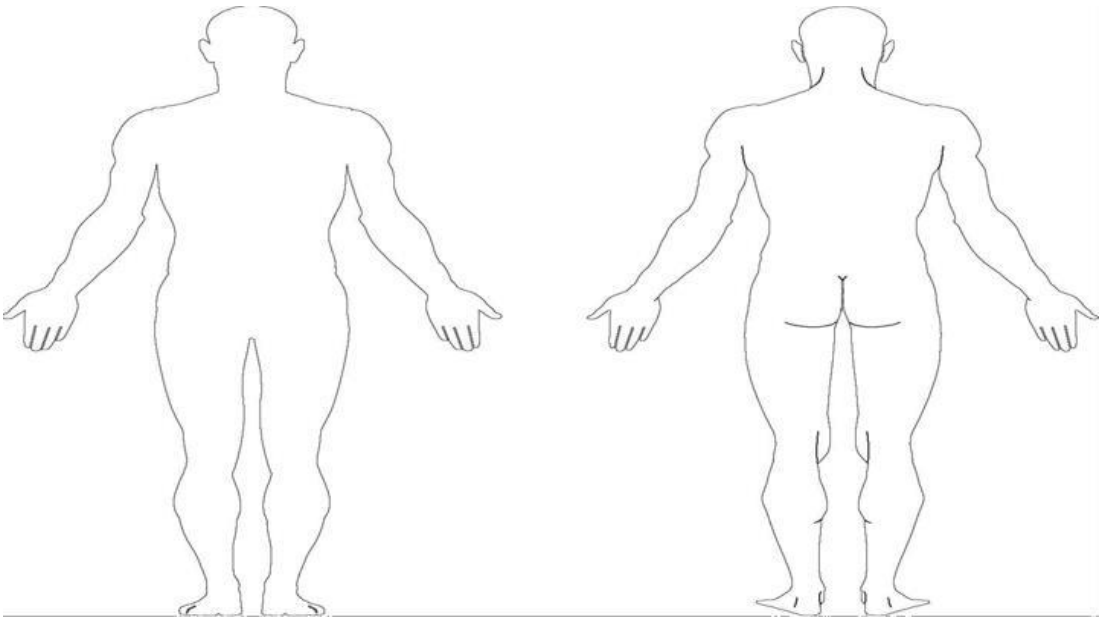
List of Symptoms in Order

Major Complaint/Reason for Visit	Date Condition Began	Have you had this before?
1._____	_____	[ ] Yes [ ] No
2. _____	_____	[ ] Yes [ ] No
3._____	_____	[ ] Yes [ ] No
4. _____	_____	[ ] Yes [ ] No
5. _____	_____	[ ] Yes [ ] No

GENERAL SYMPTOMS CHART

Please use the following notations on the figures below to indicate the type and location of your symptoms, as it relates to the purpose of your visit today.

A = ACHE	G = STABBING	N = NUMBNESS
B = BURNING	M = SPASMS	P = PINS & NEEDLES
T = TINGLING	F = STIFFNESS	O = OTHER



Please Check any Problems you are currently experiencing:

General [ ] Low Energy [ ] Sleep Disturbance [ ] Nausea [ ] dizziness [ ] headaches
[ ] TMJ/ clicking [ ] depression [ ] anxiety [ ] irritability [ ] snoring

Bowel and bladder Function: If you have had any change in your bowel or bladder function, do you:

[ ] Urinate more often [ ] Have loss of control or accidents [ ] Have a sense of urgency
[ ] Have problems with sexual function [ ] Have a loss of sensation around the groin or buttocks
[ ] Constipation [ ] Diarrhea [ ] Recurrent bladder/ urinary tract infections

Neurological/ Orthopedic

[ ] Neck pain [ ] Shoulder pain [ ] Mid-back pain [ ] Low back pain
[ ] Pain in ribs/ chest [ ] scoliosis [ ] Muscular Cramps/ spasms
[ ] Numbness/ tingling into hands/ arms [ ] Pain into shoulders/ arms/ hands
[ ] Weakness into arms/ hands [ ] Numbness/tingling into legs/ feet
[ ] Pain into hips/ legs/ feet [ ] Weakness into the legs
[ ] Osteoporosis [ ] Arthritis [ ] Seizures

Other:

[ ] Immune problems	[ ] Hearing disturbances	[ ] Hearth murmurs	[ ] Hypoglycemia
[ ] Infectious Disease	[ ] Thyroid Conditions	[ ] Asthma	[ ] Gall Bladder
[ ] Pain with breathing	[ ] High cholesterol	[ ] Acid Reflux	[ ] Dizziness/ Fainting
[ ] Sinusitis	[ ] Kidney Disease	[ ] Liver Disease	[ ] Cold hands/ Feet
[ ] Heart palpitations	[ ]Diabetes	[ ] Bleeding disorder	[ ] Sleep Apnea
[ ] Arthritis	[ ]Shortness of breath	[ ]Ulcers/ gastritis	
[ ] Visual Disturbances	[ ] High Blood Pressure	[ ] Indigestion/ Heartburn	[ ] Lung Disease

Please Explain Any of The Above: _____

General Healthcare Providers

Primary Care Provider—Name _____ Date of Last Visit: _____

Other Healthcare Providers—

Name _____ Specialty _____ Date of Last Visit _____

Name _____ Specialty _____ Date of Last Visit _____

Allergies (and reactions) _____

Previous Major Injuries or trauma and dates: _____

_____

Previous surgeries and dates: _____

_____

Previous hospitalizations or major conditions and dates: _____

_____

What other testing or treatments have you tried to date for present condition: _____

_____

Have you ever been diagnosed with cancer? [ ] Yes [ ] No If yes, explain _____

_____

Have YOU or any of your immediate family members ever had the following:

[ ] Mental health disease [ ] Neurological Problems [ ] Lung Disease [ ] Thyroid [ ] Arthritis
[ ] Circulatory problems [ ] Immune system problems [ ] back pain [ ] Cancer [ ] Scoliosis
[ ] Heart Disease [ ] Stroke [ ] Kidney disease [ ] Diabetes [ ] Osteoporosis
[ ] Migraine Headache [ ] Digestive Disorders [ ] Infectious disease [ ] Seizures
[ ] Liver Disease [ ] Other:_____

Social and Lifestyle History

Do you exercise? [ ] Yes [ ] No How often? 1X 2X 3X 4X 5X Week Other: _____
What activities? [ ] Running/ Jogging [ ] Weight Training [ ] Cycling [ ] Yoga [ ] Pilates [ ] Swimming Other:
Do you consider yourself to be….? [ ] Underweight [ ] Normal Weight [ ] Over Weight [ ] Obese
Smoking History? [ ] Never [ ] Former [ ] Currently How many?___/ per [ ] Day [ ] Week [ ] Month [ ] Year
Do you use recreational drugs? [ ] Yes [ ] No Type: _____How much? _/ day/week/month/ year Do you drink alcohol? [ ] Yes [ ] No How much? _____/per [ ] Day [ ] Week [ ] Month [ ] Year
Do you drink coffee? [ ] Yes [ ] No How much? _____/ per [ ] Day [ ] Week [ ] Month [ ] Year
What is your Height _____ Weight _____? What is your trade: _____
How do you rate your overall health? [ ] Excellent [ ] Very Good [ ] Good [ ] Fair [ ] Poor) ?
What kind of hobbies do you enjoy? (ie: Outdoors, sports, etc.) _____
_____
How has you current condition changed your ability to do things? _____
_____
_____

_____

Authorization of Care

*I authorize and agree to allow the doctor and/or his designated staff to work with my spine or the spine of the charge I represent through the use of spinal adjustments and rehabilitative exercises for the sole purpose of postural and structural restoration of normal bio-mechanical and neurological function.
*I understand that I am responsible for all fees incurred for the services provided, and agree to ensure full payment of all charges.
*The Doctor and/or his staff will not be held responsible for any health conditions or diagnoses which are pre-existing, given by another healthcare practitioner, or are not related to the spinal structural conditions diagnosed at this clinic.
*I also clearly understand that if I do not follow the doctors and/or staff's specific recommendations at this clinic that I will not receive the full benefit from these programs; and that if I terminate my care prematurely that all fees incurred will be due and payable at that time.

Patient's Signature:_____Date:___/_____/_____
Patient's Name Printed:_____

FOR MALE PATIENTS CONSENT FOR DIAGNOSTIC TESTING

I, _____, consent to the performance of diagnostic imaging studies and diagnostic testing studies upon me. I understand that Midvalley Clinic physician(s) consider(s) it necessary or advisable to perform studies during the course of my examination and treatment.

Signature: _____Date: _____

FOR FEMALE PATIENTS PREGNANCY STATEMENT

Patient Name: _____

- ☐ I understand that if I am pregnant and have X-rays taken that expose my lower torso to radiation, it is possible to injure the fetus.
- ☐ I have been advised that the 10 days following onset of a menstrual period are generally considered safe for X-ray exams (low risk of pregnancy during that time).

With those factors in mind, I am advising my doctor:

I am pregnant	_____Yes	_____No	_____Don't Know
I could be pregnant	_____Yes	_____No	_____Don't Know
My menstrual period is late	_____Yes	_____No	_____Don't Know
I am taking oral contraceptives	_____Yes	_____No	_____Don't Know
I have an IUD	_____Yes	_____No	_____Don't Know
I have had a tubal ligation	_____Yes	_____No	_____Don't Know
I have had a hysterectomy	_____Yes	_____No	_____Don't Know
I have irregular menstrual periods	_____Yes	_____No	_____Don't Know

My last menstrual period began _____
I have begun menopause _____Yes _____No

An X-ray may be performed on me with my consent, I authorize Midvalley Clinic physician(s) to perform **diagnostic imaging studies and diagnostic testing**, as deemed necessary or advisable during the course of treatment.

Signature: _____Date: _____

FOR MINORS CONSENT TO DIAGNOSTIC TESTING

As the legal guardian of _____, who is _____years of age, I _____, authorize MidValley Clinic physician(s) to perform **diagnostic imaging studies and diagnostic testing** on said minor as deemed necessary or advisable during the course of treatment.

Signature: _____Date: _____

CRASH QUESTIONAIRRE

1. What was the date and time of the crash? _____ _____AM/PM

2. How many vehicles were involved in the accident?_____

4. What was the estimated damage to the vehicle you were in? $_____ or Totalled

5. What street or intersection did the crash occurred? _____

6. What direction were you traveling in? (north, south, east, etc.) _____

7. What city and state did the crash happen? _____

8. What type of impact was the auto accident? (rear, side, T-bone, etc.) _____

9. Where were you sitting in the vehicle during the accident? (ie: Driver, Passenger, Rear Passenger drivers or passenger side)
_____

10. Did you know the accident was coming?_____

11. What type of vehicle were you in? _____

12. What type of vehicle impacted yours? _____

13. Did the airbag deploy, if so which airbags deployed? _____

14. At the time of the impact, how fast was your vehicle moving? _____

15. At the time of impact, how fast was the other vehicle moving? _____

16. During and after the crash what happened to your vehicle? (Ie: Stopped, kept going straight, hit something else, etc)_____
_____

17. Did you lose consciousness during the accident? [ ]yes [ ] no

18. How was your head positioned during the accident? (forward, turned right, left, etc.) _____

19. How were you positioned in the vehicle? (ie: seated both hands on the wheel, etc) _____
_____

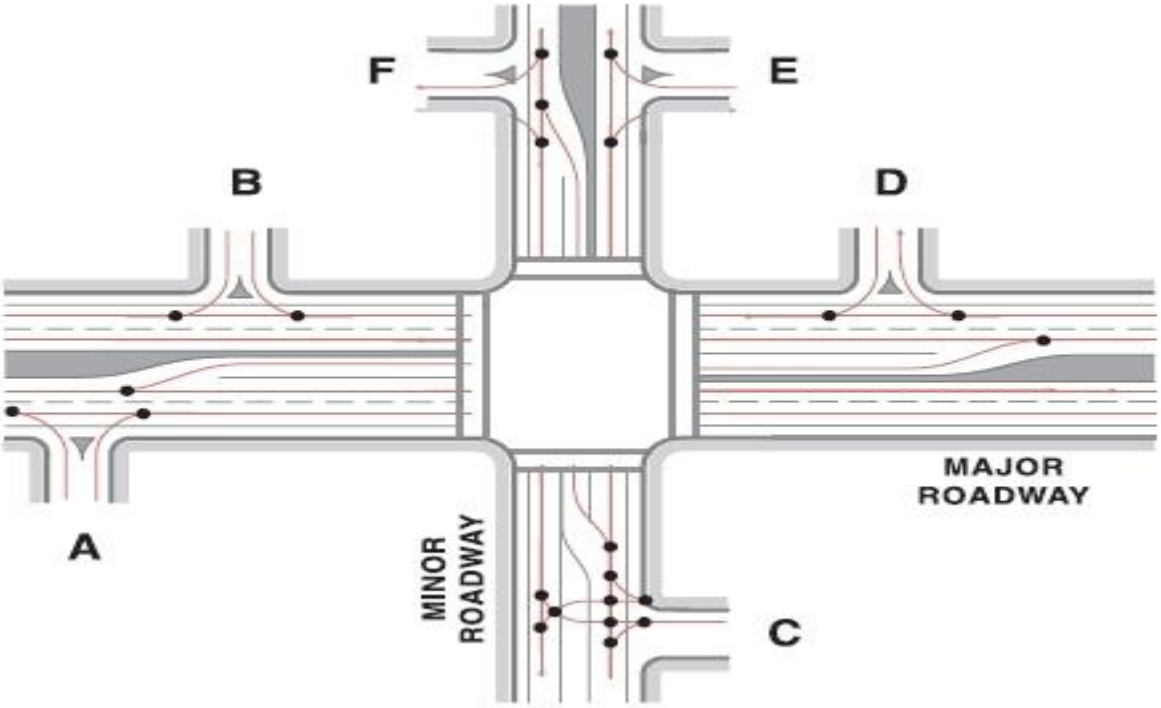
20. Did any part of your body hit anything inside the vehicle? (ie: head hit windshield, etc.) _____
_____

21. What kind of headrest does your vehicle have? And what position does your head rest at? (Ie: moveable headrest, sitting at the middle of the back of head, etc) _____

22. What kind of seatbelt where you wearing? (Shoulder with lap, lap only, etc) _____
_____ Did you remain in the seatbelt? _____

23. Please describe the damage to the vehicle: (Ie: driver's side at the front fender, could not open the door)
_____
_____

Please Use Diagram Below And Sketch Your Accident



24. Did you go to the hospital or Instacare? If Yes, please tell us where so that we may get your records: _____
How did you get there? (ambulance, drove, ride, etc) _____

25. What treatment(s) were you given? (Medications, stiches, etc) _____
_____

26. Did you get imaging or special tests? (MRI, CT, X-ray, etc) Please list and describe: _____
_____
_____
_____

Other Comments: Below

Name _____ Date _____

Please read carefully:

This questionnaire has been designed lo enable us to understand how your back pain has affected your ability to manage everyday life. Please answer every section, and mark in each section only ***ONE CHOICE*** *which applies to you. We realize that you may consider that two of the statements in any one sec/ion relate to you, but please just mark the one box which most closely describes* ***your problem right now.***

SECTION I - Pain Intensity

A. The pain comes and goes and is very mild.
B. The pain is mild and does not vary much.
C. The pain comes and goes and is moderate.
D. The pain is moderate and does not vary much.
E. The pain comes and goes and is severe.
F. The pain is severe and does not vary much.

SECTION 2 - Personal Care

A. I would not have to cbange my way of washing or dressing in order to avoid pain.
B. I do not normally change my way of washing or dressing even though it causes some pain.
C. Washing and dressing increases the pain, but I manage not to change my way of doing it.
D. Washing and dressing increases the pain and I find it necessary to change my way of doing it.
E. Because oftbe pain, I am unable to do some washing and dressing without help.
F. Because oftbe pain, 1 am unable to do any wash.ing or dressing without help.

SECTION 3 - Lifting

A. 1 can lift heavy weights without extra pain.
B. I can lift heavy weights but it gives me extra pain.
C. Pain prevents me from lifting heavy weights off the floor.
D. Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned-eg, on a table
E. Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
F. I can only lift very light weights, at the most.

SECTION 4 - Walking

A. Pain does not prevent me from walking any distance.
B. Pain prevents me from walking more than I mile.
C. Pain prevents me from walking more than ½ mile.
D. Pain prevents me from walking more than ¼ mile.
E. I can only walk using a stick or crutches.
F. I am in bed most of the time and have to crawl to the toilet.

SECTION 5 - Sitting

A. I can sit in any chair as long as I like without pain.
B. I can only sit in my favorite chair as long as I like.
C. Pain prevents me sitting more than I hour.
D. Pain prevents me sitting more than ½ hour.
E. Pain prevents me sitting more than IO minutes.
F. Pain prevents me from sitting at all.

OTHER COMMENTS:

_____

_____

SECTION 6 - Standing

A. I can stand as long as I want without pain.
B. I have some pain while standing, but it does not increase with time.
C. I cannot stand for longer than 1 hour without increasing pain.
D. I cannot stand for longer than ½ hour without increasing pain.
E. I cannot stand for longer than IO minutes without increasing pain.
F. Pain prevents me from standing at all.

SECTION 7 - Sleeping

A I get no pain in bed.
B. I get pain in bed, but it does not prevent roe from sleeping well.
C. Because of pain, my normal night's sleep is reduced by less than one-quarter.
D. Because of pain, my normal night's sleep is reduced by less than one-half.
E. Because of pain, my normal night's sleep is reduced by less than three-quarters.
F. Pain prevents me from sleeping at all.

SECTION 8 - Social Life

A. My social life is normal and gives me no pain.
B. My social life is normal, but increases the degree ofmy pain.
C. Pain has no significant effect on my social life apart from limiting my more energetic interests, eg, dancing, etc.
D. Pain has restricted my social life and I do not go out very often.
E. Pain has restricted my social life to my home.
F. I have hardly any social life because oftbe pain.

SECTION 9 - Traveling

A. I get no pain wh.ile traveling.
B. I get some pain wh.ile traveling but none ofmy usual forms of travel make it any worse.
C. I get extra pain while traveling but it does not compel me to seek alternative forms of travel.
D. I get extra pain while traveling which compels me to seek alternative forms of travel.
E. Pain restricts all forms of travel.
F. Pain prevents all forms of travel except that done lying dovm.

SECTION 10 - Changing Degree of Pain

A. My pain is rapidly getting better.
B. My pain fluctuates, but overall is definitely getting better.
C. My pain seems to be getting better, but improvement is slow at present.
D. My pain is neither getting better nor worse.
E. My pain is gradually worsening.
F. My pain is rapidly worsening.

_____

Examiner

With Pem,ission fi-om:Hudson-Cook N, Tomes-Nicholson K., Breen AC. **A** Revised Oswestry Back Disability Questionnaire. Manchester Univ Press, 1989.

Patient Name _____ Date _____

Please read carefully:

This questionnaire has been designed lo enable us to understand how your neck pain has affected your ability to manage everyday life. Please answer every section, and mark in each section only ***ONE CHOICE*** *which applies to you. We realize that you may consider rhat two of the statements in any one section relate to you, bur please just mark the one box which most closely describes* ***your problem right now.***

SECTION **1 - Pain Intensity**

A. I have no pain at the moment.
B. The pain is *very* mild at the moment.
C. The pain is moderate at the moment.
D. The pain is fairly severe at tbe moment.
E. The pain is very severe at the moment.
F. The pain is the worst imaginable at the moment.

SECTION 2 - Personal Care (washing, dressing, etc.)

A. I can look after myself without causing extra pain.
B. l can look after myselfnonnally but it causes extra pain.
C. lt is painful to look after myself and lam slow and careful.
D. l need some help but manage most of my personal care.
E. I need help every day in most aspects of self care.
F. I do not get dressed, wash with difficulty and stay in bed.

SECTION 3 - **Lifting**

A. I can lift heavy weights without extra pain.
B. I can lift heavy weights but it gives extra pain.
C. Pain prevents me from lifting heavy objects off the floor, but I can manage if they are conveniently positioned, e.g. on a table.
D. Pain prevents me from lifting heavy weights but l can manage light lo medium weights if they are conveniently positioned.
E. I can lift very light weights.
F. I cannot lift or carry anything al all.

SECTION 4 - Reading

A. l can read as much as I want with no pain in my neck.
B. l can read as much as I want with slight pain in my neck.
C. I can read as much as l want with moderate pain in my neck.
D. I cannot read as much as I want because of moderate pain in my neck.
E. I can hardly read at all because of severe pain in my neck.
F. I cannot read at all.

SECTION S - Headaches

A. I have no headaches al all.
B. I have slight headaches which come infrequently.
C. I have moderate headaches which come infrequently.
D. I have moderate headaches which come frequently.
E. l have severe headaches which come frequently.
F. I have headaches almost all the time.

SECTION 6 - Concentration

A. I can concentrate fully when l want to with no difficulty.
B. I can concentrate fully when l want to with slight difficulty.
C. I have a fair degree of difficulty in concentrating when I want to.
D. I have a lot of difficulty in concentrating when I want to.
E. I have a great deal of difficulty in concentrating when I want to.
F. I cannot concentrate at all.

SECTION 7 - **Work**

A. I can do as much work as l want to.
B. I can only do my usual work, but no more.
C. I can do most of my usual work, but no more.
D. [cannot do my usual work.
E. I can hardly do any work al all.
F. l cannot do any work at all.

SECTION 8 - Driving

A. I can drive without any neck pain.
B. l can drive as long as I want with slight pain in my neck.
C. I can drive as long as I want with moderate pain in my neck.
D. I cannot drive as long as **l** want because of moderate pain in my neck.
E. I can hardly drive at all because of severe pain in my neck.
F. I cannot drive my car at all.

SECTION 9 - Sleeping

A. I have no trouble sleeping.
B. **My** sleep is slightly disturbed (less than I hr. sleepless).
C. **My** sleep is mildly disturbed (1-2 hrs. sleepless).
D. My sleep is moderately disturbed (2-3 hrs. sleepless).
E My sleep is greatly disturbed (3-5 hrs. sleepless).
F. My sleep is completely disturbed (5-7 hrs. sleepless).

SECTION 10 - Recreation

A. I am able to engage in all my recreation activities with ao neck pain at all.
B. I am able to engage in all my recreation activities with some pain in my neck.
C. I am able to engage in most, but not all of my usual recreation activities because of pain in my neck.
D. I am able to engage io a few of my usual recreation activities because of pain in my neck.
E. I can hardly do any recreation activities because of paio in my neck.
F. l cannot do any recreation activities at all.

OTHER COMMENTS:

_____

_____

_____

_____
Examiner

HEALTH STATUS QUESTIONNAIRE - RAND 36

Patient Name _____ Date _____

1. In general, would you say your health is:
(circle one number)

Excellent	1
Very Good	2
Good	3
Fair	4
Poor	5

2. Compared to one year ago, how would you rate your health in general now?
(circle one number)

Much better now than one year ago	1
Somewhat better now than one year ago	2
About the same	3
Somewhat worse now than one year ago	4
Much worse now than one year ago	5

The following items are about activities you might do during a typical day. Does your health now limit you in these activities? If so, how much?

	(circle one number on each line) Yes, limited a lot	Yes, limited a little	No, not limited at all
3. Vigorous activities, such as running, lifting heavy objects, participating in strenuous sports.	1	2	3
4. Moderate activities, such as moving a table, pushing a vacuum cleauer, bowling, or playing golf	1	2	3
5. Lifting or carrying groceries.	1	2	3
6. Climbing several flights of stairs.	1	2	3
7. Climbing one flight of stairs.	1	2	3
8. Bending, kneeling or stooping	1	2	3
9. Walking more than a mile.	1	2	3
10. Walking several blocks		2	3
11. Walking one block		2	3
12. Bathing or dressing yourself		2	3

During the past 4 weeks, have you had any of the following problems with your work or other regular daily activities as a result of your physical health?
(circle one number on each line)

	Yes	No
13. Cut down the amount of time you spent on work or other activities.	1	2
14. Accomplished less than you would like.	1	2
15. Were limited in the kind of work or other activities.	1	2
16. Had difficulty performing the work or other activities. (for example, it took extra effort)	1	2

During the past 4 weeks, have you had any of the following problems with your work or other regular daily activities as a result of any emotional problems (such as feeling depressed or anxious)? (circle one number on each line)

	Yes	No
17. Cut down the amount of time you spent on work or other activities.	1	2
18. Accomplished less than you would like.		2
19. Didn't do work or other activities as carefully as usual.		2

20. During the past 4 weeks, to what extent has your physical health or emotional problems interfered with your normal social activities with family, friends, neighbors, or groups? (circle one number)

Not at all	1
Slightly	2
Moderately	3
Quite a bit	4
Extremely	5

21. How much bodily pain have you had during the past 4 weeks?
(circle one number)

None	1
Very mild	2
Mild	3
Moderate	4
Severe	5
Very Severe	6

22. During the past 4 weeks how much did pain interfere with your normal work (including both work outside the home and housework)?
(circle one number)

None at all	1
A little bit	2
Moderately	3
Quite a bit	4
Extremely	5

These questions are about how you feel and how things have been with you during the past 4 weeks. For each question, please give the one answer that comes closest to the way you have been feeling.

How much of the time during the past 4 weeks ... (circle one number on each line)

	All of the time	Most of the time	A good bit of the time	Some of the time	Little of the time	None of the time
23. Did you feel full of pep?		2	3	4	5	6
24. Have you been a very nervous person?		2	3	4	5	6
25. Have you felt so down in the dumps that nothing could cheer you up?		2	3	4	5	6
26. Have you felt calm and peaceful?		2	3	4	5	6
27. Did you have a lot of energy?		2	3	4	5	6
28. Have you felt downhearted and blue?		2	3	4	5	6
29. Did you feel worn out?		2	3	4	5	6
30. Have you been a happy person?		2	3	4	5	6
31. Did you feel tired?		2	3	4	5	6

32. During the past 4 weeks, how much of the time has your physical health or emotional health problems interfered with your social activities? (like visiting with friends, relatives, etc.)

(circle one number)

All of the time I
Most of the time 2
Some of the time 3
little of the time 4
None of the time 5

How TRUE or FALSE is each of the following statements for you?

	Definitely true	Mostly true	Don't know	Mostly false	Definitely false
33. I seem to get sick a little easier than other people.	I	2	3	4	5
34. I am as healthy as anybody I know.	1	2	3	4	5
35. I expect my health to get worse.	1	2	3	4	5
36. My health is excellent.	1	2	3	4	5