Tyran G. Mincey D.C

27 Downing Street
NY NY 10014

295 Bloomfield Ave.
Montclair NJ 07024
(973) 744-1155

Your first visit.

1. Please fill out the office forms enclosed.

2. Dr. Mincey or another authorized person will review your history.

3. You will be examined by Dr. Mincey

4. Any necessary tests will be ordered or performed.

5. After examination and testing the visit will end and another visit will be scheduled.

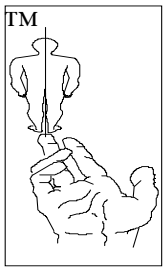
6. This process may take anywhere from as long as one hour.

7. During this second visit Dr. Mincey will review all of the findings from testing and examination. At this time we will determine whether we will accept your case. If so then treatment options will be presented to you as well as the estimated cost and time frame of treatment. You will be given an opportunity to get all of your questions answered at this time.

8. Extended treatment will not be given on the first visit.

Expectations

We understand that you have the expectation to get well and that is the goal of this care. As with all types of health care and medical care there are no guarantees made in any way shape or form except that we will do everything possible to help your body heal itself and when we have done all we can we will let you know and advise you of other options. Our success rate of helping people in this office is about 90-95%. With regard to how long it will take to heal, in some cases healing seems almost instant while in others it is more gradual. There are many variables that impact healing time these include your compliance with Dr.'s recommendations, overall lifestyle, diet and other factors that may be unique to you. **(Please remove all jewelry and turn off cell phones before entering examination room.)**



Integrated Health Care
Tyran G. Mincey D.C.
295 Bloomfield Avenue Ste. #5
Montclair NJ 07042
(973)744-1155

27 Downing Street
NY NY 10014
(212) 463-7315

Financial Policies

Accounts Receivable Policy Letter

We first want to thank you for choosing Integrated HealthCare LLC as your healthcare provider. We consider it a privilege to serve you.

With service in mind, effective **09/30/2005**, we are advising new patients, and updating existing patients, to our new payment and billing policies to avoid possible misunderstandings or difficulties at a later date.

By far the majority of our patients regularly pay their accounts within a reasonable amount of time. In order to insure the level of service you require and deserve, without added cost, we have integrated a new program to hold down our operating expenses. Our new payment policy and program ensures that **your account** will not be penalized to cover costs incurred by us from those who do not pay in a timely manner. The accounts receivable policy that we follow states that:

1. **Insurance.** If you ***are not*** insured by a plan with which we are participating, payment in full is expected at each visit. If you are insured by a plan with which we are participating, but don't have an up-to-date insurance card, payment in full for each visit is required until we can verify your coverage. Knowing your insurance benefits is your responsibility. Please contact your insurance company with any questions you may have regarding your coverage.

2. **Co-payments and deductibles.** All co-payments and deductibles must be paid at the time of service. This arrangement is part of your contract with your insurance company. Failure on our part to collect co-payments and deductibles from patients can be considered fraud. Please help us in upholding the law by paying your co-payment at each visit. Account balances over 30 (thirty) days are subject to interest charges of 1 ½% per month (18% per year). Unpaid accounts reaching 60 days will be automatically transferred to Transworld Systems, Inc. for the purposes of collecting on your account. An additional fee of $10.00 will be added to your accounts and is due in addition to any balance and interest charges owed.

3. **Non-covered services.** Please be aware that some, and perhaps all, of the services you receive may be non-covered or not considered reasonable or medically necessary by your insurance company. If you still opt to receive these services, you must pay for them in full at the time of your visit unless other arrangements have been made ***prior*** to receiving them.

4. **Proof of insurance.** All patients must complete our patient information form before seeing the doctor. We must obtain a copy of your driver's license and current valid insurance to provide proof of insurance.

We thank you in advance for your understanding, support and agreement in this matter.

If you have any questions regarding this policy, or would like to discuss your account at any time, please feel free to contact LaTisha or Dr. Mincey at 973-744-1155 to arrange a confidential review of your personal account.

Sincerely,

Tyran G. Mincey D.C.
Chiropractic Physician

For cash payers
First visit: ***Initial Exam*** cost $210.00

Duration is dependent on patient's presentation.
Description

1. Taking of a detailed history

2. A Comprehensive physical examination (blood pressure etc), complaint oriented examination. Chiropractic examination of spine, muscles and nervous system and entire body.
3. Applied kinesiology examination which includes meridian examination,
4. Minor diagnostic testing such as Spirometry, Ph of saliva, Zinc deficiency, Homocysteine screening, nerve balance screening, aerobic deficiency screening, electrolyte imbalances, emotional screening, Body fat testing. Other examinations may be needed depending on individual need.
5. Any other Lab tests and X-rays will be extra if needed.

Second visit Cost $75.00
Description: Review of findings: presentation of case, with a treatment plan, outline of the time, expectations, and whether or not we will accept your case, referrals are made if need be.

Third visit and any thereafter Cost $65.00-$150.00

Description: Our goal each and every visit is to balance the nervous system. We do this using a variety of therapies and do not charge cash payers by therapy type. This may include recommendations for supplementation, lifestyle changes, exercises, total hands on muscle, and joint adjusting, accupressure, reflexology, use of essential oils etc. Extended visits are available; ask Dr. Mincey.

For patients who have insurance everything above applies except that the insurers may not pay for certain therapies and we must bill what is reasonable and customary by therapy. So you may be required to pay a portion of the care that your insurer will not underwrite. Dr. Mincey will advise you as such prior to beginning any treatment. A portion of the initial examination may not be paid for.

I _____ have read and understand and agree to abide by the terms as outlined and applying to the office of Integrated Health care, LLC. I understand that if my insurer will not cover costs of services that I am responsible and agree to pay them.

Signature:_____
Date:_____

Print name _____ Date_____

Name_____ Phone number_____ Work number_____

Address (include city, state and zip)

_____

Date of birth_____ Age_____ M___ F___ Marital status_____ No. of children____

Occupation_____ Referred by_____

Soc. Sec#___ -__- _____ email address _____@ _____. _____

Please check the appropriate space for any of the following symptoms that you now have or have had previously. This is a confidential health questionnaire.

O = Occasional F = Frequent C = Constant

O F C **General**

☐ ☐ ☐ Allergy
☐ ☐ ☐ Chills
☐ ☐ ☐ Convulsions
☐ ☐ ☐ Dizziness
☐ ☐ ☐ Fainting
☐ ☐ ☐ Fatigue
☐ ☐ ☐ Fever
☐ ☐ ☐ Headaches
☐ ☐ ☐ Insomnia
☐ ☐ ☐ Excess weight loss
☐ ☐ ☐ Excess weight gain
☐ ☐ ☐ Nervousness
☐ ☐ ☐ Depression
☐ ☐ ☐ Sweats
☐ ☐ ☐ Tremors

Muscle and joint

☐ ☐ ☐ Arthritis
☐ ☐ ☐ Foot trouble
☐ ☐ ☐ Hernia
☐ ☐ ☐ Low back pain
☐ ☐ ☐ Neck pain
☐ ☐ ☐ Poor posture
☐ ☐ ☐ Sciatica

Pain/Numbness in:

☐ ☐ ☐ Shoulders
☐ ☐ ☐ Arms
☐ ☐ ☐ Elbows
☐ ☐ ☐ Wrists/Hand
☐ ☐ ☐ Hips
☐ ☐ ☐ Legs
☐ ☐ ☐ Knees
☐ ☐ ☐ Feet

O F C **Gastrointestinal**

☐ ☐ ☐ Belching or gas
☐ ☐ ☐ Colitis
☐ ☐ ☐ Constipation
☐ ☐ ☐ Diarrhea
☐ ☐ ☐ Indigestion
☐ ☐ ☐ Distention
☐ ☐ ☐ Excess hunger
☐ ☐ ☐ Gallbladder problems
☐ ☐ ☐ Hemorrhoids
☐ ☐ ☐ Liver problems
☐ ☐ ☐ Nausea
☐ ☐ ☐ Stomach pain
☐ ☐ ☐ Poor appetite
☐ ☐ ☐ Vomiting

EENT

☐ ☐ ☐ Asthma
☐ ☐ ☐ Colds/Flu
☐ ☐ ☐ Crossed eyes
☐ ☐ ☐ Deafness
☐ ☐ ☐ Dental decay
☐ ☐ ☐ Ear problems
☐ ☐ ☐ Enlarged glands
☐ ☐ ☐ Eye pain
☐ ☐ ☐ Near-sightedness
☐ ☐ ☐ Far-sightedness
☐ ☐ ☐ Gum problems
☐ ☐ ☐ Hay fever
☐ ☐ ☐ Hoarseness
☐ ☐ ☐ Nasal obstruction
☐ ☐ ☐ Nosebleeds
☐ ☐ ☐ Sinus problems
☐ ☐ ☐ Sore throats

O F C **Cardiorespiratory**

Blood pressure:

☐ ☐ ☐ High
☐ ☐ ☐ Low
☐ ☐ ☐ High cholesterol
☐ ☐ ☐ Chest pain
☐ ☐ ☐ Poor circulation
☐ ☐ ☐ Rapid pulse
☐ ☐ ☐ Slow pulse
☐ ☐ ☐ Ankle swelling
☐ ☐ ☐ Chronic cough
☐ ☐ ☐ Difficulty breathing
☐ ☐ ☐ Wheezing

Spitting up:

☐ ☐ ☐ Blood
☐ ☐ ☐ Phlegm

Skin

☐ ☐ ☐ Boils
☐ ☐ ☐ Bruise easily
☐ ☐ ☐ Dryness
☐ ☐ ☐ Hives or rash
☐ ☐ ☐ Itching
☐ ☐ ☐ Varicose veins

Genitourinary

☐ ☐ ☐ Bed-wetting
☐ ☐ ☐ Blood in urine
☐ ☐ ☐ Frequent urination
☐ ☐ ☐ Painful urination
☐ ☐ ☐ Pus in urine
☐ ☐ ☐ Kidney stones
☐ ☐ ☐ Prostate problems

For women only:

Date of last period (day 1):_____
Birth control:_____

☐ ☐ ☐ Menstrual problems
☐ ☐ ☐ Hot flashes
☐ ☐ ☐ Irregular cycle
☐ ☐ ☐ Menopausal symptoms

What is your major complaint?_____

How long have you had this condition?_____

Have you had this or similar conditions in the past?_____

Is this problem getting worse?_____ Constant?_____ Worse in morning?_____ Evening?_____

Is this interfering with work?_____ Sleep?_____ Exercise?_____ Other?_____

What do you believe is wrong with you?_____

List other problems you have now_____
_____

List past operations and dates_____
_____

Have you ever been hospitalized other than for surgery?_____

Have you ever had any mental or emotional disorder?_____

Have you had any other injury in the past two years?_____

Are you taking medication?_____ Describe_____

Are you taking nutritional supplements?_____ Describe_____
_____

Are you allergic to any foods, drugs, etc?_____

Do you have any dental problems?_____ Dr.:_____

Do you wear arch supports?_____ Heel lifts?_____ Special shoes?_____ What is your shoe size?_____

Date of your last physical exam?_____ Dr.:_____

Habits (describe with amounts):

Alcohol_____ Coffee_____

Cigarettes_____ Drugs not listed above_____

Describe your present exercise habits (or attach additional page):_____
_____

Please list the main health problems in your family:

Name: Relation: Problem:

_____
_____
_____

In case of emergency, please list the name and number of a friend or relative NOT living with you:

_____

Your signature:_____ Date:_____

Patient _____ Doctor_____ Date_____

Instructions: Number the boxes that apply to you. Use (1) for MILD symptoms (occurring once or twice a year), (2) for MODERATE symptoms (occurring several times a year), and (3) for SEVERE symptoms (you are aware of the symptom almost constantly).

GROUP ONE

1. ☐ Acid foods upset
2. ☐ Get chilled often
3. ☐ "Lump" in throat
4. ☐ Dry mouth/eyes/nose
5. ☐ Pulse speeds after meal
6. ☐ Keyed up—fail to calm
7. ☐ Cuts heal slowly
8. ☐ Gag easily
9. ☐ Unable to relax; startle easily
10. ☐ Extremities cold, clammy
11. ☐ Strong light irritates
12. ☐ urine amount reduced
13. ☐ Heart pound after retiring
14. ☐ "Nervous" stomach
15. ☐ Appetite reduced
16. ☐ Cold sweat often
17. ☐ Fever easily raised
18. ☐ Neuralgia-like pains
19. ☐ Staring, blink little
20. ☐ Sour stomach frequently

GROUP TWO

21. ☐ Joint stiffness after arising
22. ☐ Muscle/leg/ toe cramps at night
23. ☐ "Butterfly" stomach, cramps
24. ☐ Eyes or nose watery
25. ☐ Eyes blink often
26. ☐ Eyelids swollen, puffy
27. ☐ Indigestion soon after meal
28. ☐ Always seem hungry; feel "lightheaded" often
29. ☐ Digestion rapid
30. ☐ Vomiting frequent
31. ☐ Hoarseness frequent
32. ☐ Breathing irregular
33. ☐ Pulse slow; feels "irregular"
34. ☐ Gagging reflex slow
35. ☐ Difficulty swallowing
36. ☐ Constipation, diarrhea alternating
37. ☐ "Slow Starter"
38. ☐ Get "Chilled frequently
39. ☐ Perspire easily
40. ☐ Circulation poor, sensitive in cold
41. ☐ Subject to colds, asthma, bronchitis

GROUP THREE

42. ☐ Eat when nervous
43. ☐ Excessive appetite
44. ☐ Hungry between meals
45. ☐ Irritable before meals
46. ☐ Get "Shaky" if hungry
47. ☐ Fatigue, eating relieves
48. ☐ "Lightheaded" if meals delayed
49. ☐ Heart palpitates if meal missed or delayed
50. ☐ Afternoon headaches
51. ☐ Have had reaction to overeating sweets
52. ☐ Awaken after few hours sleep—hard to get back to sleep
53. ☐ Crave candy or coffee in afternoon
54. ☐ Moods of depression—"blues" or melancholy
55. ☐ Abnormal craving for sweets or snacks

GROUP FOUR

56. ☐ Hands and feet go to sleep easily, numbness
57. ☐ Sigh frequently, "air hunger"
58. ☐ Aware of "breathing heavily"
59. ☐ High-altitude discomfort
60. ☐ Open windows in closed room
61. ☐ Susceptible to colds and fevers
62. ☐ afternoon "yawner"
63. ☐ Get "drowsy" often
64. ☐ Swollen ankles, worse at night
65. ☐ Muscle cramps, worse during exercise; get "charley horses"
66. ☐ Shortness of breath on exertion
67. ☐ Dull pain in chest or radiating into left arm, worse on exertion
68. ☐ Bruise easily, "black and blue" spots
69. ☐ Tendency to anemia
70. ☐ "Nosebleeds" frequently
71. ☐ Noises in head, or "ringing in ears"
72. ☐ Tension under the breastbone, or feeling of "tightness," worse on exertion

GROUP FIVE

73. ☐ Dizziness
74. ☐ Dry skin
75. ☐ Burning feet
76. ☐ Blurred vision
77. ☐ Itching skin and feet
78. ☐ Excessive falling hair
79. ☐ Frequent skin rashes
80. ☐ Bitter, metallic taste in mouth in mornings
81. ☐ Bowel movements painful or difficult
80. ☐ Worrier, feel insecure
81. ☐ Feeling queasy; headache over eyes
82. ☐ Greasy foods upset
83. ☐ Stools light-colored
84. ☐ skin peels on foot soles
85. ☐ Pain between shoulder blades
86. ☐ Use laxatives
87. ☐ Stools alternate from soft to watery
88. ☐ History of gallbladder attacks or gallstones
89. ☐ Sneezing attacks
90. ☐ Dreaming, nightmare-type bad dreams
91. ☐ Bad breath (halitosis)
92. ☐ Milk products cause distress
93. ☐ Sensitive to hot weather
94. ☐ Burning or itching anus
95. ☐ Crave sweets

96. ☐ Loss of taste for meat
97. ☐ Lower bowel gas several hours after eating
98. ☐ Burning stomach sensations, eating relieves

GROUP SIX

99. ☐ Coated tongue
100. ☐ Pass large amounts of foul-smelling gas
101. ☐ Indigestion ½-1 hour after eating; may be up to 3-4 hours

102. ☐ Mucous colitis or "irritable bowel
103. ☐ Gas shortly after eating
104. ☐ Stomach "bloating" after eating

GROUP SEVEN

(A)

105. ☐ Insomnia
106. ☐ Nervousness
107. ☐ Can't gain weight
108. ☐ Intolerance to heat
109. ☐ Highly emotional
110. ☐ Flush easily
111. ☐ Night sweats
112. ☐ Thin, moist skin
113. ☐ Inward trembling
114. ☐ Heart palpitates
115. ☐ Increased appetite without weight gain
116. ☐ Pulse fast at rest
117. ☐ Eyelids and face twitch
118. ☐ Irritable and restless
119. ☐ Can't work under pressure

(B)

120. ☐ Increase in weight
121. ☐ Decrease in appetite
122. ☐ Fatigue easily
123. ☐ Ringing in ears
124. ☐ Sleepy during day
125. ☐ Sensitive to cold
126. ☐ Dry or scaly skin
127. ☐ Constipation
128. ☐ Mental sluggishness
129. ☐ Hair coarse, falls out
130. ☐ Headaches upon arising, wear off during day
131. ☐ Slow pulse, below 65
132. ☐ Frequency of urination
133. ☐ Impaired hearing
134. ☐ Reduced initiative

(C)

135. ☐ Failing memory
136. ☐ Low blood pressure
137. ☐ Increased sex drive
138. ☐ Headaches, "splitting or rending" type
139. ☐ Decreased sugar tolerance

(D)

140. ☐ Abnormal thirst
141. ☐ Bloating of abdomen
142. ☐ Weight gain around hips or waist
143. ☐ Sex drive reduced or lacking
144. ☐ Tendency to ulcers, colitis
145. ☐ Increased sugar tolerance
146. ☐ Women: menstrual disorders
147. ☐ Young girls: lack of menstrual function

(E)

148. ☐ Dizziness
149. ☐ Headaches
150. ☐ Hot flashes
151. ☐ Increased blood pressure
152. ☐ Hair growth on face or body (female)
153. ☐ Sugar in urine (not diabetes)
154. ☐ Masculine tendencies on

(F)

155. ☐ Weakness, dizziness
156. ☐ Chronic fatigue
157. ☐ blood pressure
158. ☐ Nails weak, ridged
159. ☐ Tendency to hives
160. ☐ Arthritic tendencies
161. ☐ Perspiration increase
162. ☐ Bowel disorders
163. ☐ Poor circulation
164. ☐ Swollen ankles
165. ☐ Crave salt
166. ☐ Brown spots or bronzing on skin
167. ☐ Allergies—tendency to asthma
168. ☐ Weakness after colds, influenza
169. ☐ Exhaustion—Muscular and nervous
170. ☐ respiratory

171. ☐ Easily fatigued
172. ☐ Premenstrual stress
173. ☐ Painful menses
174. ☐ Depressed feelings before menstruation
175. ☐ Menstruation excessive

GROUP EIGHT A: Female Only

176. ☐ Painful breast
177. ☐ Menstruate too frequently
178. ☐ Vaginal discharge
179. ☐ Hysterectomy/ovaries removed

180. ☐ Hot flashes
181. ☐ Menses scanty or missed
182. ☐ Acne, worse at menses
183. ☐ Depression long-standing

184. ☐ Prostate trouble
185. ☐ Urination difficult or dribbling
186. ☐ Night urination frequent
187. ☐ Depression

Group Eight B: Male Only

188. ☐ Pain on inside of legs or heel
189. ☐ Feeling of incomplete bowel evacuation
190. ☐ Lack of energy

191. ☐ Migrating aches and pains
192. ☐ Tire too easily
193. ☐ Avoid activity
194. ☐ Leg nervousness at night
195. ☐ Diminished sex drive

196. ☐ Sleep after meals
197. ☐ Bloated after meals
198. ☐ Poor concentration after meals

GROUP NINE

199. ☐ Diabetes in family
200. ☐ High blood pressure, cholesterol, or triglycerides
201. ☐ Always hungry

202. ☐ Fingers swollen or tight after exercise
203. ☐ Heart disease, stroke, breast cancer in family

204. ☐ Asprin improves symptoms 205. ☐ Menstrual cramps 206. ☐ Chronic inflammation	**GROUP TEN** 207. ☐ Dry itchy skin or scalp 208. ☐ React badly to sweets or excess carbohydrates	209. ☐ Eat restaurant or fast food often 210. ☐ Spring allergies
211. ☐ Low blood pressure 212. ☐ Poor circulation 213. ☐ Slow metabolism	**GROUP ELEVEN** 214. ☐ Intolerant to noise 215. ☐ Slow or irregular heartbeat	216. ☐ Headaches with feeling or tight band around head 217. ☐ Carbohydrate intolerance
218. ☐ Tense, irritable, and high-strung 219. ☐ High blood pressure	**GROUP TWELVE** 220. ☐ Poor fat metabolism 221. ☐ Restless, jumpy, and shaky legs	222. ☐ Overreact to caffeine 223. ☐ Tendency to spasm 224. ☐ Rapid heartbeat

Important: Please list below the five main complaints you have in order of their importance.

1. _____
2. _____
3. _____
4. _____
5. _____

(Please do not write below this line.)

Doctor's notes:

Name _____Case No. _____ Age _____ Sex ____

1. Are you taking medication? ……Yes_____ No_____
   If yes, list the kind and dosage and whether it is taken on a regular basis. _____
   _____
   _____
   _____
   Do you feel the medication is helping you? _____
2. Are you taking nutritional supplements? ……Yes_____ No_____
   If yes, list the kind and dosage and whether they are taken on a regular basis. _____
   _____
   _____
   _____
   Do you feel the nutritional supplements are helping you? For example, do you notice a specific improvement in the way you feel? _____
3. Approximately how many regular-size drinking glasses of water do you drink per day? _____
   Is the water usually regular tap water, or special water such as distilled or well water?
   _____
4. If you are a smoke, what do you smoke (cigarettes, pipe, etc.) and how many daily?
   _____
5. How often do you consume alcohol?
   Never_____ Once in a while _____ Often _____ Daily _____
6. How many cups of regular coffee (caffeinated) do you drink daily? _____
7. How many cups of decaffeinated coffee do you drink per day? _____
8. How many cups to tea or glasses of iced tea do you drink per day? _____
9. Approximately what percentage of your food is of the "convenience" variety? (Example: Hamburger Helpers, TV dinners, frozen pot pies, etc.)_____
10. When you eat out, do you prefer the "quick food" approach, such as McDonald's, Burger King, etc.
    _____
11. Do you use extra salt on your food at the table?……..Yes _____ No _____
12. Do you eat a lot of condiments such as catsup and other spicy foods?……Yes _____ No_____
13. Do you like sour foods such as lemon (unsweetened), dill pickles, and other pickled foods?…….. ……..Yes _____ No_____
14. Do you avoid or cut fat from your meat? ……Yes_____ No_____
15. Do you use butter or margarine?……..Yes_____ No_____
16. Do you like oil-type dressings on your salad?……Yes_____ No_____
17. Do you enjoy eating cheese? ……...Yes_____ No_____
18. Do you drink milk?……..Yes_____ No_____
    How much per day? _____ is it pasteurized?…….Yes_____ No_____
19. Do you like foods that have a high sugar content, such as pastries, donuts, etc?Yes_____ No_____
20. When you eat a donut, do you prefer to have it plain, with frosting, or filled?_____
21. Do you eat sugar-coated cereal?……..Yes_____ No_____
    When you eat cereal, how many teaspoons of sugar do you us on an average-size serving? _____
22. How many teaspoons of sugar do you use in coffee or tea? _____
23. How many soft drinks do you consume daily? _____

(Continued)

24. Do you try, as often as possible, to drink sugar-free soft drinks and use artificial sweeteners with coffee and food?……Yes_____ No_____
25. What kind of fruit do you prefer to eat?……Fresh _____Canned _____ Sugar-free_____
26. Do you often feel hungry, no matter how much you eat? ……..Yes_____ No_____
27. When you eat bread, is it white or whole wheat? _____
28. Do you usually eat breakfast?……Yes_____ No_____
29. Do you usually feel better after eating? ……Yes_____ No_____
30. Do you usually feel worse after eating? ……Yes_____ No_____
31. Do you snack a lot between the three major meals? ……Yes_____ No_____
32. When you have a snack, what type of food do you prefer? For example, sweet roll, cookies, cheese, cracker, fruit, vegetables. _____
    _____
    _____
    _____
33. Do you frequently skip meals?……..Yes_____ No_____
34. Do you have to watch what you eat to avoid gaining weight?……..Yes_____ No_____
35. Do you have more than one meal per day that lacks a vegetable other than corn, potatoes, peas, or green beans? ……Yes_____ No_____
36. Are there days when you do not eat any raw vegetables?……Yes_____ No_____
37. Do any foods create problems? If so, describe the problem.
    _____
    _____
    _____
38. What foods do you especially like? _____
    _____
    _____
39. What foods do you dislike?_____
    _____
    _____
40. Do you feel your diet is excessive in some respect? ……...Yes_____ No_____
    If yes, describe. _____
    _____
    _____
41. Do you feel your diet is deficient in some respect?……..Yes_____ No_____
    If yes, describe. _____
    _____
    _____

Notes

_____
_____
_____
_____
_____
_____
_____

Reprinted, by permission, from D. Walther, 1988, *Nutrition questionnaire (Pueblo, CO: Systems DC).*

Integrated Health Care of Montclair LLC

Dr. Tyran G. Mincey

Visual Analog Scale of Spinal Pain

Name_____ Date___/____/____

Please mark on the 1 to 10 scale your involvement with pain to the following locations and situations, from no involvement (0) to maximum involvement (10). Mark with a vertical line like this:

1. Do you have any pain in your neck ? How severe is it ?
0 . . . . | . . . . | . . . . | . . . . |. . . . | . . . . | . . . . | . . . . | . . . . | 10
No pain
Intolerable

2. Do you have any pain between your shoulder blades ? How severe is it?
0 . . . . | . . . . | . . . . | . . . . |. . . . | . . . . | . . . . | . . . . | . . . . | 10
No pain Intolerable

3. Do you have any pain in your low back? How severe is it?
0 . . . . | . . . . | . . . . | . . . . |. . . . | . . . . | . . . . | . . . . | . . . . | 10
No pain Intolerable

4. Do you have any pain at night? How severe is it?
0 . . . . | . . . . | . . . . | . . . . |. . . . | . . . . | . . . . | . . . . | . . . . | 10
No pain Intolerable

5. Does activity give you pain? Yes____ No____ If so, how much activity is required to cause you pain?
0 . . . . | . . . . | . . . . | . . . . |. . . . | . . . . | . . . . | . . . . | . . . . | 10
A great deal of activity Almost no activity

6. Do you use pain killers? Yes_____ No_____ If so how much relief?
0 . . . . | . . . . | . . . . | . . . . |. . . . | . . . . | . . . . | . . . . | . . . . | 10
Complete relief No relief

7. Do you have any stiffness in your neck and/or back?
0 . . . . | . . . . | . . . . | . . . . |. . . . | . . . . | . . . . | . . . . | . . . . | 10
No stiffness Intolerable stiffness

8. Do you have any pain in your shoulder and/or arm? (mark for right and left.)
Right 0 . . . . | . . . . | . . . . | . . . . |. . . . | . . . . | . . . . | . . . . | . . . . | 10
Left 0 . . . . | . . . . | . . . . | . . . . |. . . . | . . . . | . . . . | . . . . | . . . . | 10
None at all Intolerable

9. Does your pain interfere with the use of your arm and/or hand? (mark for right and left.)
Right 0 . . . . | . . . . | . . . . | . . . . |. . . . | . . . . | . . . . | . . . . | . . . . | 10
Left 0 . . . . | . . . . | . . . . | . . . . |. . . . | . . . . | . . . . | . . . . | . . . . | 10

None at all Not able to use at all

10.Do you have numbness of tingling in your arm and/or hand? (mark for right and left.)
0 . . . . | . . . . | . . . . | . . . . |. . . . | . . . . | . . . . | . . . . | . . . . | 10
None at all Intolerable

11. Do you have headaches? If so, how severe are they?
0 . . . . | . . . . | . . . . | . . . . |. . . . | . . . . | . . . . | . . . . | . . . . | 10

None at all *Intolerable*

12. How frequent are your headaches if you have them?

0 . . . . | . . . . | . . . . | . . . . |. . . . | . . . . | . . . . | . . . . | . . . . | 10

Infrequent *All the time*

13. Does your back pain interfere with your freedom to walk?

0 . . . . | . . . . | . . . . | . . . . |. . . . | . . . . | . . . . | . . . . | . . . . | 10

Complete freedom to walk *Completely unable to walk because of pain*

14. Does your pain interfere with your ability to stand still?

0 . . . . | . . . . | . . . . | . . . . |. . . . | . . . . | . . . . | . . . . | . . . . | 10

Can stand still for an hour or more *Not able to stand still at all*

15. Does your pain interfere with you sitting in a chair?

0 . . . . | . . . . | . . . . | . . . . |. . . . | . . . . | . . . . | . . . . | . . . . | 10

Complete comfort *Such discomfort that I cannot sit in a chair at all*

16. Is your pain worse when riding in a car?

0 . . . . | . . . . | . . . . | . . . . |. . . . | . . . . | . . . . | . . . . | . . . . | 10

Complete freedom to ride in a car *Such discomfort that I cannot ride in a car at all*

17. Do you have pain when lying down in bed?

0 . . . . | . . . . | . . . . | . . . . |. . . . | . . . . | . . . . | . . . . | . . . . | 10

Complete comfort *No comfort at all*

18. What is you overall handicap in you complete life style because of pain?

0 . . . . | . . . . | . . . . | . . . . |. . . . | . . . . | . . . . | . . . . | . . . . | 10

Completely free to perform any task *Totally handicapped*

19. To what extent does you pain interfere with your work?

0 . . . . | . . . . | . . . . | . . . . |. . . . | . . . . | . . . . | . . . . | . . . . | 10

No interference at all *Totally incapable of work*

20. To what extent does your work have to be modified so that you are able to do your job?

0 . . . . | . . . . | . . . . | . . . . |. . . . | . . . . | . . . . | . . . . | . . . . | 10

No adjustment to work *So much adjustment that I have had to change jobs*