Low Back Pain
Education Program

ENROLLMENT FORM

Please print clearly, answer all questions, sign and return to your regional office.

NAME _____ (Last) _____ (First)

PHONE NO. (home) ___ - ___ - ____ (Area Code)

ADDRESS _____ (Street or P.O. Box)

PHONE NO. (work) ___ - ___ - ____ (Area Code)

CITY _____ STATE _____ ZIP _____ - _____

SOCIAL SECURITY NO. ___ - ___ - ____ (This will be your ID no. for this program.)

E-mail Availability: Yes / No (Circle one.)

E-MAIL ADDRESS _____

PHYSICIAN NAME _____ (Last) _____ (First)

ADDRESS _____ (Street or P.O. Box)

CITY _____ STATE _____ ZIP _____ - _____

In order to assist us in identifying health education needs, please answer the following questions by circling or completing the correct answer:

1) How frequently do you experience back pain? A. Daily B. Weekly C. Monthly D. Less than monthly

2) When you have an episode of back pain, how long does the episode usually last? A. Less than 1 hour B. Several hours C. Several days

3) Please circle **all** of the daily activities that you are unable to do because of your back pain:
A. Sleeping B. Walking C. Sitting/Standing D. Exercising E. Traveling F. Socializing G. Housework/Yardwork H. Job duties

4) On a scale from 1-10 with 1 being the least amount of pain and 10 being the most severe pain, please circle the number indicating the severity of your back pain: 1 2 3 4 5 6 7 8 9 10

5) What is your current weight? _____ pounds
What is your current height? _____ feet and inches

6) Are you a smoker? Yes No

7) How many days of work did you miss last year due to your back pain?
A. 0 days B. 1-3 days/week C. 4-5 days/week D. More than 5 days E. Unemployed/Retired

8) How often do you exercise for a minimum of 30 minutes without stopping?
A. Never B. 1 day/week C. 3 days/week D. 5 days/week E. Every day

We are very interested in providing you with information regarding self-management of back pain. Please list below any topics that you would like to see included in the Low Back Pain Education Program materials. (Use the back of this form, if necessary.)

_____

_____

I understand and agree that the information provided on this form is to be used by Arkansas Blue Cross and Blue Shield, Health Advantage and BlueAdvantage Administrators of Arkansas to provide health educational and informational resources regarding low back pain.

By my signature, I hereby indicate my decision to enroll in the Low Back Pain Education Program. I understand that there is no cost to me or my family for this program. I further authorize Arkansas Blue Cross and Blue Shield, Health Advantage or BlueAdvantage to communicate with my physician(s) regarding any related treatment or records of treatment, and to release my identity and related records for the purpose of my participation in the Health Survey and other aspects of the Low Back Pain Education Program as described in the Low Back Pain Education Program brochure.

Signature (Required): _____ **Date:** _____

Arkansas BlueCross BlueShield
An Independent Licensee of the Blue Cross and Blue Shield Association

Health Advantage
An Independent Licensee of the Blue Cross and Blue Shield Association

BlueAdvantage Administrators of Arkansas
An Independent Licensee of the Blue Cross and Blue Shield Association

Form No. 10-122LBP-OL 9/02

Welcome to the Program!