

# Motor Vehicle Accident - Patient Data Form - MVA/PDF

## Patient Information

Date \_\_\_\_\_

Patient Name \_\_\_\_\_

Last Name

First Name

Middle Name

Sex  Male  Female Date of Birth \_\_\_\_\_ Age \_\_\_\_\_ SS# \_\_\_\_\_

Apt \_\_\_\_\_

Street Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_

Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ Other \_\_\_\_\_

Single  Married  Partner for \_\_\_\_\_ years  Separated  Divorced  Widowed

Student  Not Employed  Employed Part Time  Employed Full Time  Retired

Occupation \_\_\_\_\_ Employer/ School \_\_\_\_\_

Address \_\_\_\_\_

Education \_\_\_\_\_

How did you hear about us? \_\_\_\_\_

Spouse/ Parent/ Guardian/ or Significant Other \_\_\_\_\_

Work Phone \_\_\_\_\_ Home Phone \_\_\_\_\_

Person to Contact in Case of Emergency \_\_\_\_\_

Work Phone \_\_\_\_\_ Home Phone \_\_\_\_\_

1. Date of Accident: \_\_\_\_\_ Time: \_\_\_\_\_

2. Driver of vehicle: \_\_\_\_\_ Where were you \_\_\_\_\_

3. Owner of vehicle: \_\_\_\_\_ Year, make and model: \_\_\_\_\_

4. What approx. damage was done to the vehicle? \$ \_\_\_\_\_

5. Visibility at time of accident: poor / fair / good / other: \_\_\_\_\_

6. Road condition at time of accident: icy / rainy / dry / other: \_\_\_\_\_

7. Where was your vehicle struck: right / left / rear / front / side / other: \_\_\_\_\_

8. Type of  head on  broad side  rear end  front impact

non-collision: \_\_\_\_\_

9. Describe what happened to you upon \_\_\_\_\_

10. Did you see the accident Yes No

11. Did you brace for impact? Yes No

12. Were seat belts worn? Yes No

13. Were shoulder harnesses worn? Yes No

14. Was the car braking? Yes No

15. Does your car have headrests? Yes No

If yes, what was the position of those headrests compared to your head before the accident?

top of headrest was even with bottom of head

top of headrest was even with top of head

top of headrest was even with middle of neck

16. Was your vehicle moving at the time of the Yes No

If yes, how fast were you \_\_\_\_\_ MPH (estimate)

17. Was there another vehicle involved in the \_\_\_\_\_ Yes No

If yes, how fast was the other car traveling? \_\_\_\_\_ MPH (estimate)

18. What was your head / body position at the time of impact:

- head turned left/right       body straight in sitting position  
 head looking back       body rotated left/right  
 head looking straightforward       other: \_\_\_\_\_

19. At the time of the accident, recall what parts of your head or body hit what parts on the inside of your car:

\_\_\_\_\_

20. As a result of the accident were  rendered unconscious  dazed, circumstances vague

21. Could you move all of your body parts? Yes No

If no, what parts and why? \_\_\_\_\_

22. Were you able to get out of the vehicle and walk unaided? Yes No

If no, why not? \_\_\_\_\_

23. What bleeding cuts did you get from this accident, if any? \_\_\_\_\_

24. What bruises did you get from this accident, if any? \_\_\_\_\_

25. Please describe how you felt (please be specific)

Immediately after accident: \_\_\_\_\_

Later that day: \_\_\_\_\_

The next day: \_\_\_\_\_

26. Check symptoms apparent since the accident:

- |  |  |  |  |
|--|--|--|--|
| <input type="checkbox"/> Neck pain/stiffness | <input type="checkbox"/> Loss of smell           | <input type="checkbox"/> Headaches       | <input type="checkbox"/> Sleeping problems |
| <input type="checkbox"/> Mid back pain       | <input type="checkbox"/> Loss of taste           | <input type="checkbox"/> Dizziness       | <input type="checkbox"/> Fatigue           |
| <input type="checkbox"/> Low back pain       | <input type="checkbox"/> Loss of memory          | <input type="checkbox"/> Cold sweats     | <input type="checkbox"/> Tension           |
| <input type="checkbox"/> Numbness in toes    | <input type="checkbox"/> Eyes sensitive to light | <input type="checkbox"/> Fainting        | <input type="checkbox"/> Anxious           |
| <input type="checkbox"/> Numbness in fingers | <input type="checkbox"/> Pain behind eyes        | <input type="checkbox"/> Ringing in ears | <input type="checkbox"/> Irritability      |
| <input type="checkbox"/> Cold hands          | <input type="checkbox"/> Chest pain              | <input type="checkbox"/> Constipation    | <input type="checkbox"/> Nervousness       |
| <input type="checkbox"/> Cold feet           | <input type="checkbox"/> Shortness of breath     | <input type="checkbox"/> Diarrhea        | <input type="checkbox"/> Depression        |
| <input type="checkbox"/> Other: _____        |  |  |  |

27. Did you go and seek medical attention immediately/soon after the accident? Yes No (if no, skip to #46)

If yes, how did you get there:  Someone else drove me  Ambulance  Drove myself  Police

Other: \_\_\_\_\_

28. Doctor / Hospital / \_\_\_\_\_

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

29. Were you examined? Yes No

30. Were x-rays or other images taken? Yes No

If yes, what kind of images and what areas of the \_\_\_\_\_

31. What treatment did you receive?  Bed rest  Brace  Physiotherapy  Adjustments

Other: \_\_\_\_\_

32. What benefits did you receive from the above mentioned treatment?

33. Date of last \_\_\_\_\_

34. Doctor 2 / Hospital / Clinic: \_\_\_\_\_ Date: \_\_\_\_\_

35. Were you examined? Yes No

36. Were x-rays or other images taken? Yes No

If yes, what kind of images and what areas of the body? \_\_\_\_\_

37. What treatment did you receive?  Bed rest  Brace  Physiotherapy  Adjustments

Other: \_\_\_\_\_

38. What benefits did you receive from the above mentioned treatment?

39. Date of last treatment: \_\_\_\_\_

40. Doctor 3 / Hospital / Clinic: \_\_\_\_\_ Date: \_\_\_\_\_

41. Were you examined? Yes No

42. Were x-rays or other images taken? Yes No

If yes, what kind of images and what areas of the body? \_\_\_\_\_

43. What treatment did you receive?  Bed rest  Brace  Physiotherapy  Adjustments

Other: \_\_\_\_\_

44. What benefits did you receive from the above mentioned treatment?

45. Date of last treatment: \_\_\_\_\_

46. Occupation \_\_\_\_\_ Employer: \_\_\_\_\_

47. Have you missed time from work due to accident? Yes No

Full time off work \_\_\_\_\_ to \_\_\_\_\_, \_\_\_\_\_ to \_\_\_\_\_

Part time off work \_\_\_\_\_ to \_\_\_\_\_, \_\_\_\_\_ to \_\_\_\_\_

Been unable to work since the accident.

48. Did you have any physical complaints JUST BEFORE THE ACCIDENT? Yes No

If yes, please describe in \_\_\_\_\_

49. Prior to the accident, have you EVER had symptoms similar to what you are experiencing now? Yes No

If yes, please explain: \_\_\_\_\_

50. Briefly describe past falls, injuries, accidents, operations, \_\_\_\_\_

51. Do you notice any activities of your home daily routines that are different now than before the accident? Yes No

If yes, please list them in the correct category:

Those you are unable to do: \_\_\_\_\_

Those that are painful to do: \_\_\_\_\_

Those that are difficult to \_\_\_\_\_

52. Is there anything else we should know in regards to this \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**53. Do you have an attorney in this case? Yes No**

If yes, please provide their information: Name: \_\_\_\_\_

Firm Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_

State: \_\_\_\_\_

ZIP: \_\_\_\_\_

Phone Number: \_\_\_\_\_

Fax: \_\_\_\_\_

**Automobile Accident Insurance Data**

**54. Patient's Regular Insurance Company Information:**

Company Name: \_\_\_\_\_

Phone #: \_\_\_\_\_

Policy #: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_

State: \_\_\_\_\_

ZIP: \_\_\_\_\_

**55. Patient's Automobile Insurance Company Information:**

Company Name: \_\_\_\_\_

Phone #: \_\_\_\_\_

Adjuster Name: \_\_\_\_\_

Policy #: \_\_\_\_\_

Claim Number: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_

State: \_\_\_\_\_

ZIP: \_\_\_\_\_

**If your insurance adjuster told you that another insurance company is to be billed directly than please fill out the next**

**56. Other Insurance Company Information:**

Company Name: \_\_\_\_\_

Phone #: \_\_\_\_\_

Adjuster Name: \_\_\_\_\_

Policy #: \_\_\_\_\_

Claim Number: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_

State: \_\_\_\_\_

ZIP: \_\_\_\_\_

# Neck Index

**Patient Name** \_\_\_\_\_ **Date** \_\_\_\_\_

*This questionnaire will give your provider information about how your neck 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**

- 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.

## **Personal Care**

- ⓪ I can look after myself normally without causing extra pain.
- ① I can look after myself normally but it causes extra pain.
- ② It is painful to look after myself and I am slow and careful.
- ③ I need some help but I 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.

## **Lifting**

- ⓪ I can lift heavy weights without extra pain.
- ① I can lift heavy weights but it causes extra pain.
- ② Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned (e.g., on a table).
- ③ Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
- ④ I can only lift very light weights.
- ⑤ I cannot lift or carry anything at all.

## **Reading**

- ⓪ I can read as much as I want with no neck pain.
- ① I can read as much as I want with slight neck pain.
- ② I can read as much as I want with moderate neck pain.
- ③ I cannot read as much as I want because of moderate neck pain.
- ④ I can hardly read at all because of severe neck pain.
- ⑤ I cannot read at all because of neck pain.

## **Headaches**

- ⓪ I have no headaches at all.
- ① I have slight headaches which come infrequently.
- ② I have slight headaches which come frequently.
- ③ I have moderate headaches which come infrequently.
- ④ I have moderate headaches which come frequently.
- ⑤ I have headaches almost all the time.

## **Concentration**

- ⓪ I can concentrate fully when I want with no difficulty.
- ① I can concentrate fully when I want with slight difficulty.
- ② I have a fair degree of difficulty concentrating when I want.
- ③ I have a lot of difficulty concentrating when I want.
- ④ I have a great deal of difficulty concentrating when I want.
- ⑤ I cannot concentrate at all.

## **Work**

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

## **Driving**

- ⓪ I can drive my car without any neck pain.
- ① I can drive my car as long as I want with slight neck pain.
- ② I can drive my car as long as I want with moderate neck pain.
- ③ I cannot drive my car as long as I want because of moderate neck pain.
- ④ I can hardly drive at all because of severe neck pain.
- ⑤ I cannot drive my car at all because of neck pain.

## **Sleeping**

- ⓪ I have no trouble sleeping.
- ① My sleep is slightly disturbed (less than 1 hour sleepless).
- ② My sleep is mildly disturbed (1-2 hours sleepless).
- ③ My sleep is moderately disturbed (2-3 hours sleepless).
- ④ My sleep is greatly disturbed (3-5 hours sleepless).
- ⑤ My sleep is completely disturbed (5-7 hours sleepless).

## **Recreation**

- ⓪ I am able to engage in all my recreation activities without neck pain.
- ① I am able to engage in all my usual recreation activities with some neck pain.
- ② I am able to engage in most but not all my usual recreation activities because of neck pain.
- ③ I am only able to engage in a few of my usual recreation activities because of neck pain.
- ④ I can hardly do any recreation activities because of neck pain.
- ⑤ I cannot do any recreation activities at all.

Neck  
Index  
Score

# **Back Index**

**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.
- 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 very severe.
- ⑤ The pain is very severe and does not vary much.

## ***Personal Care***

- ① I would 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.

## ***Lifting***

- ① I can lift heavy weights without extra pain.
- ① I can lift heavy weights but it causes extra pain.
- ② Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned (e.g., on a table).
- ③ Pain prevents me from lifting heavy weights off the floor.
- ④ Pain prevents me from lifting heavy weights, but I can manage medium weights if they are conveniently positioned.
- ⑤ I can only lift very light weights at the most.

## ***Walking***

- ① 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 one mile without increasing pain.
- ③ I cannot walk more than ½ mile without increasing pain.
- ④ I cannot walk more than ¼ mile without increasing pain.
- ⑤ I cannot walk at all without increasing pain.

## ***Sitting***

- ① 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 ½ hour.
- ④ 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 extra 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 ½ hour without increasing pain.
- ④ I cannot stand for longer than 10 minutes without increasing pain.
- ⑤ I avoid standing because it increases pain immediately.

## ***Sleeping***

- ① I 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%.
- ④ Because of pain, my normal sleep is reduced by less than 75%.
- ⑤ Pain prevents me from sleeping at all.

## ***Social Life***

- ① My social life is normal and gives me no extra pain.
- ① My social life is normal but increases the degree of pain.
- ② Pain has no significant effect 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 as often.
- ④ Pain has restricted my social life to my home.
- ⑤ I have hardly any social life because of the pain.

## ***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.
- ④ Pain restricts all forms of travel.
- ⑤ Pain prevents all forms of travel except that done by lying down.

## ***Changing Degree of Pain***

- ① 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 at present.
- ③ My pain is neither getting better nor worse.
- ④ My pain is gradually worsening.
- ⑤ My pain is rapidly worsening.

**Back  
Index  
Score**



**ORTMAN<sup>®</sup>**  
**CHIROPRACTIC CLINIC**

PO BOX 157, CANISTOTA, SD 57012  
 (605) 296-3431 • WWW.ORTMANCLINIC.COM

**IRREVOCABLE ASSIGNMENT AND AUTHORIZATION TO PAY  
 INSURANCE BENEFITS, HEALTH INSURANCE, AUTO - MEDICAL PAYMENTS, 3<sup>RD</sup> PARTY PAYOR  
 AND/OR ATTORNEY**

To Whom It May Concern:

I, \_\_\_\_\_, hereby authorize and direct you, my insurance company, 3<sup>rd</sup> party payor and/or my attorney, to **pay directly to Ortman Chiropractic Clinic**, any and all sums as may be due and owing me for services rendered to me by Ortman Chiropractic Clinic, both by reason of accident or illness, and by reason of any other bills that are due this office. I further direct my insurance company, 3<sup>rd</sup> party payor and/or my attorney to withhold such sums from any disability benefits, medical payment benefits, no-fault benefits, health and accident benefits, 3<sup>rd</sup> party payor benefits, or any other insurance benefits and/or monies received and/or owing me from any payments received from any settlement, judgment or verdict on my behalf in an amount equal to any outstanding balance that is owed to Ortman Chiropractic Clinic for my treatment. I hereby further irrevocably assign to Ortman Chiropractic Clinic any and all insurance benefits named herein, and any and all proceeds of any settlement, judgment or verdict which may be paid to me as a result of the injuries or illness for which I have been treated by Ortman Chiropractic Clinic, said assignment to be equal to any outstanding balance owed by me to Ortman Chiropractic Clinic. This is to act as an irrevocable assignment of my rights and benefits to any monies owed or received for my benefit in an amount equal to any outstanding balance owed by me to the Ortman Chiropractic Clinic. This said assignment is binding under South Dakota Codified Law (SDCL) 57A-9, SDCL 57A-9-102(46) and SDCL 57A-9-309 (5).

In the event my insurance company, 3<sup>rd</sup> party payor or attorney are obligated to make payments to me for compensation of any claims, benefits, money owed, settlements and /or judgments, and the insurance company, 3<sup>rd</sup> party payor, attorney or any other party so obligated refuses to make such payments either upon demand by me or Ortman Chiropractic Clinic, I hereby assign and transfer to Ortman Chiropractic Clinic any and all causes of action that I might have or that might exist in my favor against such company and/or party, and authorize Ortman Chiropractic Clinic to prosecute said cause of action either in my name or in Ortman Chiropractic Clinic name. I further authorize Ortman Chiropractic Clinic to compromise, settle or otherwise resolve such claim or cause of action as they see fit.

In the event I, my attorney, heirs, attorney-in-fact or any other person acting on my behalf, receives monies owed me for compensation of benefits, claims, money owed, settlements and /or judgments, I further agree that an amount equal to that which is owed to Ortman Chiropractic Clinic by me for any treatment that I receive, shall be placed in trust for the benefit of Ortman Chiropractic Clinic, for which trust I or anyone that I so designate to be trustee, and Ortman Chiropractic Clinic being the beneficiary. Said trust will be dissolved upon all amounts due and owing Ortman Chiropractic Clinic being paid to Ortman Chiropractic Clinic.

I understand that I remain personally responsible for the total amounts due to Ortman Chiropractic Clinic for their services. I further understand and agree that this Assignment and Authorization do not constitute any consideration for Ortman Chiropractic Clinic to await payments and that they may demand payments from me immediately upon rendering services at their option.

I authorize Ortman Chiropractic Clinic to release any information pertinent to my case to any insurance company, including 3<sup>rd</sup> party payor, adjuster or attorney to facilitate collection under this Assignment and Authorization. I agree that Ortman Chiropractic Clinic shall be given the Power of Attorney to endorse and/or sign my name on any and all checks for payment of any outstanding bill owed Ortman Chiropractic Clinic. I further understand and agree, that if Ortman Chiropractic Clinic must take any action to collect an outstanding balance on my account, I will be responsible for payment of and will reimburse Ortman Chiropractic Clinic for all costs of such collection efforts, including but not limited to all court costs and all attorney fees. I also understand that interest will be charged on all balances 60 days past due.

I further direct that this Authorization and Assignment shall be binding upon my legal heirs, successors, assignees, legatees or any other party legally acting on my behalf.

Patient's Signature X \_\_\_\_\_ SS# \_\_\_\_\_ Date: \_\_\_\_\_

Guardian or Spouse's  
 Signature Authorizing Care X \_\_\_\_\_ Date: \_\_\_\_\_

## ACTIVITIES OF Daily Living

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

### Daily Activities: Effects of Current Conditions On Performance

Please identify how your current condition is affecting your ability to carry out activities that are routinely part of your life:

ACTIVITY				
Bending	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (Limits)	<input type="checkbox"/> Unable to Perform
Concentrating	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (Limits)	<input type="checkbox"/> Unable to Perform
Doing computer Work	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (Limits)	<input type="checkbox"/> Unable to Perform
Gardening	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (Limits)	<input type="checkbox"/> Unable to Perform
Playing Sports	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (Limits)	<input type="checkbox"/> Unable to Perform
Recreation Activities	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (Limits)	<input type="checkbox"/> Unable to Perform
Shoveling	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (Limits)	<input type="checkbox"/> Unable to Perform
Sleeping	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (Limits)	<input type="checkbox"/> Unable to Perform
Watching TV	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (Limits)	<input type="checkbox"/> Unable to Perform
Carrying	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (Limits)	<input type="checkbox"/> Unable to Perform
Dancing	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (Limits)	<input type="checkbox"/> Unable to Perform
Dressing	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (Limits)	<input type="checkbox"/> Unable to Perform
Lifting	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (Limits)	<input type="checkbox"/> Unable to Perform
Pushing	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (Limits)	<input type="checkbox"/> Unable to Perform
Rolling Over	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (Limits)	<input type="checkbox"/> Unable to Perform
Sitting	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (Limits)	<input type="checkbox"/> Unable to Perform
Standing	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (Limits)	<input type="checkbox"/> Unable to Perform
Working	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (Limits)	<input type="checkbox"/> Unable to Perform
Climbing	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (Limits)	<input type="checkbox"/> Unable to Perform
Doing Chores	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (Limits)	<input type="checkbox"/> Unable to Perform
Driving	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (Limits)	<input type="checkbox"/> Unable to Perform
Performing Sexual Activity	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (Limits)	<input type="checkbox"/> Unable to Perform
Reading	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (Limits)	<input type="checkbox"/> Unable to Perform
Running	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (Limits)	<input type="checkbox"/> Unable to Perform
Sitting to Standing	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (Limits)	<input type="checkbox"/> Unable to Perform
Walking	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (Limits)	<input type="checkbox"/> Unable to Perform