

Integrated Spinal Solutions Patient Information

Patient Name:		Today's Date:	
Address:		Home Telephone:	
City/State/Zip:		Work Telephone:	
Birth Date:	Age:	Employer's Name:	
Height:	Weight:	Employer's Address:	
Social Security Number:			
Drivers License No:		Primary MD Name & Address:	
Marital Status: Single Married Divorced Widowed			

Emergency Contact Information

Nearest Adult Relative:		Relation to Patient:	
Address:			Phone #:

Insurance Information

Does your insurance cover Chiropractic treatment?	<input type="checkbox"/> Yes <input type="checkbox"/> No If yes, we need a copy of your card		
If yes, indicate Insurance Company Name. If you are being seen for a work related or car accident injury we need the Claim Number and the Claims Adjusters Name.	Carrier Name:		
	Address:		
	Telephone Number:		
	Claim Number:		
	Claim Adjusters Name:		
Are you the insured person or a dependent?	<input type="checkbox"/> Insured <input type="checkbox"/> Dependent (wife/husband/child)		
If you are the insured persons dependent (spouse or child), we need the insured persons name, date of birth, social security number, name of the insured employers business and the address of the business.	Name of Insured Person:		
	Social Security Number:		
	Insured Date of Birth:		
	Name of Insured Company:		
	Insured Company Address:		
How were you referred to us? <input type="checkbox"/> Location <input type="checkbox"/> Provider Manual <input type="checkbox"/> Existing Patient <input type="checkbox"/> Our Web Site <input type="checkbox"/> Internet Search <input type="checkbox"/> Yellow Pages <input type="checkbox"/> Spinal Talk <input type="checkbox"/> Other:			

As a courtesy, our office will provide insurance billing services for you if you so desire. Please remember that you are ultimately responsible for any charges incurred in this office. It is your responsibility to pay any deductible amount, co-pay and or any other balances not paid by your insurance carrier (except for contracted discounts). Your signature on this document indicates that you agree to pay for any outstanding bills incurred in this office.

IN ORDER TO KEEP OUR OFFICE OVERHEAD DOWN AND KEEP OUR PATIENT FEES REASONABLE, WE REQUIRE PAYMENT AT THE CONCLUSION OF EACH TREATMENT FOR CASH PATIENTS AND THE CO-PAYMENT FOR INSURANCE PATIENTS.

Patient Signature (Parent or responsible party): _____ **Date:** _____

Patient History
Integrated Spinal Solutions, pc
 1000 Caughlin Crossing #55 Reno, NV 89519

Date: _____

Patient Name: _____ Age: _____ Height: _____ Weight: _____

ONSET: This form is for vehicle accident history only. If your injury resulted from something else please let the receptionist know.

Accident Date: _____ Your Occupation: _____

Have you missed time from work? No Yes _____

Accident Details: Your position in the vehicle:	<input type="checkbox"/> I was the Driver <input type="checkbox"/> Motorcycle Operator	<input type="checkbox"/> I was a Passenger:	<input type="checkbox"/> Front <input type="checkbox"/> Rear left <input type="checkbox"/> Rear Right <input type="checkbox"/> Rear Middle
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Impact Details:.....	<input type="checkbox"/> My vehicle was struck <input type="checkbox"/> My vehicle struck the other vehicle		
Type of Impact:.....	<input type="checkbox"/> Front End <input type="checkbox"/> Rear <input type="checkbox"/> Drivers Side Impact <input type="checkbox"/> Passenger Side Impact		
Seat Belts Used:.....	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Did your head or body hit:.....	<input type="checkbox"/> Steering wheel <input type="checkbox"/> Door <input type="checkbox"/> Windshield <input type="checkbox"/> Other: _____		
Did you brace for the impact?.....	<input type="checkbox"/> Yes <input type="checkbox"/> No		

Body position when struck?	<input type="checkbox"/> Looking up. <input type="checkbox"/> Looking straight ahead <input type="checkbox"/> Both hands in lap <input type="checkbox"/> Both hands on steering wheel <input type="checkbox"/> Left hand on steering wheel <input type="checkbox"/> Right hand on steering wheel <input type="checkbox"/> Right hand on gear shift <input type="checkbox"/> Head turned right <input type="checkbox"/> Head turned left	<input type="checkbox"/> Body twisted to the left looking at back seat <input type="checkbox"/> Body twisted to the right looking at back seat <input type="checkbox"/> Body leaning to the right <input type="checkbox"/> Body leaning to the left <input type="checkbox"/> looking up and right at rear view mirror <input type="checkbox"/> Sitting straight up <input type="checkbox"/> Slouched in the seat <input type="checkbox"/> Head against the head restraint <input type="checkbox"/> Leaning forward away from the head restraint
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Your Estimated Speed at impact:.....	<input type="checkbox"/> Stopped <input type="checkbox"/> Slow <input type="checkbox"/> Slowing <input type="checkbox"/> Accelerating <input type="checkbox"/> Highway Speed <input type="checkbox"/> Other: _____
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Other Vehicle's Estimated Speed at impact:...	<input type="checkbox"/> Slow <input type="checkbox"/> Slowing <input type="checkbox"/> Posted speed <input type="checkbox"/> Excessive <input type="checkbox"/> Highway Speed <input type="checkbox"/> Other: _____
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Head Restraints / Head Rest.....	<input type="checkbox"/> None <input type="checkbox"/> Integral Type <input type="checkbox"/> Adjustable Type <input type="checkbox"/> Up <input type="checkbox"/> Down <input type="checkbox"/> Don't Know If Adjustable, was the position altered by the crash? <input type="checkbox"/> Yes <input type="checkbox"/> No
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Air Bags:	Did the Air Bag Deploy? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Vehicle not equipped with Air Bags.
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Seats:	Was the seat back adjustment altered by the crash? <input type="checkbox"/> Yes <input type="checkbox"/> No Was it Broken? <input type="checkbox"/> Yes <input type="checkbox"/> No
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Estimated property damage to YOUR vehicle?	\$ _____ <input type="checkbox"/> Totaled
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Estimated property damage to OTHER vehicle?	<input type="checkbox"/> None <input type="checkbox"/> Minimal <input type="checkbox"/> Moderate <input type="checkbox"/> Major <input type="checkbox"/> Totaled
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Year Make & Model:	YOUR Vehicle: _____	OTHER Vehicle: _____
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Continued on Next Page --->

Patient History
Integrated Spinal Solutions, pc
 1000 Caughlin Crossing #55 Reno, NV 89519

Prior treatment:	<input type="checkbox"/> Paramedics / REMSA <input type="checkbox"/> ER Visits <input type="checkbox"/> Primary MD <input type="checkbox"/> Surgeries <input type="checkbox"/> Physical Therapy <input type="checkbox"/> Specialist <input type="checkbox"/> Other:
	<input type="checkbox"/> Location of facilities:
Imaging Relating to this complaint:	<input type="checkbox"/> X-Ray <input type="checkbox"/> CT Scan <input type="checkbox"/> MRI <input type="checkbox"/> Ultrasound <input type="checkbox"/> Other _____ Where did you have the above imaging? _____

Medical History:	<input type="checkbox"/> Heart Disease <input type="checkbox"/> Diabetes <input type="checkbox"/> High Blood Pressure <input type="checkbox"/> Ulcers	Me	Family	<input type="checkbox"/> Trauma <input type="checkbox"/> Nerve Disease <input type="checkbox"/> Psychiatric Disorders <input type="checkbox"/> Depression	Me	Family	<input type="checkbox"/> Lung Disease <input type="checkbox"/> Seizures <input type="checkbox"/> Arthritis <input type="checkbox"/> Toxin Exposure	Me	Family
	<input type="checkbox"/> Other:								

List <u>All</u> Past	<input type="checkbox"/> Work related Injuries:	
	<input type="checkbox"/> Car Accidents:	
	<input type="checkbox"/> Hospitalization:	
	<input type="checkbox"/> Severe Illnesses:	
	<input type="checkbox"/> Surgeries:	

Notes:	
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Impact on daily Activities

What activities seem to exacerbate your condition worse?	<input type="checkbox"/> Standing <input type="checkbox"/> Sitting <input type="checkbox"/> Walking <input type="checkbox"/> Walk up hill <input type="checkbox"/> Walk down hill <input type="checkbox"/> Bending <input type="checkbox"/> Climbing stairs	<input type="checkbox"/> Stooping <input type="checkbox"/> Lay Down <input type="checkbox"/> Lifting <input type="checkbox"/> Sleeping <input type="checkbox"/> Sneezing <input type="checkbox"/> Coughing <input type="checkbox"/> Exercise	<input type="checkbox"/> Straining <input type="checkbox"/> Reaching <input type="checkbox"/> Twisting <input type="checkbox"/> Looking up <input type="checkbox"/> Looking down <input type="checkbox"/> Changing positions <input type="checkbox"/> Getting adjusted	<input type="checkbox"/> Rest <input type="checkbox"/> Lying on back <input type="checkbox"/> Lying on stomach <input type="checkbox"/> Driving <input type="checkbox"/> Household chores _____ _____
What relieves or lessens your condition or pain?	<input type="checkbox"/> Standing <input type="checkbox"/> Sitting <input type="checkbox"/> Walking <input type="checkbox"/> Walk up hill <input type="checkbox"/> Walk down hill <input type="checkbox"/> Bending <input type="checkbox"/> Climbing stairs	<input type="checkbox"/> Stooping <input type="checkbox"/> Lay Down <input type="checkbox"/> Lifting <input type="checkbox"/> Sleeping <input type="checkbox"/> Sneezing <input type="checkbox"/> Coughing <input type="checkbox"/> Exercise	<input type="checkbox"/> Straining <input type="checkbox"/> Reaching <input type="checkbox"/> Twisting <input type="checkbox"/> Looking up <input type="checkbox"/> Looking down <input type="checkbox"/> Changing positions <input type="checkbox"/> Getting adjusted	<input type="checkbox"/> Rest <input type="checkbox"/> Lying on back <input type="checkbox"/> Lying on stomach <input type="checkbox"/> Driving <input type="checkbox"/> Household chores _____ _____
Please check all the words that describe your pain:	<input type="checkbox"/> Local <input type="checkbox"/> Radiates <input type="checkbox"/> Shoots to legs <input type="checkbox"/> Shoots to arms	<input type="checkbox"/> Shock <input type="checkbox"/> Sharp <input type="checkbox"/> Dull <input type="checkbox"/> Burning	<input type="checkbox"/> Ache <input type="checkbox"/> Tingle <input type="checkbox"/> Cramping <input type="checkbox"/> Stinging	<input type="checkbox"/> Stabbing <input type="checkbox"/> Throbbing

Brain / Neuropsych / MTBI / PTSD Symptoms

<input type="checkbox"/> I prefer being alone now (not socializing) <input type="checkbox"/> I am sleepy, tired during the day or doze off easily <input type="checkbox"/> Upset stomach, nausea, heartburn or vomiting <input type="checkbox"/> Difficulty concentrating, mind wanders easily <input type="checkbox"/> I get overwhelmed easily <input type="checkbox"/> Mood swings, happy one moment then sad <input type="checkbox"/> Agitation (can't sit still, need to move around) <input type="checkbox"/> Sadness, tearful episodes, crying easily <input type="checkbox"/> Blurry vision, had to get or change glasses <input type="checkbox"/> Asking people to repeat things or hearing problems <input type="checkbox"/> I make wrong turns driving or can't remember time <input type="checkbox"/> I get confused easily and cannot multi-task anymore <input type="checkbox"/> I have difficulty finding some words when talking <input type="checkbox"/> Bright lights bother me <input type="checkbox"/> I cannot pay attention as long as before <input type="checkbox"/> I am eating more or less than normal <input type="checkbox"/> Room spins, lightheaded or woozy feeling <input type="checkbox"/> Balance problems <input type="checkbox"/> I feel like my head is "foggy" <input type="checkbox"/> I have forgotten computer passwords or ATM / PIN <input type="checkbox"/> I have to re-read things to understand what I read <input type="checkbox"/> My thinking is slowed down <input type="checkbox"/> Difficulty with adding / subtracting numbers	<input type="checkbox"/> Difficulty learning new things <input type="checkbox"/> Difficulty understanding what people say to me <input type="checkbox"/> Difficulty remembering or memory problems <input type="checkbox"/> Cannot take on any more responsibilities <input type="checkbox"/> I can't make decisions as fast as before <input type="checkbox"/> Loss of libido or lack of sexual desire <input type="checkbox"/> I do not feel as confident in my abilities <input type="checkbox"/> I get panic attacks, fast heartbeat, nervous <input type="checkbox"/> I am more irritable than usual <input type="checkbox"/> Some food or drink tastes "funny" to me now <input type="checkbox"/> I get frustrated very easily <input type="checkbox"/> Difficulty planning my life or organizing my work <input type="checkbox"/> Flashbacks or frightening thoughts about the accident <input type="checkbox"/> I have had bad dreams about the accident <input type="checkbox"/> I avoid places and objects that remind me about it <input type="checkbox"/> I feel emotionally numb – no interest in my hobbies <input type="checkbox"/> I'm feeling strong guilt, worry or depression <input type="checkbox"/> I am having trouble remembering the accident <input type="checkbox"/> I am easily startled since the accident – "Jumpy" <input type="checkbox"/> I feel tense or "on edge" most of the time <input type="checkbox"/> I am having difficulty sleeping <input type="checkbox"/> I get angry easily or even yell at people now <input type="checkbox"/> Fear I will never be the same again
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Patient Name (please print): _____

Patient Signature: _____ Date: _____

INTEGRATED SPINAL SOLUTIONS, PC

TERMS OF ACCEPTANCE

Agreement to Financial Policy

I have agreed to pay charges at the time of service. I understand that I may pay by check, Visa or MasterCard. Emergency and after hours visits will be subject to additional charges. I agree to be charged a **missed appointment fee of \$10.00** if I miss an appointment without giving at least **4 hours** advance notice. I understand that as the parent or guardian, I am responsible for full payment of my child's care. I further understand that for unaccompanied minors, payment in full is still required at time of service. If I have insurance coverage I hereby assign directly to Integrated Spinal Solutions, pc all medical benefits, if any, payable to me for services rendered. I also understand that there is a 1.5% monthly interest charge on any unpaid balance over one (1) month old. It is at the discretion of the doctor to collect or waive said fee and will depend upon the payment history of the account. By signing below, I agree that should my account be referred to a collection agency or an attorney for collections, I will be directly responsible for paying all reasonable attorney's fees, other legal fees and/or any and all collection expenses.

Patient Accepts Responsibility for Insurance Reimbursements and Approvals

I accept responsibility to know my policy limits and requirements. I further accept responsibility to seek pre-authorization, bill and collect reimbursement from my insurance carrier if applicable. I understand that my insurance policy is a contract between the insurance carriers and myself. I further understand that Integrated Spinal Solutions, pc is in no way a guarantee of coverage or reimbursement from my insurance carrier. I further understand that my health insurance will be billed as a courtesy but that I am ultimately responsible for payment. I understand that some or perhaps all of the services that I receive may not be considered reasonable and necessary under the Medicare program and/or other insurance plans. I understand that insurance claims that are over 90 days old and unpaid, will become my responsibility. By my presence and continuation of appointments, I consent and elect care provided by Dr. Xavier Martinez and or his staff.

Patient Will Truthfully and Fully Disclose Health Status and History

I hereby state that all information that I hereby give Integrated Spinal Solutions, pc and/or it's staff will be complete and truthful. I will not misrepresent my presence, nature, severity or cause of my injuries. I further state that I will fully disclose my health history and authorize the release of all past medical records to Integrated Spinal Solutions, pc. I present myself for health reasons only and it is not my intent to mislead, defraud or coerce this office or any third party or misrepresent myself in any manner.

Patient Consents to Care and Accepts Responsibility

I consent to recommendations and care by the Doctor(s) of Integrated Spinal Solutions, pc for myself (or my children if minors) including, but not limited to examinations, x-rays, chiropractic adjustments, rehabilitative and physical therapy. I understand that my care will be individualized to me and therefore may not be comparable to standards or guidelines used or required by insurance companies, professional associates, and/or consensus groups. I understand that my treatment will comply with the inherent risks. These risks, though rare, could occur ranging from minor aggravation of current condition to serious conditions such as cerebral vascular accident or death. I am signing this consent after having been fully informed to my satisfaction by the Doctor(s) of Integrated Spinal Solutions, pc and/or his staff of the risks and benefits of the care and the risks and benefits of not having the recommended treatment. I have been informed and fully understand that there are no guarantees of treatment success. By my presence and continuation of appointments, I consent and elect to care provided by Doctor(s) of Integrated Spinal Solutions, pc and/or his staff.

Medicare Limits and Responsibilities Advance Notice

The only charge for Chiropractic that is covered by Medicare is manual manipulation of the spine. I also understand that Medicare requires an initial Examination be preformed but provides no payment for such. I accept responsibility to pay for all covered non-covered or denied services. I accept responsibility to know the current Medicare guidelines and limits for covered services. I have been notified by my physician that he believes that in my case Medicare is likely to deny payment for some services. If Medicare denies payment, I agree to be personally and fully responsible for payment. I understand that I must pay for services at the time of treatment. I also understand that Integrated Spinal Solutions, pc will bill all charges directly to Medicare as required by law. I authorize the release of my records as necessary for Medicare Billing.

I have read, understand and agree to the provisions and terms of acceptance. This agreement shall become effective upon signing and be irrevocable for the full extent of my treatment by the doctor.

Patient Name (please print): _____

Patient Signature: _____

Date: _____

LOW BACK PAIN QUESTIONNAIRE (OSWESTRY)

PATIENT NAME: _____

DATE: _____

Please read: This questionnaire is designed to enable us to understand how much your **LOW BACK PAIN** has affected your ability to manage your everyday activities. Please answer each section by circling the **ONE CHOICE** that most applies to you. We realize that you may feel that more than one statement may relate to you, but **PLEASE, JUST MARK THE ONE CHOICE WHICH MOST CLOSELY DESCRIBES YOUR PROBLEM RIGHT NOW.**

<p>SECTION 1 - Pain Intensity</p> <p><input type="checkbox"/> 0 The pain comes and goes and is very mild.</p> <p><input type="checkbox"/> 1 The pain is mild and does not vary much.</p> <p><input type="checkbox"/> 2 The pain comes and goes and is moderate.</p> <p><input type="checkbox"/> 3 The pain is moderate and does not vary much.</p> <p><input type="checkbox"/> 4 The pain comes and goes and is severe.</p> <p><input type="checkbox"/> 5 The pain is severe and does not vary much.</p>	<p>SECTION 6 -Standing</p> <p><input type="checkbox"/> 0 I can stand as long as I want without pain.</p> <p><input type="checkbox"/> 1 I have some pain on standing but it does not increase with time.</p> <p><input type="checkbox"/> 2 I cannot stand for longer than one hour without increasing pain.</p> <p><input type="checkbox"/> 3 I cannot stand for longer than 1/2 hour without increasing pain.</p> <p><input type="checkbox"/> 4 I cannot stand for longer than 10 minutes without increasing pain.</p> <p><input type="checkbox"/> 5 I avoid standing because it increases the pain immediately.</p>
<p>SECTION 2 - Personal Care</p> <p><input type="checkbox"/> 0 I do not have to change my way of washing or dressing in order to avoid pain.</p> <p><input type="checkbox"/> 1 I do not normally change my way of washing or dressing even though it causes some pain.</p> <p><input type="checkbox"/> 2 Washing and dressing increases the pain but I manage not to change my way of doing it.</p> <p><input type="checkbox"/> 3 Washing and dressing increases the pain and I find it necessary to change my way of doing it.</p> <p><input type="checkbox"/> 4 Because of the pain I am unable to do some washing and dressing without help.</p> <p><input type="checkbox"/> 5 Because of the pain I am unable to do any washing and dressing without help.</p>	<p>SECTION 7 -Sleeping</p> <p><input type="checkbox"/> 0 I get no pain in bed.</p> <p><input type="checkbox"/> 1 I get pain in bed but it does not prevent me from sleeping well.</p> <p><input type="checkbox"/> 2 Because of pain my normal night's sleep is reduced by less than 1/4.</p> <p><input type="checkbox"/> 3 Because of pain my normal night's sleep is reduced by less than 1/2.</p> <p><input type="checkbox"/> 4 Because of pain, my normal night's sleep is reduced by less than 3/4.</p> <p><input type="checkbox"/> 5 Pain prevents me from sleeping at all.</p>
<p>SECTION 3 - Lifting</p> <p><input type="checkbox"/> 0 I can lift heavy weights without extra pain.</p> <p><input type="checkbox"/> 1 I can lift heavy weights but it causes extra pain</p> <p><input type="checkbox"/> 2 Pain prevents me from lifting heavy weights off the floor.</p> <p><input type="checkbox"/> 3 Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned, e.g., on a table</p> <p><input type="checkbox"/> 4 Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.</p> <p><input type="checkbox"/> 5 I can only lift very light weights at the most.</p>	<p>SECTION 8 - Social Life</p> <p><input type="checkbox"/> 0 My social life is normal and gives me no pain.</p> <p><input type="checkbox"/> 1 My social life is normal but increases the degree of my pain.</p> <p><input type="checkbox"/> 2 Pain has no significant effect on my social life apart from limiting my more energetic interests, e.g., dancing, etc.</p> <p><input type="checkbox"/> 3 Pain has restricted my social life, and I do not go out very often.</p> <p><input type="checkbox"/> 4 Pain has restricted my social life to my home.</p> <p><input type="checkbox"/> 5 I have hardly any social life because of the pain.</p>
<p>SECTION 4 - Walking</p> <p><input type="checkbox"/> 0 I have no pain on walking.</p> <p><input type="checkbox"/> 1 I have some pain on walking but it does not increase with distance.</p> <p><input type="checkbox"/> 2 I cannot walk more than one mile without increasing pain.</p> <p><input type="checkbox"/> 3 I cannot walk more than 1/2 mile without increasing pain.</p> <p><input type="checkbox"/> 4 I cannot walk more than 1/4 mile without increasing pain.</p> <p><input type="checkbox"/> 5 I cannot walk at all without increasing pain.</p>	<p>SECTION 9 - Travel</p> <p><input type="checkbox"/> 0 I get no pain while traveling.</p> <p><input type="checkbox"/> 1 I get some pain while traveling, but none of my usual forms of travel make it any worse.</p> <p><input type="checkbox"/> 2 I get extra pain while traveling, but it does not compel me to seek alternative forms of travel.</p> <p><input type="checkbox"/> 3 I get extra pain while traveling, which compels me to seek alternative forms of travel.</p> <p><input type="checkbox"/> 4 Pain restricts all forms of travel.</p> <p><input type="checkbox"/> 5 Pain prevents all forms of travel except that done lying down.</p>
<p>SECTION 5 -Sitting</p> <p><input type="checkbox"/> 0 I can sit in any chair as long as I like.</p> <p><input type="checkbox"/> 1 I can sit only in my favorite chair as long as I like.</p> <p><input type="checkbox"/> 2 Pain prevents me from sitting more than one hour.</p> <p><input type="checkbox"/> 3 Pain prevents me from sitting more than 1/2 hour.</p> <p><input type="checkbox"/> 4 Pain prevents me from sitting more than 10 minutes.</p> <p><input type="checkbox"/> 5 I avoid sitting because it increase the pain right away.</p>	<p>SECTION 10 - Changing degree of pain</p> <p><input type="checkbox"/> 0 My pain is rapidly getting better.</p> <p><input type="checkbox"/> 1 My pain fluctuates but overall is definitely getting better.</p> <p><input type="checkbox"/> 2 My pain seems to be getting better but improvement is slow</p> <p><input type="checkbox"/> 3 My pain is neither getting better nor worse.</p> <p><input type="checkbox"/> 4 My pain is gradually worsening.</p> <p><input type="checkbox"/> 5 My pain is rapidly worsening.</p>

Patient Signature: _____ **LOW BACK PAIN**

NECK PAIN DISABILITY INDEX QUESTIONNAIRE

PATIENT NAME: _____

DATE: _____

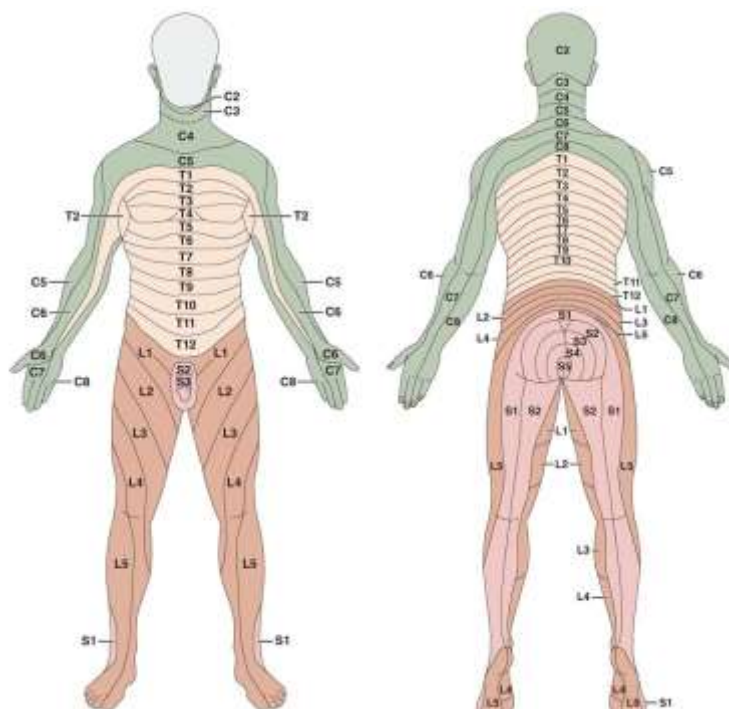
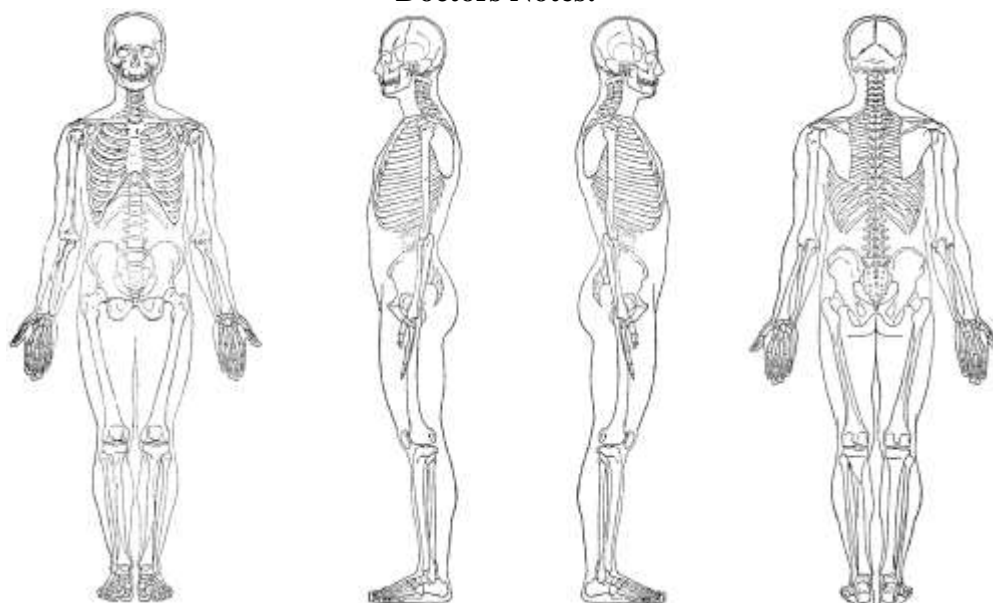
Please read: This questionnaire is designed to enable us to understand how much your **NECK PAIN** has affected your ability to manage your everyday activities. Please answer each section by circling the **ONE CHOICE** that most applies to you. We realize that you may feel that more than one statement may relate to you, but **PLEASE, JUST MARK THE ONE CHOICE WHICH MOST CLOSELY DESCRIBES YOUR PROBLEM RIGHT NOW.**

<p>SECTION 1 - Pain Intensity</p> <p><input type="checkbox"/> 0 I have no pain at the moment.</p> <p><input type="checkbox"/> 1 The pain is very mild at the moment.</p> <p><input type="checkbox"/> 2 The pain is moderate at the moment.</p> <p><input type="checkbox"/> 3 The pain is fairly severe at the moment.</p> <p><input type="checkbox"/> 4 The pain is very severe at the moment.</p> <p><input type="checkbox"/> 5 The pain is the worst imaginable at the moment.</p>	<p>SECTION 6 -Concentration</p> <p><input type="checkbox"/> 0 I can concentrate fully when I want to with no difficulty.</p> <p><input type="checkbox"/> 1 I can concentrate fully when I want to with slight difficulty.</p> <p><input type="checkbox"/> 2 I have a fair degree of difficulty in concentrating when I want to.</p> <p><input type="checkbox"/> 3 I have a lot of difficulty in concentrating when I want to.</p> <p><input type="checkbox"/> 4 I have a great deal of difficulty in concentrating when I want to.</p> <p><input type="checkbox"/> 5 I cannot concentrate at all.</p>
<p>SECTION 2 - Personal Care (washing, dressing, etc)</p> <p><input type="checkbox"/> 0 I can look after myself normally without causing extra pain.</p> <p><input type="checkbox"/> 1 I can look after myself normally, but it causes extra pain.</p> <p><input type="checkbox"/> 2 It is painful to look after myself; I am slow and careful.</p> <p><input type="checkbox"/> 3 I need some help but manage most of my personal care.</p> <p><input type="checkbox"/> 4 I need help every day in most aspects of self-care.</p> <p><input type="checkbox"/> 5 I do not get dressed; I wash with difficulty and stay in bed.</p>	<p>SECTION 7 -Work</p> <p><input type="checkbox"/> 0 I can do as much work as I want to.</p> <p><input type="checkbox"/> 1 I can only do my usual work, but no more.</p> <p><input type="checkbox"/> 2 I can do most of my usual work, but no more.</p> <p><input type="checkbox"/> 3 I cannot do my usual work.</p> <p><input type="checkbox"/> 4 I can hardly do any work at all.</p> <p><input type="checkbox"/> 5 I can't do any work at all.</p>
<p>SECTION 3 - Lifting</p> <p><input type="checkbox"/> 0 I can lift heavy weights without extra pain.</p> <p><input type="checkbox"/> 1 I can lift heavy weights, but it gives me extra pain.</p> <p><input type="checkbox"/> 2 pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned for example on a table.</p> <p><input type="checkbox"/> 3 pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.</p> <p><input type="checkbox"/> 4 I can with only very light weights.</p> <p><input type="checkbox"/> 5 I cannot lift or carry anything at all.</p>	<p>SECTION 8 - Driving</p> <p><input type="checkbox"/> 0 I can drive my car without any neck pain.</p> <p><input type="checkbox"/> 1 I can drive my car as long as I want with slight pain in my neck.</p> <p><input type="checkbox"/> 2 I can drive my car as long as I want with moderate pain in my neck.</p> <p><input type="checkbox"/> 3 I can't drive my car as long as I want because of moderate pain in my neck.</p> <p><input type="checkbox"/> 4 I can hardly drive at all because of severe pain in my neck.</p> <p><input type="checkbox"/> 5 I can't drive my car at all.</p>
<p>SECTION 4 - Reading</p> <p><input type="checkbox"/> 0 I can read as much as I want to with no pain in my neck.</p> <p><input type="checkbox"/> 1 I can read as much as I want to with slight pain in my neck.</p> <p><input type="checkbox"/> 2 I can read as much as I want with moderate neck pain.</p> <p><input type="checkbox"/> 3 I can't read as much as I want because of moderate neck pain.</p> <p><input type="checkbox"/> 4 I can hardly read at all because of severe pain in my neck.</p> <p><input type="checkbox"/> 5 I cannot read at all.</p>	<p>SECTION 9 - Sleeping</p> <p><input type="checkbox"/> 0 I have no trouble sleeping.</p> <p><input type="checkbox"/> 1 My sleep is slightly disturbed (less than one hour sleeplessness).</p> <p><input type="checkbox"/> 2 My sleep is mildly disturbed (1-2 hours sleepless).</p> <p><input type="checkbox"/> 3 My sleep is moderately disturbed (2-3 hours sleepless).</p> <p><input type="checkbox"/> 4 My sleep is greatly disturbed (3-5 hours sleepless).</p> <p><input type="checkbox"/> 5 My sleep is completely disturbed (5-7 hours sleepless).</p>
<p>SECTION 5 -Headaches</p> <p><input type="checkbox"/> 0 I have no headaches at all.</p> <p><input type="checkbox"/> 1 I have slight headaches that come infrequently.</p> <p><input type="checkbox"/> 2 I have slight headaches that come frequently.</p> <p><input type="checkbox"/> 3 I have moderate headaches that come infrequently.</p> <p><input type="checkbox"/> 4 I have moderate headaches that come frequently.</p> <p><input type="checkbox"/> 5 I have headaches almost all the time.</p>	<p>SECTION 10 -Recreation</p> <p><input type="checkbox"/> 0 I am able to engage in all my recreation activities with no neck pain at all.</p> <p><input type="checkbox"/> 1 I am able to engage in all my recreational activities, with some pain in my neck.</p> <p><input type="checkbox"/> 2 I am able to engage in most, but not all of my usual of recreational activities because of pain in my neck.</p> <p><input type="checkbox"/> 3 I am able to engage in a few of my recreational activities because of pain in my neck.</p> <p><input type="checkbox"/> 4 I can hardly do any recreational activities because of pain in my neck.</p> <p><input type="checkbox"/> 5 I can't do any recreational activities at all.</p>

Patient Signature: _____

NECK PAIN

Doctors Notes:



Daily Activity Limitations / Restrictions / Difficulties:

Social: _____

Work: _____

Recreational: _____

Prior episodes of the above complaints?: No: : Yes

If Yes then indicate Pain level **BEFORE** crash 0 1 2 3 4 5 6 7 8 9 10