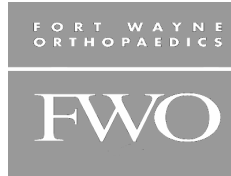


7601 W. JEFFERSON BLVD.  
P.O. BOX 2526  
FORT WAYNE IN 46801-2526



(260) 436-8686  
(800) 566-5659  
FAX (260) 436-8585

It is very important that you fill out this form as completely as possible before you arrive for your appointment. **If your injury is not work-related, please disregard this page and complete the remainder of the form.**

PATIENT NAME	ACCOUNT NO.
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DATE OF VISIT:
----------------

Dear Back or Neck Patient:

The questionnaire you have received from Fort Wayne Orthopaedics, LLC will allow your physician to give you the best available treatment for your spinal problem.

**If your injury is work-related and has been reported to your employer's worker's compensation carrier, to better facilitate the transfer of information regarding your care, we need you to complete the form below. Please contact your employer to obtain this information prior to your visit.**

<b>NAME OF EMPLOYER</b>
<b>EMPLOYER'S ADDRESS</b>
<b>WORKER'S COMPENSATION CARRIER (INSURANCE)</b>
<b>INSURANCE CO. ADDRESS</b>
<b>CASE MANAGER</b>

If you have any other questions, please ask the nurse at the time of your appointment.

Thank you,

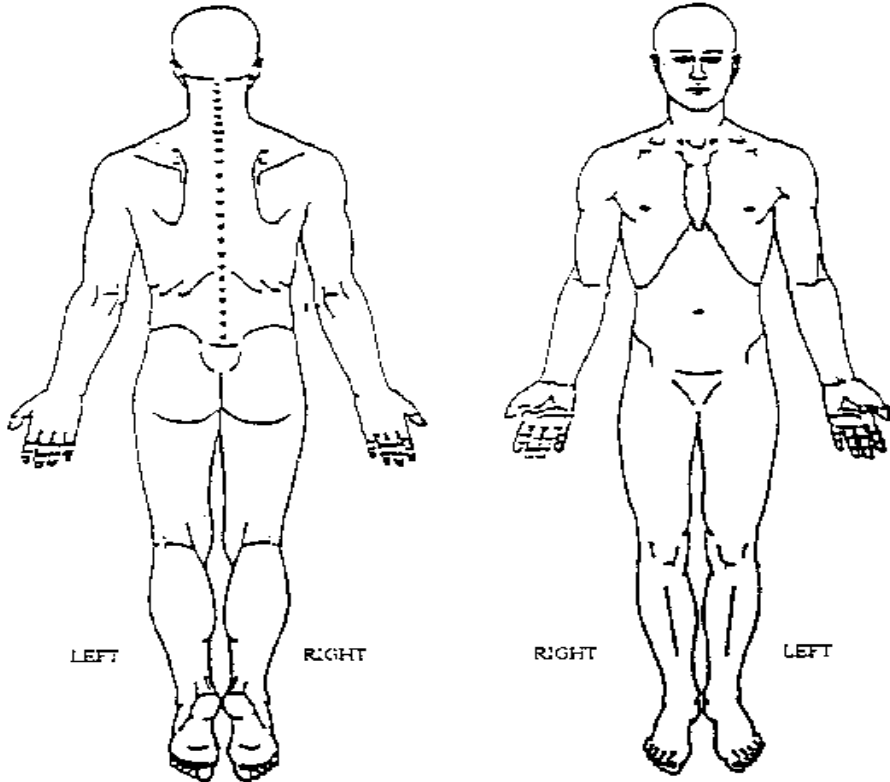
Fort Wayne Orthopaedics, LLC

Dr. \_\_\_\_\_

PATIENT NAME:	ACCOUNT NO.:
DATE OF VISIT:	TIMEPOINT:

Mark these drawings according to where you hurt. (If the back of your neck hurts, mark the drawing on the back of the neck, etc.) If you feel any of the following symptoms, please indicate where you feel them by placing the marks shown here on the diagram.

<u>Numbness</u> =====	<u>Burning</u> XXXXXX	<u>Ache</u> ^^^^^^	<u>Pins &amp; Needles</u> OOOOO	<u>Stabbing</u> ////////
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How would you describe your current pain ratio? (Please check one box)

Back Pain vs. Leg Pain			Neck Pain vs. Arm Pain		
✓	% Back Pain	% Leg Pain	✓	% Neck Pain	% Arm Pain
<input type="checkbox"/>	100%	0%	<input type="checkbox"/>	100%	0%
<input type="checkbox"/>	75%	25%	<input type="checkbox"/>	75%	25%
<input type="checkbox"/>	50%	50%	<input type="checkbox"/>	50%	50%
<input type="checkbox"/>	25%	75%	<input type="checkbox"/>	25%	75%
<input type="checkbox"/>	0%	100%	<input type="checkbox"/>	0%	100%

HEIGHT:
WEIGHT:
RADIAL PULSE:

**Current Pain Intensity**

Please circle the number which best describes your current pain level

(0 represents "no pain")

(10 is "the worst pain you could imagine")

<b>Today</b>	0	1	2	3	4	5	6	7	8	9	10
<b>Best Day</b>	0	1	2	3	4	5	6	7	8	9	10
<b>Worst Day</b>	0	1	2	3	4	5	6	7	8	9	10

PATIENT NAME:	ACCOUNT NO.:
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Sex: M or F	Age:	Dominant Hand: R or L	Date Your Pain Started:
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Which physician referred you to Fort Wayne Orthopaedics?	Name of Physician _____ Office Address _____ _____
--	--

What is the main reason for your visit?

What are your present symptoms? \_\_\_\_\_

Describe how the injury occurred? \_\_\_\_\_

Did you sustain any other injuries at the time of this injury? If yes, please describe. \_\_\_\_\_

Is this injury work related?       Yes       No       Unsure

Is there an upcoming worker's compensation hearing?       Yes       No

Do you have a lawyer for your injury?       Yes       No

Did an automobile accident cause your pain?       Yes       No      Date of Accident: \_\_\_\_\_

Description of the accident  
 \_\_\_\_\_  
 \_\_\_\_\_

Were you wearing a seatbelt?       Yes       No

Is there upcoming litigation?       Yes       No

Do you get leg pain as you walk?       Yes       No

How far can you walk? (check one box)       Less than 1 block       1 block       5-10 blocks       more than 1 mile

If you sit down after you walk, does your leg pain get better?       Yes       No

How long have you had your current pain? (check one box)

<input type="checkbox"/> Unknown	<input type="checkbox"/> About 6 months
<input type="checkbox"/> About 1 Day	<input type="checkbox"/> About 6 months to 1 year
<input type="checkbox"/> About 3 days	<input type="checkbox"/> About 1 to 2 years
<input type="checkbox"/> About 1 week	<input type="checkbox"/> About 2 to 3 years
<input type="checkbox"/> About 1 month	<input type="checkbox"/> About 3 to 5 years
<input type="checkbox"/> About 3 months	<input type="checkbox"/> More than 5 years

PATIENT NAME:	ACCOUNT NO.:
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Have you recently or are you now experiencing numbness and /or tingling in your leg, foot, arm, or hand?     Yes     No     Right     Left

If yes, in which body part?

Have you recently or are you now experiencing weakness in your arms?     Yes     No     Right     Left

In your legs     Yes     No     Right     Left

Have you experienced any of the following changes in urination?     Increased frequency     Inability to hold urine     Dribbling after voiding     Cannot pass urine

Have you experienced any of the following changes in your bowels?     Constipation     Diarrhea     Loss of control

Have you noticed changes in sexual function?     Yes     No

If yes, what?

Do you have headaches?     Yes     No

Have you recently been depressed because of your pain?     Yes     No     Sometimes

Does the pain wake you up at night?     Yes     No

How many hours per night do you sleep?

Is the pain in your back or neck constant or intermittent?     Constant     Intermittent

Is the pain in your leg or arm constant or intermittent?     Constant     Intermittent

Which word in each group best describes your pain?     Dull     Superficial     Burning     Stabbing  
 Sharp     Deep     Throbbing     Aching  
 Shooting

Does the pain keep you from participating in activities you enjoy?     Yes     No

Is your pain severe enough to consider surgery?     Yes     No     Maybe

**Please mark the activities that make your pain worse**

Sitting     Standing     Leaning forward     Walking  
 Lying on your side     Lying on your back     Lying on your stomach     Driving  
 Coughing/Sneezing     Lifting     Getting out of bed

**Please mark the activities that make your pain better**

Sitting     Standing     Leaning forward     Walking  
 Lying on your side     Lying on your back     Lying on your stomach     Driving  
 Coughing/Sneezing     Lifting     Getting out of bed

PATIENT NAME:	ACCOUNT NO.:
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Please check the boxes next to those treatments you have used for your present condition. Then indicate whether the treatment was helpful or not helpful.

Treatment	Helpful	Not Helpful
<input type="checkbox"/> <b>Physical therapy</b> If so, how many visits? _____		
<input type="checkbox"/> <b>Hot packs/ice, massage, muscle stimulation, ultrasound, etc.</b>		
<input type="checkbox"/> <b>Exercises for proper posture</b> (stabilization)		
<input type="checkbox"/> <b>Exercises to build strength/ endurance</b> (bike, treadmill, etc.)		
<input type="checkbox"/> <b>Back School education</b>		
<input type="checkbox"/> <b>Work hardening/conditioning</b>		
<input type="checkbox"/> <b>Traction</b>		
<input type="checkbox"/> <b>Chiropractic Adjustment</b>		
<input type="checkbox"/> <b>Acupuncture</b>		
<input type="checkbox"/> <b>Epidural Injection</b> If so, how many have you had? _____		
<input type="checkbox"/> <b>TENS Unit</b>		
<input type="checkbox"/> <b>Pain Medicine</b>		
<input type="checkbox"/> <b>Prednisone</b>		
<input type="checkbox"/> <b>Brace</b>		

Please mark the following tests you have undergone for your present condition.

Test	Date of Testing	Location of Testing (Hospital etc.)	Place a check for those results you will bring or have sent to FWO
<input type="checkbox"/> <b>Regular spine x-ray</b>			
<input type="checkbox"/> <b>CT Scan</b>			
<input type="checkbox"/> <b>MRI</b>			
<input type="checkbox"/> <b>Myelogram</b>			
<input type="checkbox"/> <b>EMG (needle test)</b>			
<input type="checkbox"/> <b>Discogram</b>			
<input type="checkbox"/> <b>Bone Scan</b>			

Have you had back or neck problems before? If yes, describe below.  Yes  No

Description of Injury	Date of Treatment	Months off Work

Have you ever had any previous injuries at work? If yes, describe below.  Yes  No

Description of Injury	Date of Treatment	Months off Work

If you had previous episodes, did they cause any of the following?

<input type="checkbox"/> <b>Back or neck pain only</b>			
<input type="checkbox"/> <b>Leg or arm pain only</b>	<input type="checkbox"/> <b>Right</b>	<input type="checkbox"/> <b>Left</b>	<input type="checkbox"/> <b>Both</b>
<input type="checkbox"/> <b>Back pain and leg pain</b>	<input type="checkbox"/> <b>Right</b>	<input type="checkbox"/> <b>Left</b>	<input type="checkbox"/> <b>Both</b>
<input type="checkbox"/> <b>Neck pain and arm pain</b>	<input type="checkbox"/> <b>Right</b>	<input type="checkbox"/> <b>Left</b>	<input type="checkbox"/> <b>Both</b>

PATIENT NAME:	ACCOUNT NO.:
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Have you had any previous surgeries on or relating to your **neck or back**?  Yes  No

Procedure	Date	Surgeon

What were your symptoms before your last surgery?

- |   |   |
|---|---|
| <input type="checkbox"/> Back pain only             | <input type="checkbox"/> Neck pain only             |
| <input type="checkbox"/> Back and right leg pain    | <input type="checkbox"/> Neck and right arm pain    |
| <input type="checkbox"/> Back and left leg pain     | <input type="checkbox"/> Neck and left arm pain     |
| <input type="checkbox"/> Back and pain in both legs | <input type="checkbox"/> Neck and pain in both arms |

Did you improve after your last surgery?  Yes  No

How long were you better after your last surgery?

- |                                   |                                      |  |
|-----------------------------------|--------------------------------------|--|
| <input type="checkbox"/> Unknown  | <input type="checkbox"/> 6 months    | <input type="checkbox"/> 2-3 years         |
| <input type="checkbox"/> 1 day    | <input type="checkbox"/> 6-12 months | <input type="checkbox"/> 3-5 years         |
| <input type="checkbox"/> 1 month  | <input type="checkbox"/> 1 year      | <input type="checkbox"/> more than 5 years |
| <input type="checkbox"/> 3 months | <input type="checkbox"/> 1-2 years   |  |

What was your work status after your last surgery?

- Returned to same job
- Returned to same job part-time or light duty
- Retrained and worked at new job
- Never returned to work

List below all the physicians, chiropractors and clinics you have consulted for your present condition.

Name	Address	Date 1 <sup>st</sup> Visit	Date Last Visit

Please list **ALL PAST HOSPITALIZATIONS** and **ALL PREVIOUS SURGERY** If none, circle: **NONE**

Past Illnesses or Surgeries	Date

**Occupational History**

Name of Employer:

Occupation: How long?:

Date Last Worked: Previous Employment:

PATIENT NAME:	ACCOUNT NO.:
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How many hours of your usual work day do you spend?					
Sitting:	Standing:	Walking:	Driving:	Lifting:	How heavy?
Which type of duty are you currently working?				<input type="checkbox"/> Light duty	<input type="checkbox"/> Heavy duty
Do you want a different job?				<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you plan to return to your job?				<input type="checkbox"/> Yes	<input type="checkbox"/> No

<b>Medications</b>		
Do you have any allergies to medications? If yes, which ones?		
	<input type="checkbox"/> Yes	<input type="checkbox"/> No

Which medications are you currently using for your back or neck?

Medication	# per day	Medication	# per day

Which medications did you previously use for your back or neck?

Medication	# per day	Medication	# per day

Which medication are you taking for other problems? *List all of your medications*

Medication	# per day	Medication	# per day

<b>Past Medical History</b> (Please check any of the following problems you have had in the past)		
<input type="checkbox"/> Diabetes <input type="checkbox"/> Heart Disease <input type="checkbox"/> High Blood Pressure <input type="checkbox"/> Cancer <input type="checkbox"/> Heart Attack <input type="checkbox"/> Seizure <input type="checkbox"/> Loss of Consciousness <input type="checkbox"/> Unexplained Weight Loss <input type="checkbox"/> Night Sweats <input type="checkbox"/> Blood Clots	<input type="checkbox"/> Tuberculosis <input type="checkbox"/> Arthritis <input type="checkbox"/> Hepatitis (Yellow Jaundice) <input type="checkbox"/> Asthma <input type="checkbox"/> Stomach Ulcers <input type="checkbox"/> Dizziness <input type="checkbox"/> Fainting <input type="checkbox"/> Difficulty Swallowing <input type="checkbox"/> Change in Ability to Pass Urine <input type="checkbox"/> Fever	<input type="checkbox"/> Difficulty in Bowel Movements <input type="checkbox"/> Prostatic Problems <input type="checkbox"/> Kidney Infections <input type="checkbox"/> Kidney Stones <input type="checkbox"/> Swelling of Toe or Finger Joints <input type="checkbox"/> Headaches <input type="checkbox"/> Infections <input type="checkbox"/> Depression <input type="checkbox"/> Strokes <input type="checkbox"/> Other _____



PATIENT NAME:	ACCOUNT NO.:
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Modified by Fort Wayne Orthopaedics from the North American Spine Society questionnaire.

Please tell us HOW PAIN HAS AFFECTED YOUR ABILITY TO PERFORM the following daily activities during the last four weeks.

<p><b>Dressing</b> (check one box)</p> <ul style="list-style-type: none"> <li><input type="checkbox"/> I can usually dress myself without pain</li> <li><input type="checkbox"/> I can dress myself without increasing pain</li> <li><input type="checkbox"/> I can dress myself but pain increases</li> <li><input type="checkbox"/> I can dress myself but have significant pain</li> <li><input type="checkbox"/> I can dress myself but with very severe pain</li> <li><input type="checkbox"/> I cannot dress myself</li> </ul>	<p><b>Sleeping</b> (check one box)</p> <ul style="list-style-type: none"> <li><input type="checkbox"/> I sleep well</li> <li><input type="checkbox"/> Pain occasionally interrupts my sleep</li> <li><input type="checkbox"/> Pain interrupts my sleep half of the time</li> <li><input type="checkbox"/> Pain often interrupts my sleep</li> <li><input type="checkbox"/> Pain always interrupts my sleep</li> <li><input type="checkbox"/> I never sleep well</li> </ul>
<p><b>Lifting</b> (check one box)</p> <ul style="list-style-type: none"> <li><input type="checkbox"/> I can lift heavy objects without pain</li> <li><input type="checkbox"/> I can lift heavy objects but it is painful</li> <li><input type="checkbox"/> Pain prevents me from lifting heavy objects but I can manage if they are on a table</li> <li><input type="checkbox"/> Pain prevents me from lifting heavy objects but I can manage light to medium objects if they are on a table.</li> <li><input type="checkbox"/> I can only lift light objects</li> <li><input type="checkbox"/> I cannot lift anything</li> </ul>	<p><b>Social and Recreational Life</b> (check one box)</p> <ul style="list-style-type: none"> <li><input type="checkbox"/> My social and recreational life is unchanged.</li> <li><input type="checkbox"/> My social and recreational life is unchanged but it increases pain.</li> <li><input type="checkbox"/> My social and recreational life is unchanged but it severely increases pain.</li> <li><input type="checkbox"/> Pain has restricted my social and recreational life.</li> <li><input type="checkbox"/> Pain has severely restricted my social and recreational life.</li> <li><input type="checkbox"/> I have essentially no social and recreational life because of pain.</li> </ul>
<p><b>Walking</b> (check one box)</p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Pain does not prevent me from walking.</li> <li><input type="checkbox"/> Pain prevents me from walking more than 1 hour.</li> <li><input type="checkbox"/> Pain prevents me from walking more than 30 minutes.</li> <li><input type="checkbox"/> Pain prevents me from walking more than 10 minutes.</li> <li><input type="checkbox"/> I can only walk a few steps at a time.</li> <li><input type="checkbox"/> I am unable to walk.</li> </ul>	<p><b>Traveling</b> (check one box)</p> <ul style="list-style-type: none"> <li><input type="checkbox"/> I can travel anywhere.</li> <li><input type="checkbox"/> I can travel anywhere but it gives me pain.</li> <li><input type="checkbox"/> Pain is bad but I can manage to travel over 2 hours.</li> <li><input type="checkbox"/> Pain restricts me to trips of less than 1 hour.</li> <li><input type="checkbox"/> Pain restricts me to trips of less than 30 minutes.</li> <li><input type="checkbox"/> Pain prevents me from traveling</li> </ul>
<p><b>Sitting</b> (check one box)</p> <ul style="list-style-type: none"> <li><input type="checkbox"/> I can sit in any chair as long as I like.</li> <li><input type="checkbox"/> I can only sit in a special chair for as long as I like.</li> <li><input type="checkbox"/> Pain prevents me from sitting more than 1 hour.</li> <li><input type="checkbox"/> Pain prevents me from sitting for more than 30 minutes.</li> <li><input type="checkbox"/> Pain prevents me from sitting more than a few minutes.</li> <li><input type="checkbox"/> Pain prevents me from sitting at all.</li> </ul>	<p><b>Sex Life</b> (check one box)</p> <ul style="list-style-type: none"> <li><input type="checkbox"/> My sex life is unchanged.</li> <li><input type="checkbox"/> My sex life is unchanged but causes some extra pain.</li> <li><input type="checkbox"/> My sex life is nearly unchanged but is very painful.</li> <li><input type="checkbox"/> My sex life is severely restricted by pain.</li> <li><input type="checkbox"/> My sex life is nearly absent because of pain.</li> <li><input type="checkbox"/> Pain prevents any sex life at all.</li> </ul>
<p><b>Standing</b> (check one box)</p> <ul style="list-style-type: none"> <li><input type="checkbox"/> I can stand as long as I want.</li> <li><input type="checkbox"/> I can stand as long as I want but it gives me pain.</li> <li><input type="checkbox"/> Pain prevents me from standing for more than 1 hour</li> <li><input type="checkbox"/> Pain prevents me from standing for more than 30 minutes.</li> <li><input type="checkbox"/> Pain prevents me from standing for more than 10 minutes.</li> <li><input type="checkbox"/> Pain prevents me from standing at all.</li> </ul>	<p><b>Pain Intensity</b> (check one box)</p> <ul style="list-style-type: none"> <li><input type="checkbox"/> I can tolerate the pain I have without having to use pain killers.</li> <li><input type="checkbox"/> The pain is bad but I manage without taking pain killers.</li> <li><input type="checkbox"/> Pain killers give complete relief from pain.</li> <li><input type="checkbox"/> Pain killers give moderate relief from pain.</li> <li><input type="checkbox"/> Pain killers give very little relief from pain.</li> <li><input type="checkbox"/> Pain killers have no effect on the pain and I do not use them.</li> </ul>

**SF-36**

PATIENT NAME:	ACCOUNT NO.:
TIMEPOINT:	DATE:

This survey asks for your views about your health. This information will help keep track of how you feel and how well you are able to do your usual activities. Answer every question by filling in the appropriate box. If you are unsure about how to answer the questions, please provide the best answer you can.

<b>1.</b> Are you male or female? <input type="checkbox"/> Male <input type="checkbox"/> Female			
<b>2.</b> How old were you on your last birthday? <input type="checkbox"/> Less than 35 <input type="checkbox"/> 35-44 <input type="checkbox"/> 45-54 <input type="checkbox"/> 55-64 <input type="checkbox"/> 65-74 <input type="checkbox"/> 75-84 <input type="checkbox"/> 85 or older			
<b>3.</b> In general, how would you say your health is? <input type="checkbox"/> Excellent <input type="checkbox"/> Very Good <input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor			
<b>4.</b> Compared to one year ago, how would you rate your health in general now? <input type="checkbox"/> Much better now than 1 year ago <input type="checkbox"/> Somewhat better now than 1 year ago <input type="checkbox"/> About the same <input type="checkbox"/> Somewhat worse now than 1 year ago <input type="checkbox"/> Much worse now than 1 year ago			
<b>5.</b> The following items are about activities you might do during a typical day. Does your health limit you in these activities? If so, how much? (Mark one box at each line)			
	Yes, limited a lot	Yes, limited A little	No, not limited at all
<b>a)</b> <b>Vigorous activities</b> such as running, lifting heavy objects, participating in strenuous sports			
<b>b)</b> <b>Moderate activities</b> such as moving a table, pushing a vacuum cleaner, bowling or playing golf			
<b>c)</b> Lifting or carrying groceries			
<b>d)</b> Climbing <b>several</b> flights of stairs			
<b>e)</b> Climbing <b>one</b> flight of stairs			
<b>f)</b> Bending, kneeling or stooping			
<b>g)</b> Walking <b>more than a mile</b>			
<b>h)</b> Walking <b>several blocks</b>			
<b>i)</b> Walking <b>one block</b>			
<b>j)</b> Bathing or dressing yourself			
<b>6.</b> During the past <b>4 weeks</b> , have you had any of the following problems with your work or other regular daily activities as a result of your <b>physical health</b> ? (Mark one box on each line)			
<b>a)</b> Cut down the <b>amount of time</b> you spent on work or other activities	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
<b>b)</b> <b>Accomplished less</b> than you would like	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
<b>c)</b> Were <b>limited in the kind</b> of work or other activities	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
<b>d)</b> Had <b>difficulty</b> performing the work or other activities (for example, it took extra effort)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
<b>7.</b> During the <b>past 4 weeks</b> , have you had any of the following problems with your work or other regular daily activities as a result of any <b>emotional problems</b> (such as feeling depressed or anxious)? (Mark one box on each line)			
<b>a)</b> Cut down the <b>amount of time</b> you spent on work or other activities	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
<b>b)</b> <b>Accomplished less</b> than you would like	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
<b>c)</b> <b>Didn't do work</b> or other activities as carefully as usual	<input type="checkbox"/> Yes	<input type="checkbox"/> No	

**SF-36**

PATIENT NAME						ACCOUNT NO.
TIMEPOINT:						DATE:
<b>8.</b> 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? (mark one box)						
<input type="checkbox"/> Not at all <input type="checkbox"/> Slightly <input type="checkbox"/> Moderately <input type="checkbox"/> Quite a bit <input type="checkbox"/> Extremely						
<b>9.</b> How much bodily pain have you had in the <b>past 4 weeks</b> ? (mark one box)						
<input type="checkbox"/> Non e <input type="checkbox"/> Very Mild <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe <input type="checkbox"/> Very Severe						
<b>10.</b> During the past 4 weeks, how much did pain interfere with your normal work (including both work outside the home and housework)? (mark one box)						
<input type="checkbox"/> Not at all <input type="checkbox"/> A little bit <input type="checkbox"/> Moderately <input type="checkbox"/> Quite a bit <input type="checkbox"/> Extremely						
<b>11.</b> These questions are about how you feel and how things have been with you during <b>the past 4 weeks</b> . 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 did you experience the following? (mark one box 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
<b>a)</b> Did you feel full of pep?						
<b>b)</b> Have you been a very nervous person?						
<b>c)</b> Have you felt so down in the dumps nothing could cheer you up?						
<b>d)</b> Have you felt calm and peaceful?						
<b>e)</b> Did you have a lot of energy?						
<b>f)</b> Have you felt downhearted and blue?						
<b>g)</b> Did you feel worn out?						
<b>h)</b> Have you been a happy person?						
<b>i)</b> Did you feel tired?						
<b>12.</b> During the <b>past 4 weeks</b> , how much of the time has your physical health or emotional problems interfered with your social activities (like visiting with friends, relatives, etc.) (mark one box)						
<input type="checkbox"/> All of the time <input type="checkbox"/> Most of the time <input type="checkbox"/> Some of the time <input type="checkbox"/> A little of the time <input type="checkbox"/> None of the time						
<b>13.</b> Please choose the answer that best describes how true or false each of the following statements is for you. (mark one box on each line)						
	Definitely true	Mostly true	Don't know	Mostly false	Definitely false	
<b>a)</b> I seem to get sick a little easier than other people						
<b>b)</b> I am as healthy as anybody I know						
<b>c)</b> I expect my health to get worse						
<b>d)</b> My health is excellent						
<b>14.</b> Have you ever filled out this form before? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't remember						