Print Name: _____ DOB:_____

Yellowstone Naturopathic Clinic

We are now sending appointment reminders through email 3 days prior to your appointment and a text message 2 days prior to your appointment.

Email: _____

Cell Phone:_____

_____ Opt me out of text communication. (Appointment reminders and continuing care)

_____Opt me out of email communication. (Customer promotions, appointment reminders, continuing care, birthday message, thank you message)

Signature: _____ Date:_____

Lung Screening Questions

Do you smoke? ___Yes ____ No ____ Never

If **Yes** :

How many packs per day do you smoke? _____

How many years have you smoked? _____

If **No**:

Have you ever smoked? _____ Yes _____ No

How many packs per day did you smoke? _____

How many years did you smoke? _____

How many years ago did you quit? _____

If **No/Never**:

Have you been exposed to second-hand smoke?

____Yes ____No ____Never

Name: _____ DOB: _____

Dr. Initials: _____ Date: _____

YELLOWSTONE NATUROPATHIC CLINIC
720 N 30th St Billings, MT 59101 406-259-5096 Fax: 406-545-0044

Patient's **LEGAL** Name _____ aka/Nickname _____ Date _____

Date of Birth _____ Soc. Sec. #_____ Male ___ Female ___ Marital Status _____

Primary Contact Phone Number _____ *(circle one)* Landline or Mobile

→Can we leave messages with detailed medical information at your primary contact phone number?

(mark one) Yes _____ *No _____

**If "No", to remain HIPAA Compliant, we will be required to leave a vague message asking you to return our call to receive any medical information.*

Residence Address (physical address) _____

City _____ State _____ Zip Code _____

Mailing Address (if different) _____

City _____ State _____ Zip Code _____

How long at present address? _____

If patient is a minor, parent/guardian's name _____

Employer _____ Work Phone Number _____

City _____ State _____ Zip Code _____

Responsible Party for Account _____

Address (if different from above) _____

City _____ State _____ Zip Code _____

In Case of Emergency, Whom Should We Notify? _____

Address _____ Relationship _____

Primary Contact Number _____ Alternate Phone Number _____

How did you learn of our Clinic?

Personal Referral (please tell us who so we may thank them) _____

Doctor Referral (which physician?) _____

Gazette/ Simply Family/ Yellowstone Valley Women/ Rimrock Mall/ other media (circle one)

Other (please describe) _____

Payment is due at the time of service as we do **NOT** bill insurance.

We accept cash, check and all major credit cards.

Yellowstone Naturopathic Clinic will verify this contact information whenever you come in for an appointment. However, if your circumstances change, it is your responsibility to give us your new contact information.

Signature _____ Date _____

Rev. 04/16

Yellowstone Naturopathic Clinic - 720 N 30th St. - Billings, MT 59101 (406-259-5096)

Name _____ Doctor _____ Date _____

Please list any additions to your **current** Medications and Supplements below.

(Include all prescribed and over-the-counter items.)

Medication	Dosage	Directions

Any Drug or Other Allergies? No _____ Yes (please list) _____, _____

_____, _____, _____, _____

Are you having difficulty in your ability to perform routine daily living activities, or has there been a change since your last visit? No _____ Yes (please explain) _____

_____

Have you had any recent x-rays, imaging or scans? No ____ Yes (please list) _____

Do you use tobacco? No ____ Yes (How much?) _____

Would you like help with quitting? No _____ Yes _____

Do you have concerns about safety in your home/falls? No _____ Yes _____

Do you have concerns about physical or emotional abuse? No _____ Yes _____ (optional)

(You may discuss the above with the doctor instead of indicating your concern(s) on this form.)

Surgical History:_____

Last Mammogram:_____ **Last Pap**_____ **Last GYN exam**_____

Last Colonoscopy:_____ **Last DRE/PSA**_____

FAMILY MEDICAL HISTORY

Please list ages, health problems and, if deceased, cause of death (only include blood relatives)

Relative	Age	(L)iving or (D)eceased	Cause of Death	Health Concerns: *heart disease, diabetes, cancer, thyroid, depression/anxiety, etc.*
Mother				
Father				
Brothers				
Sisters				
Children				
Grandparents:				
Mother's mom				
Mother's dad				
Father's mom				
Father's dad				

Yellowstone Naturopathic Clinic
Policy

720 North 30th Street
Billings, MT 59101
(406) 259-5096 Phone
(406) 545-0044 Fax

Appointments:
Your appointment time has been reserved for you. If you cannot make this appointment, please inform us as soon as possible so that we may give this time to another patient. FAILURE TO PROVIDE US WITH **24** HOURS NOTICE OF APPOINTMENT CANCELLATION WILL RESULT IN A CHARGE TO YOUR ACCOUNT.

Your first visit will be scheduled for 90 minutes. The charge is $270.00. During this time your doctor will talk with you in depth about your health concerns, pertinent past medical history, etc. Medical records of previous care by other physicians may be requested at this time. Your doctor may also discuss and arrange for laboratory testing to be done before your next visit. Not all lab tests require fasting. Please remember, there is no need to fast unless specifically told to do so.

The second appointment is scheduled for 90 minutes and costs $270.00. This appointment is typically 2 - 3 weeks later and includes a comprehensive physical examination, review of laboratory results and an individual treatment plan designed to start you on the road to better health. If you have a health problem of an acute nature, we will address that problem while keeping our primary focus on uncovering and resolving the underlying cause. The charges for the two initial visits do not include any dispensary items that may be prescribed for you.

Fees, Insurance and Accounts Receivable:
Subsequent visits are scheduled as brief, routine or extended and are billed at $96, $141 and $189. **We expect payment at the time of visit unless prior arrangements have been made.** Please note that Yellowstone Naturopathic Clinic accepts VISA, Discover, MasterCard and American Express. If you have insurance coverage, we will provide you with a form that includes all the appropriate procedure and diagnostic codes your insurance company will need to process your claim. Unfortunately, Medicare and Medicaid do not currently cover naturopathic care. Numerous health insurance companies do cover naturopathic doctors as primary care physicians. Some out-of-state insurance companies are not aware of their obligation under Montana law.

Phone Consultations and Questions:
Please feel free to discuss with us any questions you may have. During all phases of your care, it is important that you fully understand your treatment program. If you have any questions please address them to the Yellowstone Naturopathic Clinic staff. The staff will relay your questions promptly to the appropriate doctor. The doctors maintain full schedules and may not be able to answer your questions directly or immediately. Either the doctor or a staff member will get back to you as soon as possible. Should you have a number of questions regarding your treatment or progress, we suggest that you make an appointment so that we may properly meet your needs. **Doctor's telephone consultations that extend beyond 5 minutes will be billed to your account.** PLEASE NOTE THAT TELEPHONE CONSULTATIONS ARE NOT USUALLY COVERED BY MOST INSURANCE COMPANIES.

Emergencies:
One of our doctors is on-call 24 hours a day. Calls to the Clinic at 259-5096, outside regular business hours, are automatically transferred to our answering service. The service will then contact the doctor to return your call. For medical emergencies, please call 911.

Acknowledgements:
We hope that you will find your visit with us pleasant as well as beneficial. Our goal is to help you in building better health.

Signing this form acknowledges that you understand and accept the policies of the Yellowstone Naturopathic Clinic.

Signed _____ Date: _____

YELLOWSTONE NATUROPATHIC CLINIC
720 N 30th St Billings, MT 59101 406-259-5096 Fax: 406-545-0044

The term 'health care provider(s)' in this form means Yellowstone Naturopathic Clinic, Oasis Health Spa, their physicians, employees and members of the medical staff who provide care to patients.

CONSENT TO TREAT

I give permission to all health care providers involved in my care to administer such examination, treatment, testing and procedures as they deem necessary in the course of my care.

RELEASE OF INFORMATION

I understand that as part of my health care, health care providers create and maintain health records that may include my health history, symptoms, examination and test results, diagnoses, treatment and any plan for care including future treatment. I understand that this information serves as a basis for planning my treatment and care and is a tool for routine health care operations including assessing quality and reviewing competency of our staff and/or other health care providers.

FINANCIAL RESPONSIBILITY

I agree to pay all charges for my health care treatment. If charges to my account are not paid after reasonable notice, the account shall be deemed delinquent. In the event that I default on payment of my account, I agree to be responsible for collection fees and interest due on amounts in default. If the debt is assigned to a third party for collection, I agree to be responsible for collection fees and interest due on amounts in default.

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

The Department of Health and Human Services has established a "Privacy Rule" to help insure that personal health care information is protected for privacy. The Privacy Rule was also created in order to provide a standard for certain health care providers to obtain their patient's consent for use and disclosure of health information about the patient to carry out treatment, payment or health care operations.

As our patient we want you to know that we respect the privacy of your personal medical records and will do all we can to secure and protect that privacy. When it is appropriate and necessary we provide the minimum necessary information to only those we feel are in need of your health care information and information about treatment, payment or health care operations in order to provide health care that is in your best interest.

We also want you to know that we support your full access to your personal records. We may have indirect treatment relationships with you (such as laboratories that only interact with physicians and not patients), and may have to disclose personal health information for purpose of treatment, payment or health care operations. These entities are most often not required to obtain patient consent.

You may refuse to consent to the use or disclosure of your personal health information, but this must be in writing. Under this law, we have the right to refuse to treat you should you choose to refuse to disclose your Personal Health Information (PHI). If you choose to give consent in this document, at some future time you may request or refuse all or part of your PHI. You may not revoke actions that have already been taken which relied on this or a previously signed consent.

If you have any objections to this form, please ask to speak with our HIPAA Compliant Officer. You have the right to review our privacy notice, to request restrictions and to revoke consent in writing after you have reviewed our privacy notice.

Patient's Representative(s): (the following must be filled out, even if the answer is none)
This person is a family member or friend who may call our office on your behalf. Unless their name is listed below, we will not be able to speak with them about your medical concerns.

*** I hereby authorize the following individuals to have access to my healthcare information:**

_____, Relationship to Patient _____
_____, Relationship to Patient _____
_____, Relationship to Patient _____

PHOTOGRAPH

I authorize YNC to take a photograph of me for my file. ☐ **Yes** ☐ **No**

A photo helps us improve medical care. Photos prevent identification errors and (in conjunction with written records) prompt our physicians in recalling your needs, concerns and medical issues. This image will not be shared outside of Yellowstone Naturopathic Clinic. The confidentiality of this image will be maintained in accordance with HIPPA regulations.

TERM

This consent will be in effect for one year from the date signed.

Printed Name of Patient _____ **Date** _____

Patient or Responsible Party Signature _____

Responsible Party's Relationship to Patient _____

Witness _____ **Date** _____

** *If you would like a copy of this form, once signed, please ask the receptionist* **

Patient Compliance Assurance Notification

To our valued families and patients:

The misuse of Personal Health Information (PHI) has been identified as a national problem causing patients inconvenience, aggravation and money. We want you to know that all of our employees continually undergo training so that they may understand and comply with government rules and regulations regarding the Health Insurance Portability and Accountability Act (HIPAA) with particular emphasis on the "Privacy Rule". We strive to achieve the very highest standards of ethics and integrity in performing services for our patients. It is our policy to properly determine appropriate use of PHI in accordance with the governmental rules, laws and regulations. We want to insure that our practice never contributes in any way to the growing problem of improper disclosure of PHI. As part of this plan, we have implemented a Compliance Program that we believe will help us prevent any inappropriate use of PHI. We also know that we are not perfect! Because of this fact our policy is to listen to our employees and our patients without any thought of penalization if they feel that an event in any way compromises our policy of integrity. More so, we welcome your input regarding any service problem so that we may remedy the situation promptly. Thank you, for being one of our highly valued patients!

Yellowstone
PAIN RELIEF CENTER

Patient Name:_____

Age:_____ Gender: _____

Phone: _____

Occupation:_____

YOUR HEALTH PROFILE

Why This Form is Important:

As a Pain Relief Center our goals are to first address your pain and the conditions that brought you to this office as well as to provide you with sustainable protocols to manage your health and wellness. The following questions will help us to identify and understand your health profile, and assist us in designing an appropriate and comprehensive treatment course.

REASON FOR CONSULTING OUR OFFICE

Please list and describe your PRIMARY SYMPTOMS: _____

_____

_____

Additional complaints/symptoms:_____

Is this condition interfering with your [] Work [] Sleep [] Daily routine [] Other_____

ONSET OF YOUR CONDITION/S:

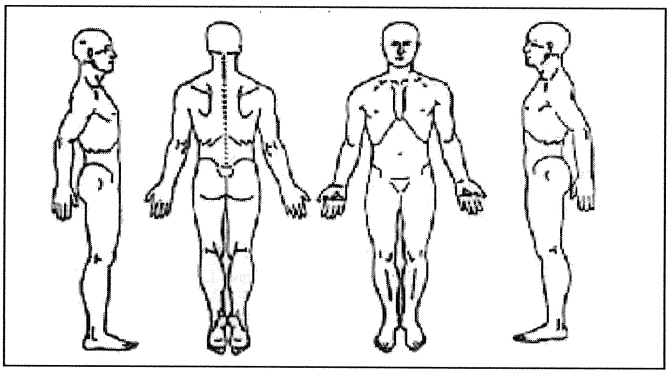
Health Concerns: List in order of severity.	When did this episode start?	Did problem begin with an injury?		Did pain begin gradually or suddenly?		Are symptoms constant or intermittent?		Have you had this condition before? When?
		Yes	No	Gradually	Suddenly	Constant	Intermt	
1.								
2.								
3.								

Please use the space below to expand upon the onset of your injury: _____

_____

Health Concerns: List in order of severity	Rate Severity 1 = mild pain 10 = excruciating	Frequency of pain (times per day, hour, etc)	What aggravates your condition?	What relieves your condition?	Does pain radiate? where?	Is there numbness or weakness? Where?
1.						
2.						
3.						

Mark the areas below showing where you experience your pain.



Quality of Pain:

[] Sharp [] Dull [] Throbbing
[] Numbness [] Aching [] Shooting
[] Burning [] Tingling [] Cramps
[] Stiffness [] Swelling [] Other

Any Other Associated Symptoms:

(swelling, range of motions, headaches)

_____

_____

_____

TREATMENTS TRIED **(Effectiveness)**

TREATMENT	YES	NO	GOOD	MODERATE	MINIMAL	POOR
NSAIDs (Motrin, Aleve, etc.)						
Oral steroids						
Anti-depressants						
Home Exercise						
Physical Therapy						
Cortisone injection						
Electrical Stimulation						
Massage Therapy						
Other injection therapies						
Other:						

WHO HAS EVLAUATED YOUR CONDITION/S

SPECIALIST	YES	NO	DIAGNOSIS	TREATMENT / ADVICE
Orthopedist				
Neurologist				
Surgeon				
Chiropractor				
Naturopath				
Acupuncturist				
Other				

IMAGING: Have you ever had any of the below taken?

TYPE OF IMAGING	AREA OF THE BODY	WHEN	AT WHAT FACILITY
X-rays			
MRI			
CT scan			
Other			

REVIEW OF SYSTEMS: Please check (X) if any of the following has occurred within the last 2 months.

CONSTITUTIONAL [] Weight Loss [] Weight Gain [] Fever	**RESPIRATORY** [] Wheezing [] Shortness of breath	**SKIN** [] Rashes [] Itching
EYES [] Changes in Vision [] Impaired Vision	**GASTROINTESTINAL** [] Nausea [] Vomiting [] Constipation [] Abdominal pain [] Bloody/Black stool [] Loss of bowel control	**HEMATOLOGIC** [] Bruises, frequent or easily [] Cuts do not stop bleeding
HENT [] Headaches [] Dizziness [] Thyroid problems		**NEUROLOGICAL** [] Memory difficulties [] Seizures [] Loss of Balance [] Lightheadedness or Faintness
CARDIOVASCULAR [] Chest pain [] Irregular Heartbeat [] Rapid Heart Rate [] Fainting [] Swelling of Legs [] Other	**GENITOURINARY** [] Urgency of urination [] Inability to urinate [] Leakage of urine [] Impotence [] **Possibly Pregnant**	**PSYCHIATRIC** [] Anxiety [] Depression [] Physical Abuse [] Sexual Abuse

Please elaborate on the condition/s you have marked above, and/or include other pertinent conditions that are not listed:

PAST HEALTH HISTORY (Please circle and describe)
Major Surgery / Operations: _____

_____

Major Accidents or Falls: _____

Hospitalizations (Other than above):_____

Significant Past Illnesses: _____

MEDICATIONS and SUPPLEMENTS that you are CURRENTLY TAKING [] Refer to the list I have provided

DRUG NAME	DOSAGE	PHYSICIAN or SELF

ALLERGIES to MEDICATIONS or SUBSTANCES *(Latex, Tape, Novocain, etc.)*

DRUG or SUBSTANCE	REACTION	DATE

Have you ever had challenges with dependency [] Alcohol [] Nicotine [] Prescription Drugs [] Recreational drugs

Do you smoke? [] No [] Yes Packs per day:_____ Number of years: _____

Do you drink alcohol? [] No [] Yes Drinks per day:_____ Drinks per week:_____

DIET

Do you consume caffeine? [] No [] Yes Do you consume pop? [] No [] Yes

What do you typically eat for Lunch? _____

EXERCISE

What form of exercise:_____ Duration:_____ # of Days per week:_____

STRESS

On a scale of 1 – 10 (1 = none, 10 = extreme) please describe your psychological/emotional stress levels:

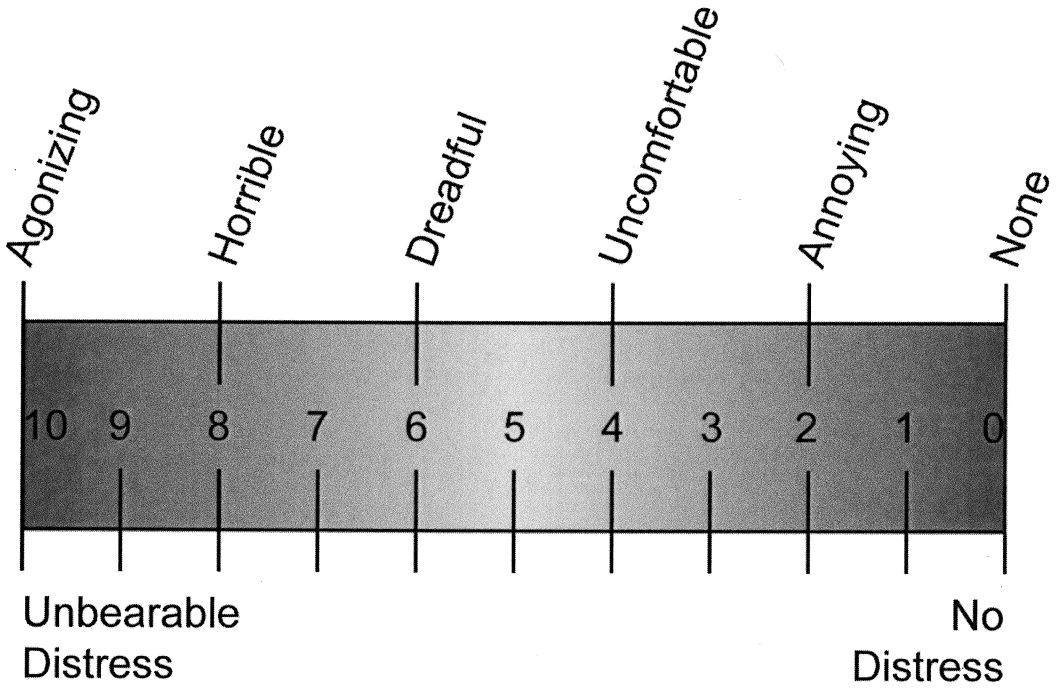
Occupational:_____ Personal:_____

Having been explained the risk of treatment, I do hereby request and consent to the performance of wellness care and related procedures upon the above-named patient (my dependent or myself). I wish to rely on the doctor to exercise judgment for my best interest during the course of treatment. I will inform the doctor who is treating me of sensitive areas or adverse conditions I may have prior to, during, or after treatment. I intend this consent to cover the entire course of this treatment.

We thank you for your patience, cooperation and thoroughness in completing this form.

Patient's Signature:_____ Date: _____

If you desire to further expand on your medical condition, please utilize the back side of this document.



Task _____

Date _____ *Start* _____ *End* _____

The Oswestry Low Back Pain Disability Questionnaire

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

Section 1- Pain Intensity
0. I can tolerate the pain I have without having to use pain medication.
1. The pain is bad, but I can manage without having to take pain medication.
2. Pain medication provides me with complete relief from pain.
3. Pain medication provides me with moderate relief from pain.
4. Pain medication provides me with little relief from pain.
5. Pain medication has no effect on my pain.

Section 2- Personal Care (Washing, Dressing, etc.)
0. I can take care of myself normally without causing increased pain.
1. I can take care of myself normally, but it increases my pain.
2. It is painful to take care of myself and I am slow and careful.
3. I need help, but I am able to manage most of my personal care.
4. I need help every day in most aspects of my care.
5. I do not get dressed, I wash with difficulty, and I stay in bed.

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

Section 4- Walking
0. Pain does not prevent me from walking any distance.
1. I cannot walk more than 1 mile without increasing pain.
2. I cannot walk more than 1/2 mile without increasing pain.
3. I cannot walk more than 1/4 mile without increasing pain.
4. I can walk only with crutches or a cane.
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 pain immediately.

Section 7- Sleeping
0. Pain does not prevent me from sleeping well.
1. I can sleep well only by using pain medication.
2. Even when I take medication, I sleep less than 6 hours.
3. Even when I take medication, I sleep less than 4 hours.
4. Even when I take medication, I sleep less than 2 hours.
5. Pain prevents me from sleeping at all.

Section 8- Social Life
0. My social life is normal and does not increase my pain.
1. My social life is normal but it increases the degree of pain.
2. Pain prevents me from participating in more energetic interests (i.e. sports, 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 my pain.

Section 9- Traveling
0. I can travel anywhere without increased pain.
1. I can travel anywhere, but it increases my pain.
2. My pain restricts my travel over 2 hours.
3. My pain restricts my travel over 1 hour.
4. My pain restricts my travel to short necessary journeys under ½ hour.
5. My pain prevents all travel except for visits to the physician/therapist or hospital.

Section 10- Employment/Homemaking
0. My normal homemaking/job activities do not cause pain.
1. My normal homemaking/job activities increase my pain, but I can still perform all that is required of me.
2. I can perform most of my normal homemaking/job duties, but pain prevents me from performing most physically stressful activities (i.e. lifting, vacuuming, etc).
3. Pain prevents me from doing anything but light duties.
4. Pain prevents me from doing even light duties.
5. Pain prevents me from performing any job or homemaking chores.

Total Score: _____/50 **% Disability: _____**

The RAND 36-Item Health Survey

Introduction

The RAND 36-Item Health Survey (Version 1.0) laps eight concepts: physical functioning, bodily pain, role limitations due to physical health problems, role limitations due to personal or emotional problems, emotional well-being, social functioning, energy/fatigue, and general health perceptions. It also includes a single item that provides an indication of perceived change in health. These 36 items, presented here, are identical to the MOS SF-36 described in Ware and Sherbourne (1992). They were adapted from longer instruments completed by patients participating in the Medical Outcomes Study (MOS), an observational study of variation in physician practice styles and patient outcomes in different systems of health care delivery (Hays & Shapiro, 1992: Stewart, Sherbourne, Hays, et al., 1992).

A revised version of the RAND 36-Item Health Survey (Version 1.1) that differs slightly from version 1.0 in terms of item wording is currently in development.

SCORING RULES FOR THE RAND 36-ITEM HEALTH SURVEY (Version 1.0)

We recommend that responses be scored as described below. A somewhat different scoring procedure for the MOS SF-36 has been distributed by the International Resource Centre for Health Care Assessment (located in Boston, MA). Because the scoring method described here (a simpler and more straightforward procedure) differs from that of the MOS SF-36, persons using this scoring method should refer to the instrument as the RAND 36-Item Health Survey 1.0.

Scoring the RAND 36-Item Health Survey is a two-step process. First, precoded numeric values are recoded per the scoring key given in Table 1. Note that all items are scored so that a high score defines a more favourable health state. In addition, each item is scored on a 0 to 100 range so that the lowest and highest possible scores are set at 0 and 100, respectively. Scores represent the percentage of total possible score achieved. In step 2, items in the same scale are averaged together to create the 8 scale scores. Table 2 lists the items averaged together to create each scale. Items that are left blank (missing data) are not taken into account when calculating the scale scores. Hence, scale scores represent the average for all items in the scale that the respondent answered.

Example: Items 20 and 32 are used to score the measure of social functioning. Each of the two items has 5 response choices. However, a high score (response choice 5) on item 20 indicates extreme limitations in social functioning, while a high score (response choice 5) on item 32 indicates the absence of limitations in social functioning. To score both items in the same direction, Table 1 shows that responses 1 through 5 for item 20 should be recoded to values of 100, 75, 50, 25, and 0, respectively. Responses 1 through 5 for item 32 should be recoded to values of 0, 25, 50, 75, and 100, respectively. Table 2 shows that these two recoded items should be averaged together to form the social functioning scale. If the respondent is missing one of the two items, the person's score will be equal to that of the non missing item.

Table 3 presents information on the reliability, central tendency and variability of the scales scored using this method.

References

1. Ware, J.E., Jr., and Sherbourne, C. D. "The MOS 36-Item Short-Form Health Survey (SF-36): I. Conceptual Framework and item Selection," *Medical Care*, 30:473-483, 1992.
2. Hays, R.D., & Shapiro, M.F. "An Overview of Generic Health-Related Quality of Life Measures For HIV Research." *Quality of Life Research*, 1:91-97, 1992.
3. Stewart, A. L., Sherbourne, C., Hays, R. D., et al. "Summary and Discussion of MOS Measures," In A. L. Stewart & J. E. Ware (eds.), *Measuring Functioning and Well-Being: The Medical Outcome Study Approach* (pp. 345-371). Durham, NC: Duke University Press, 1992.

Please refer to **www.sf-36.org** for further information

Note: The Workplace Safety & Insurance Board (WSIB) acknowledges that the RAND-36-Short Form Health Survey (SF-36) was developed at RAND as part of the Medical Outcomes Study.

The RAND 36-Item Health Survey

Table 1

STEP 1: RECORDING ITEMS

ITEM NUMBERS	Change original response category (a)	To recoded value of:
1,2,20,22,34,36	1---------->	100
	2---------->	75
	3---------->	50
	4---------->	25
	5---------->	0
3,4,5,6,7,8,9,10,11,12	1---------->	0
	2---------->	50
	3---------->	100
13,14,15,16,17,18,19	1---------->	0
	2---------->	100
21,23,26,27,30	1---------->	100
	2---------->	80
	3---------->	60
	4---------->	40
	5---------->	20
	6---------->	0
24,25,28,29,31	1---------->	0
	2---------->	20
	3---------->	40
	4---------->	60
	5---------->	80
	6---------->	100
32,33,35	1---------->	0
	2---------->	25
	3---------->	50
	4---------->	75
	5---------->	100

(a) Precoded response choices as printed in the questionnaire.

The RAND 36-Item Health Survey

Table 2

STEP 2: AVERAGING ITEMS TO FORM SCALES

Scale	Number Of Items	After Recoding Per Table 1, Average The Following Items:
Physical functioning	10	3 4 5 6 7 8 9 10 11 12
Role limitations due to physical health	4	13 14 15 16
Role limitations due to emotional problems	3	17 18 19
Energy/fatigue	4	23 27 29 31
Emotional well-being	5	24 25 26 28 30
Social functioning	2	20 32
Pain	2	21 22
General health	5	1 33 34 35 36

The RAND 36-Item Health Survey

Table 3

RELIABILITY, CENTRAL TENDENCY AND VARIABILITY OF SCALES IN THE MEDICAL OUTCOMES STUDY

Scale	Items	Alpha	Mean	SD
Physical functioning	10	0.93	70.61	27.42
Role functioning/physical	4	0.84	52.97	40.78
Role functioning/emotional	3	0.83	65.78	40.71
Energy/fatigue	4	0.86	52.15	22.39
Emotional well-being	5	0.90	70.38	21.97
Social functioning	2	0.85	78.77	25.43
Pain	2	0.78	70.77	25.48
General health	5	0.78	56.99	21.11
Health change	1	———	59.14	23.12

Note: Data is from baseline of the Medical Outcomes Study (N – 2471), except for Health change, which was obtained one year later.

RAND 36-Item Health Survey 1.0 Questionnaire Items

1. In general, would you say your health is:	
Excellent	1
Very good	2
Good	3
Fair	4
Poor	5

2. **Compared to one year ago,** how would your rate your health in general **now**?	
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

Note: The WSIB acknowledges that the RAND 36-Item Short Form Health Survey was developed at RAND as part of the Medical Outcomes Study.

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 cleaner, 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**	[1]	[2]	[3]
11. Walking **one block**	[1]	[2]	[3]
12. Bathing or dressing myself	[1]	[2]	[3]

Note: The WSIB acknowledges that the RAND 36-Item Short Form Health Survey was developed at RAND as part of the Medical Outcomes Study.

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	1	2
19. Didn't do work or other activities as **carefully** as usual	1	2

Note: The WSIB acknowledges that the RAND 36-Item Short Form Health Survey was developed at RAND as part of the Medical Outcomes Study.

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, neighbours, 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)

Not at all 1

A little bit 2

Moderately 3

Quite a bit 4

Extremely 5

Note: The WSIB acknowledges that the RAND 36-Item Short Form Health Survey was developed at RAND as part of the Medical Outcomes Study.

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	A Little of the Time	None of the Time
23. Did you feel full of pep?	1	2	3	4	5	6
24. Have you been a very nervous person?	1	2	3	4	5	6
25. Have you felt so down in the dumps that nothing could cheer you up?	1	2	3	4	5	6
26. Have you felt calm and peaceful?	1	2	3	4	5	6
27. Did you have a lot of energy?	1	2	3	4	5	6
28. Have you felt downhearted and blue?	1	2	3	4	5	6
29. Did you feel worn out?	1	2	3	4	5	6
30. Have you been a happy person?	1	2	3	4	5	6
31. Did you feel tired?	1	2	3	4	5	6

Note: The WSIB acknowledges that the RAND 36-Item Short Form Health Survey was developed at RAND as part of the Medical Outcomes Study.

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

(Circle One Number)

All of the time 1

Most of the time 2

Some of the time 3

A little of the time 4

None of the time 5

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

(Circle One Number on Each Line)

	Definitely True	Mostly True	Don't Know	Mostly False	Definitely False
33. I seem to get sick a little easier than other people	1	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

Note: The WSIB acknowledges that the RAND 36-Item Short Form Health Survey was developed at RAND as part of the Medical Outcomes Study.