Jason M. Cuéllar, M.D., Ph.D.

Board-Certified Spine Surgeon

658 W. Indiantown Road, Suite 212
Jupiter FL 33458
Office: 305-459-3175

4770 Biscayne Blvd, Suite 1100
Miami FL 33137
Office: 305-459-3175

450 N. Roxbury Drive, 3rd Floor
Beverly Hills, CA 90210
Office: 310-385-7766

Patient Details		
Name:	Age:	
Height: Weight:	DOB:	Gender:
Social Security #:		
Contact Details		
Home Address:		
City, State, Zip:		
Home #:	Mobile #:	Other #:
Email:		
Preferred method of contact:		
Referral Details		
Referral Name:		Phone #:
Additional Info:		
Primary Care Physician		
Physician Name:		Phone #:
Address:		
Emergency Contact		
Emergency Contact Name:		
Emergency Contact #:		Relationship:
Pharmacy Details		
Pharmacy Name:		
Pharmacy Address:		Phone #
Medical Insurance Details		
Insurance Name:		
Subscriber Name:		Subscriber DOB:
Relationship:	ID #:	Group #:
Claims Phone #:	Claims Fax #:	
PIP Insurance Details, if applicable:		
PIP Carrier:	Claim #:	
Insured's name:	Member ID#:	

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YOUR RIGHTS REGARDING YOUR HEALTH INFORMATION.

1) Communications. You can request that our practice communicate with you about your health and related issues in a particular manner or at a certain location. For instance, you may ask that we contact you at home, rather than work. We will accommodate reasonable requests.

2) You can request a restriction in our use or disclosure of your health information for treatment, payment or health care operations. Additionally, you have the right to request that we restrict our disclosure of your health information to only certain individuals involved in your care or the payment of your care, such as family members and friends. We are not required to agree to your request; however, if we do not agree, we are bound by our agreement except when otherwise required by law, in emergencies, or when the information is necessary to treat you.

3) You have the right to inspect and obtain a copy of the health information that may be used to make decisions about you, including patient medical records and billing records but not including psychotherapy notes. You must submit your request in writing to Jason M. Cuellar, M.D., at the address listed above.

4) You may ask us to amend your health information if you believe it is incorrect or incomplete, and as long as the information is by or for our practice. To request an amendment, your request must be made in writing and submitted to Jason M. Cuellar, M.D. at the address listed above. You must provide us with a reason that supports your request for amendment.

5) Right to a copy of this notice. You are entitled to a copy of this Notice of Privacy Practices. You may ask us to give you a copy of this notice at any time. To obtain a copy of this notice, contact our front desk receptionist.

6) Right to file a complaint. If you believe your privacy rights have been violated, you may file a complaint with our practice or with the Secretary of the Department of Health and Human Services. To file a complaint with our practice, contact Jason M. Cuellar, M.D., at the address listed above. All complaints must be submitted in writing. You will not be penalized for filing a complaint.

7) Right to provide an authorization for other uses and disclosures. Our practice will obtain your written authorization for uses and disclosures that are not identified by this notice or permitted by applicable law.

If you have any questions regarding this notice or our health information privacy policies, please contact Jason M. Cuellar, M.D., using the address or telephone number listed above.

Signature _____ Date: _____

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INSTRUCTIONS FOR COMMUNICATING PERSONAL HEALTH INFORMATION (PHI)

Dear Patient:

To respect your privacy, please tell us which of the following numbers we should call to communicate with you regarding appointment reminders, lab results, etc. Only list the phone number, or numbers you want us to call. Please specify if a message can be left on an answering machine or voice mail with a spouse or significant other or with another designated person.

METHOD OF CONTACT	OKAY TO LEAVE MESSAGE?	
Work#:	☐ Yes	☐ No
Home#:	☐ Yes	☐ No
Mobile#:	☐ Yes	☐ No
Other#:	☐ Yes	☐ No
Email Address:		

My PHI ***may be*** communicated to: _____

Do not communicate my PHI to: _____

NAME: _____ **DOB:** _____

SIGNATURE: _____ **DATE:** _____

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NEUROLOGICAL SURGERY – PATIENT QUESTIONNAIRE

Name: _____ Date: _____/ _____/ _____

1) List any allergies you have and the reaction you have when exposed to them.	
ALLERGY	**REACTION**

2) What is bothering you?

☐ Neck	☐ Shoulder	☐ Right Arm	☐ Left Arm
☐ Lower Back	☐ Buttock	☐ Right Leg	☐ Left Leg
☐ Mid/Upper Back	☐ Other:		

3) When did you first have pain? (please provide a date – even if only an approximation)	
AREA	**DATE**
Neck/Shoulder/Arms or Hands	
Low Back/Buttocks/Legs/Feet	
Mid Back	
Other:	

4) How often do you have pain?

☐ Less than 1 x month	☐ About 1x per month	☐ About 1x every 2 wks	☐ About 1x per week
☐ About 2-3x per week	☐ Every day	☐ Other:	

5) Have you ever had spinal pain in the past?	☐ Yes	☐ No
If **yes**, was it similar?	☐ Yes	☐ No
If **not similar**, briefly explain old pain:		

6) Rate your pain on a scale of 1-10 (1=no pain and 10=most severe pain)										
AREA	**MINIMAL**				**MODERATE**			**SEVERE**		
Neck	1	2	3	4	5	6	7	8	9	10
Shoulder(s)	1	2	3	4	5	6	7	8	9	10
Arm(s)	1	2	3	4	5	6	7	8	9	10
Back	1	2	3	4	5	6	7	8	9	10
Buttock(s)	1	2	3	4	5	6	7	8	9	10
Leg(s)	1	2	3	4	5	6	7	8	9	10
Other:	1	2	3	4	5	6	7	8	9	10

7) Are you able to walk normally?	☐ Yes	☐ No
8) How long are you able to walk?		
☐ less than 1 block ☐ 1 block	☐ 2 blocks	☐ 3 or more blocks
9) Does walking increase your pain?	☐ Yes	☐ No
If **yes**, is it relieved with resting?	☐ Yes	☐ No
If **yes**, do you? ☐ Sit down	☐ Bend forward	☐ Lie down

10) Which of the following activities ***worsen*** the pain? (check all that apply):			
☐ Sitting	☐ Standing	☐ Walking	☐ Lying Down
☐ Bending forward	☐ Bending backward	☐ Sneezing	☐ Coughing
☐ Driving a car	☐ Riding in a car	☐ Other:	

11) Which of the following activities ***relieve*** the pain? (check all that apply):			
☐ Sitting	☐ Lying Down	☐ Manipulations	☐ Tens Unit
☐ Standing	☐ Heat/Ice	☐ Hot Baths	☐ Exercise
☐ Walking	☐ Massage	☐ Stretching	☐ Brace
☐ Running	☐ Acupuncture	☐ Running	☐ Rest
☐ Other:			

12) Have you ever had spine surgery?	☐ Yes	☐ No
If **yes**, please indicate date(s) and procedure below:		
DATE	**TYPE**	
Did the surgery/surgeries provide relief of your symptoms?		
☐ Complete relief ☐ Partial relief	☐ No relief	☐ Short-term relief
Were you able to return to work?		
☐ No ☐ Yes, full duty	☐ Yes, light duty	☐ Yes, w/ restrictions
Are your current symptoms in the same area as they were prior to surgery?		
☐ Yes ☐ No		

13) Which of the following tests have you had? List the dates you had them, if known.			
TEST	**DATE**	**TEST**	**DATE**
☐ MRI		☐ CAT scan	
☐ X- Rays		☐ Myelogram	
☐ Discogram		☐ Epidural injection	
☐ Nerve block		☐ EMG/NCS	
☐ Other:			

14) What other methods have you tried to alleviate your symptoms? (check all that apply):			
☐ Over the Counter Meds (Aspirin, Tylenol)	☐ NSAIDS (Ibuprofen, Motrin, Aleve, etc.)	☐ Narcotics (Vicodin, Percocet, Codeine, etc.)	☐ Medrol Dose Pak (oral steroids)
☐ Epidural Injections	☐ Physical Therapy	☐ Chiropractor	☐ Aqua Therapy
☐ Meditation	☐ Acupuncture	☐ Exercise	☐ Stretching
☐ Bracing	☐ Rest	☐ Other:	

15) Do you have any of these medical conditions? (check all that apply):			
☐ Anemia	☐ Arthritis	☐ Diabetes	☐ Heart Disease
☐ Cancer	☐ High Blood Pressure	☐ High Cholesterol	☐ HIV
☐ Hepatitis-C	☐ None known	☐ Other:	

16) Do you smoke?	☐ Yes	☐ No
If **yes**, how many? _____per day. I have smoked for _____years. If **no**, but you have been a smoker in the past, please provide quit date:		
17) Do you drink alcohol?	☐ Yes	☐ No
If **yes**, how much? _____glasses of _____per week		

18) Marital Status (choose answer that fits best):			
☐ Married	☐ Divorced	☐ Divorced/Remarried	☐ Separated
☐ Domestic Partner	☐ Widowed	☐ Single	☐ Other:
If married/partnered, how many years? _____			
19) Do you have children?	☐ Yes	☐ No	
If yes, how many?	Ages?		
20) Are you currently employed?	☐ Yes	☐ No	
If employed, what is your occupation?			
Physical Labor? ☐ Light	☐ Moderate	☐ Heavy	

IF YOU TAKE MEDICATIONS & SUPPLEMENTS PLEASE ADD BELOW:

MEDICATION/ SUPPLEMENT	DOSE/SIG	DATE STARTED

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REVIEW OF SYSTEMS

SYSTEM	YES/NO		EXPLANATION
CARDIOVASCULAR:			
Chest Pain	YES ☐	NO ☐	
Shortness of breath on exertion	YES ☐	NO ☐	
Lower extremity swelling	YES ☐	NO ☐	
Difficulty breathing while laying flat in bed without multiple pillows	YES ☐	NO ☐	
PULMONARY:			
Cough	YES ☐	NO ☐	
Difficulty breathing	YES ☐	NO ☐	
Pain with deep breaths	YES ☐	NO ☐	
GASTROINTESTINAL:			
Abdominal pain	YES ☐	NO ☐	
Nausea or vomiting	YES ☐	NO ☐	
Diarrhea	YES ☐	NO ☐	
SKIN:			
Rashes	YES ☐	NO ☐	
Easy bruising	YES ☐	NO ☐	
Open sores	YES ☐	NO ☐	
HEAD:			
Headaches	YES ☐	NO ☐	
Dizziness or fainting	YES ☐	NO ☐	
VISUAL:			
Blurry vision or change in vision	YES ☐	NO ☐	
EXTREMITIES/JOINTS:			
Joint pain	YES ☐	NO ☐	
Joint swelling	YES ☐	NO ☐	
NEUROLOGICAL:			
Numbness or tingling in the hands	YES ☐	NO ☐	
Numbness or tingling in the feet	YES ☐	NO ☐	
Imbalance or frequent falls	YES ☐	NO ☐	
Difficulty with fine motor skills (like buttoning a shirt or writing)	YES ☐	NO ☐	

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ASSIGNMENT OF BENEFITS AND APPOINTMENT AS REPRESENTATIVE

ASSIGNMENT OF ALL RIGHTS AND BENEFITS:

In exchange for and in connection with any and all of the medical and related ("services") provided to me by Jason Cuellar, M.D., LLC. ("Physician"), I hereby assign to Physician all of my rights, benefits, privileges, protections, claims and any other interests of any kind whatsoever, without limitation, that I had, have or may have in the future pursuant to or in connection with any insurance policy or plan, health benefit plan, health management agreement, risk-bearing agreement, trust, fund or any other source of payment, insurance, indemnity or health or medical coverage of any kind (collectively, "Health Coverage").

This assignment includes, without limitation, direct payment by my insurance carrier or health plan directly to Physician and/or its designated associates for the Services, appeal rights (both internal and external), fiduciary rights, rights to sue, rights to payment, rights to full and fair claims review, rights to penalties or interest, rights to plan documents and plan information, and rights to notices and disclosures from any source (collectively, "Rights"). I am here by transferring to Physician all of these Rights under any Health Coverage to which I am now, previously, or may be entitled to in the future with respect to the Services. Unless otherwise agreed between me and Physician, this assignment is irrevocable.

APPOINTMENT OF AUTHORIZED REPRESENTATIVE:

I hereby designate Physician and/or Physicians' designated agents and representatives as my duly authorized representative(s) in connection with all matters arising from or relating to Rights and Health Coverage, such that Physician completely and without reservation "stands in my shoes" and takes my place for all applicable purposes, and is granted absolute power and legal authority to seek, claim and directly receive payment or reimbursement for Services; challenge or appeal any adverse benefit determination of any kind whatsoever; or take any other action or obtain anything that I would have been entitled to do, seek, claim, appeal or obtain in my own capacity pursuant to or in connection with the Rights or Health Coverage in any legal, private, administrative, formal or informal process or forum whatsoever and without limitation, including any internal or external appeal, review, grievance or any other process, procedures or entitlement under any Health Coverage.

AGREEMENT TO COOPERATE:

I hereby agree to personally cooperate with, and take all steps necessary, required or reasonably requested by any Health Coverage or by Physician (or its designated associates) to effectuate, perfect, confirm, validate or enforce my Assignment of Rights and Benefits to Physician or authorization of Physician as my authorized representative, as provided above. I promise to make my best efforts to assist and cooperate with Physician as needed or reasonably requested by Physician in connection with any action in any forum, whether legal, formal or informal, without limitation, commenced or maintained by Physician in order to exercise, secure or enforce any Rights provided under the Health Coverage.

PRINTED NAME: _____ **DOB:** _____

PLEASE READ CAREFULLY:

I hereby authorize my insurance carrier to release information regarding medical benefits payable under my policy, and to pay medical benefits directly to Jason M. Cuellar, M.D., Inc or Jason Cuellar MD LLC, a medical corporation.

I hereby authorize any medical care provider to release any medical records and reports concerning my illness and/or treatment directly to Jason M. Cuellar, M.D. a photocopy of this authorization is as valid as the original.

_____

SIGNATURE OF PATIENT OR GUARDIAN **DATE**

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ACKNOWLEDGEMENTS AND AUTHORIZATIONS REGARDING PAYMENT

CERTIFICATION OF ACCURATE PERSONAL AND COVERAGE INFORMATION:
I certify that the personal and Health Coverage information that I have provided to Physician (on the "Patient Information Sheet" or otherwise) is, to the best of my knowledge, accurate, complete and correct and that the Health Coverage information is current and in effect as of the date of this form. I certify that I have furnished all required information requested by Physician regarding any and all insurance policies or plans, health benefit plans, health management agreements, risk-bearing agreements, trusts, funds or any other source of payment, insurance, indemnity or health or medical coverage of any kind that may be responsible for my medical costs and expenses. Should my Health Coverage change or experience any additions, deletions or cancellations of coverage or benefits for any reason, I agree that I will notify Physician's office of such changes immediately. I agree that I will be responsible for any charges resulting from changes to my Health Coverage should they adversely affect the payment of health insurance or plan benefits to Physician.

ACKNOWLEDGEMENT OF PATIENT RESPONSIBILITY FOR ALL CHARGES:
I understand and agree by signing below that I am financially responsible for all charges regarding the medically necessary and related medical services rendered to me by Jason M. Cuellar, M.D., Inc ("Physician"). As a courtesy to me, Physician may submit a claim of Physician's charges for payment to my health insurance carrier and/or health plan ("Health Coverage") pursuant to the attached "Assignment of Benefits" agreement that I am executing herewith. **I hereby acknowledge that Physician may release my medical records to my health insurance carrier or health plan, or to Physician's designated Business Associates, as becomes necessary to process, complete or enforce any claim for payment submitted by Physician to my Health Coverage.** In the event that my Health Coverage refuses to cover any portion of the charges submitted by Physician for payment, I understand and agree that I (or parties responsible for me) shall be liable for any remaining unpaid charges and, unless Physician and I agree otherwise, I agree to pay such charges no later than sixty (60) days upon receiving an invoice for payment from Physician. Physician reserves the right to require that I pay any deductible required by my Health Coverage or other deposit prior to services.

LATE CHARGES AND ATTORNEY'S FEES:
I agree to pay all charges for which I am liable in a timely manner. I understand and agree that a late charge of 1.5% or $10.00 per month (whichever is greater) will be charged on accounts past due 60 days or more. If my account is referred to Physician's legal counsel or a collection agency to obtain payment, or if legal action is brought against me, I agree to pay the total amount due with applicable late charges or interest as well as all reasonable attorney's fees or collection fees or related expenses incurred in collecting or recovering payment on my debt.

CANCELLATION CHARGE:
I understand that a twenty-four (24) hour notice of cancellation of my appointment is required or a $250.00 charge will be owed and added to my account.

COPY VALID AS ORIGINAL: I agree that a photocopy of this signed form is as valid as the original and may be used in place of the original signed form.

PRINTED NAME: _____ **DOB:** _____

SIGNATURE _____ **DATE** _____

PHYSICIAN-PATIENT ARBITRATION AGREEMENT

Article 1: **Agreement to Arbitrate**: It is understood that any dispute as to medical malpractice, that is as to whether any medical services rendered under this contract were unnecessary or unauthorized or were improperly, negligently, or incompetently rendered, will be determined by submission to arbitration as provided by California law, and not by a lawsuit or resort to court process except as California law provides for judicial review or arbitration proceedings. Both parties to this contract, by entering into it, are giving up their constitutional rights to have any such dispute decided on a court of law before a jury, and instead are accepting the use of arbitration.

Article 2: **All Claims Must be Arbitrated:** It is the intention of the parties that this agreement bind all parties whose claims may arise out of or related to treatment or service provided by the physician including any spouse or heirs of the patient and any children, whether bron or unborn, at the time of the occurrence giving rise to any claim. In the case of any pregnant mother, the term "patient" herein shall mean the mother and the mother's expected child or children.

All claims for monetary damages exceeding the jurisdictional limit of the small claims court against the physician, and the physician's partners, associates, association, corporation or partnership, and the employees, agents and estates of any if them, must be arbitrated including, without limitation, claims for loss of consortium, wrongful death, emotional distress or punitive damages. Filing of any court by the physician to collect any fee from the patient shall not waive the right to compel arbitration of any malpractice claim.

Article 3: **Procedures and Applicable Law:** A demand for arbitration must communicate in writing to all parties. Each party shall select an arbitrator (party arbitrator) within thirty days and a third arbitrator (neutral arbitrator) shall be selected by the arbitrators appointed by the parties within thirty days of a demand for a neutral arbitrator by either party. Each party to the arbitration shall pay such party's pro rata share of the expenses and fees of the neutral arbitrator, together with other expenses of the arbitration incurred or approved by the neutral arbitrator, not including counsel fees or witness fees, or other expenses incurred by a party for such party's own benefit. The parties agree that the arbitrators have the immunity of a judicial officer from civil liability when acting in the capacity of arbitrator under this contract. This immunity shall supplement, nit supplant, any other applicable statutory or common law.

Either party shall have the absolute right ti arbitrate separately the issues of liability and damages upon written request to the neutral arbitrator.

The parties consent to the intervention and joinder in this arbitration of any person or entity which would otherwise be a proper additional party in a court action, and upon such intervention and joinder any existing court action against such additional person or entity shall be stayed pending arbitration.

The parties agree that provisions of California law applicable to health care providers shall apply to disputes within this arbitration agreement, including, but not limited to, Code of Civil Procedure Section 340.5 and 667.7 and Civil Code Sections 3333.1 and 3333.2. Any party may bring before the arbitrations a motion for summary judgment or summary adjudication in accordance with the Code of Civil Procedure. Discovery shall be conducted pursuant to Code of Civil Procedure section 1283.05, however, depositions may be taken without prior approval of the neutral arbitrator.

Article 4: **General Provisions:** All claims based upon the same incident, transaction or related circumstances shall be arbitrated in once proceeding. A claim shall be waived and forever barred if (1) on the date notice thereof is received, the claim, if asserted in a civil action, would be barred by the applicable California statute of limitations, or (2) the claimant fails to pursue the arbitration claim in accordance with the procedures prescribed herein with reasonable diligence. With respect to any matter not herein expressly provided for, the arbitrators shall be governed by the California Code of Civil Procedure provisions relating to arbitration.

Article 5: **Revocation:** This agreement may be revoked by written notice delivered to the physician within 30 days, or signature. It is the intent of this agreement to apply to all medical services rendered any time for any condition.

Article 6: **Retroactive Effect:** If patient intends this agreement to cover services rendered before the date it is Effective as of the date of first medical services.

_____
Patient's or Patient Representative's Initials

If any provision if this arbitration agreement is held invalid of unenforceable, the remaining provisions shall remain in full force and shall not be affected by the invalidity of any other provision.

I understand that I have the right to receive a copy of this arbitration agreement. By my signature below, I acknowledge that I have received a copy.

NOTICE: BY SIGNING THIS CONTRACT YOU ARE AGREEING TO HAVE ANY ISSUE OF MEDICAL MALPRACTICE DECIDED BY NEUTRAL ARBITRATION AND YOU ARE GIVING UP YOUR RIGHT TO A JURY OR COURT TRIAL. SEE ARTICLE 1 OF THIS CONTRACT.

By: _____ _____
Patient's or Patient Representative's Signature (Date)

By: _____ _____
Physician's or Authorized Representative's Signature Jason M. Cuellar M.D. (Date)

By: _____
Print Patient's Name

_____
Print or Stamp Name of Physician, Medical Group or Association Name

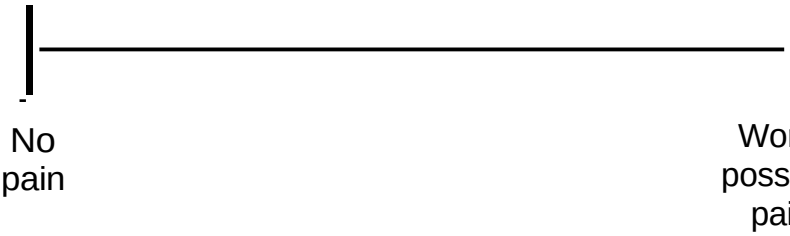
_____
(If Representative, Print Name and Relationship to Patient)

A signed copy of this document is to be given to Patient. Original is to be files in Patient's medical records.

Please draw a line on the scale below of where you feel your pain level is at.

Thank you.

Visual Analog Scale



Patient name: _____ Date: _____

Signature: _____

Emotional Distress-Depression – Short Form 4a

Please respond to each question or statement by marking one box per row.

In the past 7 days...

		Never	Rarely	Sometimes	Often	Always
EDDEP04	I felt worthless	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
EDDEP06	I felt helpless	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
EDDEP29	I felt depressed	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
EDDEP41	I felt hopeless	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5

Pain Interference – Short Form 6b

Please respond to each item by marking one box per row.

In the past 7 days…

		Not at all	A little bit	Somewhat	Quite a bit	Very much
PAININ3	How much did pain interfere with your enjoyment of life?.....	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
PAININ8	How much did pain interfere with your ability to concentrate?.....	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
PAININ9	How much did pain interfere with your day to day activities?.....	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
PAININ10	How much did pain interfere with your enjoyment of recreational activities?.....	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
PAININ14	How much did pain interfere with doing your tasks away from home (e.g., getting groceries, running errands)?.....	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5

In the past 7 days…

		Never	Rarely	Sometimes	Often	Always
PAININ26	How often did pain keep you from socializing with others?.....	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5

Physical Function – Short Form 10a

Please respond to each question or statement by marking one box per row.

		Not at all	Very little	Somewhat	Quite a lot	Cannot do
PFA1	Does your health now limit you in doing vigorous activities, such as running, lifting heavy objects, participating in strenuous sports?.....	☐ 5	☐ 4	☐ 3	☐ 2	☐ 1
PFC36r1	Does your health now limit you in walking more than a mile (1.6 km)?	☐ 5	☐ 4	☐ 3	☐ 2	☐ 1
PFC37	Does your health now limit you in climbing one flight of stairs?.....	☐ 5	☐ 4	☐ 3	☐ 2	☐ 1
PFA5	Does your health now limit you in lifting or carrying groceries?.....	☐ 5	☐ 4	☐ 3	☐ 2	☐ 1
PFA3	Does your health now limit you in bending, kneeling, or stooping?	☐ 5	☐ 4	☐ 3	☐ 2	☐ 1
		Without any difficulty	**With a little difficulty**	**With some difficulty**	**With much difficulty**	**Cannot do**
PFA11	Are you able to do chores such as vacuuming or yard work?.....	☐ 5	☐ 4	☐ 3	☐ 2	☐ 1
PFA16r1	Are you able to dress yourself, including tying shoelaces and buttoning your clothes?.....	☐ 5	☐ 4	☐ 3	☐ 2	☐ 1
PFB26	Are you able to shampoo your hair?	☐ 5	☐ 4	☐ 3	☐ 2	☐ 1
PFA55	Are you able to wash and dry your body?..	☐ 5	☐ 4	☐ 3	☐ 2	☐ 1
PFC45r1	Are you able to sit on and get up from the toilet?	☐ 5	☐ 4	☐ 3	☐ 2	☐ 1

