

Confidential Patient Data

PATIENT INFORMATION

Today's Date: _____

Name: _____ Date of Birth: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____ Cell: _____

Email: _____ Social Security #: _____ Age: _____

Male Female Marital Status:

Married Single Divorced Other _____

Name of Spouse or Nearest Relative: _____ Phone: _____

Your Occupation _____ Your Employer: _____

How did you hear about us? _____

Name of Insurance Co.: _____ Insured's Employer: _____

Insured's Social Security #: _____ Insured's Date of Birth: _____

Are you covered by more than one insurance company? Yes No Name _____

MEDICAL/FAMILY HISTORY S = Self M = Mother F = Father

(Please indicate which PAST conditions have been experienced prior to present complaint by marking appropriate boxes).

S	M	F		S	M	F		S	M	F	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	dislocated joints	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	neck pain
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	anemia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	epilepsy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	nervousness
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	arthritis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Measles	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	numbness
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	asthma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	headaches	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	polio
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	back pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	heart trouble	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	poor circulation
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	bladder trouble	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	reproductive disorders	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	hepatitis
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	bone fracture	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	high blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	rheumatic fever
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	HIV/ARC	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	rheumatism
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	chest pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	kidney disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	scarlet fever
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	concussion	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	bowel control loss	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	serious injury
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	convulsions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	menstrual cramps	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	sinus trouble
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	multiple sclerosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Stroke
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	indigestion	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	muscular dystrophy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	tuberculosis
								<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	venereal disease

Have you been treated by a physician for any health condition in the last year? Yes No

SURGICAL HISTORY:

1. _____ Date: _____
2. _____ Date: _____
3. _____ Date: _____

ACCIDENT HISTORY: Job Auto Other 1. _____ Date: _____
 Job Auto Other 2. _____ Date: _____

PLEASE DESCRIBE PRESENT MAJOR COMPLAINTS:

Please Rate your symptoms (1-10, with 1 being least serious)

1. _____
2. _____
3. _____
4. _____

NEXT PAGE

SYMPTOMS ARE WORSE IN MORNING AFTERNOON NIGHT Consistent
WHEN AND HOW OCCURRED? _____

SYMPTOMS DEVELOPED FROM: JOB RELATED INJURY AUTO ACCIDENT OTHER ACCIDENT
ILLNESS UNKNOWN CAUSE GRADUAL ONSET DATE OCCURRED: _____
SYMPTOMS HAVE PERSISTED FOR # ___ HOUR(S) ___ DAY(S) ___ WEEK(S) ___ MONTH(S) ___ YEAR(S)
SYMPTOMS/COMPLAINTS: COME & GO ARE CONSTANT
NAME AND LOCATION OF DOCTORS PREVIOUSLY SEEN FOR PRESENT CONDITION(S):

ARE YOU ALLERGIC TO ANY MEDICATIONS NO YES WHAT KIND? _____

ARE YOU TAKING ANY MEDICATIONS? NO YES WHAT KIND? _____

ARE YOU PREGNANT NO YES MAYBE

PLEASE CHECK THE FOLLOWING ACTIVITIES THAT AGGRAVATE YOUR CONDITION:
BENDING REACHING STRAINING AT STOOL COUGHING SITTING TURNING HEAD
LIFTING SNEEZING WALKING LYING DOWN STANDING

SOCIAL HISTORY

DO YOU SMOKE? YES ___ NO ___ IF YES, HOW MUCH? _____

DO YOU DRINK ALCOHOL? YES ___ NO ___ IF YES, HOW OFTEN AND HOW MUCH? _____

ILLICIT DRUGS? YES ___ NO ___ IF YES, DESCRIBE _____

Patient's Signature: _____ Date: _____

Certification and Assignment

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I, or my minor child, ever have a change in health.

I certify that I, and or my dependent(s), have insurance coverage with _____ and assign directly to Back Pain Relief Clinic all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsibility for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named doctor may use my health care information to the above-named Insurance Companies and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

Signature of Patient or Guardian Date

Please print name of patient or guardian Relationship to Patient

Review of Systems:

General:

- o Weight loss or gain
- o Fatigue
- o Fever or chills
- o Weakness
- o Trouble Sleeping

Skin:

- o Rashes/ Itching
- o Lumps
- o Dryness
- o Color changes
- o Hair/Nail Changes

Head:

- o Headache
- o Head injury

Eyes:

- o Glasses or contacts
- o Pain
- o Redness
- o Blurry/ double vision
- o Flashing lights
- o Specks

Nose:

- o Sinus Pain
- o Discharge
- o Itching
- o Hay fever
- o Nosebleeds

Throat:

- o Bleeding
- o Sore tongue
- o Sore throat
- o Hoarseness
- o Thrush
- o Non-healing sores

Neck:

- o Lumps
- o Swollen glands
- o Pain
- o Stiffness

Breasts:

- o Lumps
- o Pain
- o Discharge
- o Self-exams

Respiratory:

- o Cough
- o Coughing up blood
- o Shortness of breath
- o Wheezing
- o Painful breathing

Cardiovascular:

- o Chest pain
- o Tightness
- o Palpitations
- o Shortness of breath
- o Difficulty breathing while lying down
- o Swelling

Gastrointestinal:

- o Swallowing difficulties
- o Heartburn
- o Change in appetite
- o Nausea
- o Change in bowel habits
- o Rectal bleeding
- o Constipation
- o Diarrhea
- o Yellow eyes or skin

Urinary:

- o Frequency
- o Urgency
- o Burning or pain
- o Blood in urine
- o Incontinence
- o Change in urinary strength

Review of Systems:

Genital:

Male:

- o Pain with sex
- o Hernia
- o Penile discharge
- o Sores
- o Masses or pain
- o Erectile dysfunction
- o STD's

Female:

- o Pain with sex
- o Vaginal dryness
- o Hot flashes
- o Vaginal discharge
- o Itching or rash
- o STD's

Vascular:

- o Calf pain with walking
- o Leg cramping

Musculoskeletal:

- o Muscle or joint pain
- o Stiffness
- o Back pain
- o Redness of joints
- o Swelling of joints
- o Trauma

Neurologist:

- o Dizziness
- o Fainting
- o Seizures
- o Weakness
- o Numbness
- o Tingling
- o Tremor

Hematologic:

- o Ease of bruising
- o Ease of bleeding

Endocrine:

- o Hot or cold tolerance
- o Sweating
- o Frequent urination
- o Change in appetite
- o Thirst

Psychiatric:

- o Nervousness
- o Depression
- o Memory loss
- o Stress

I have reviewed the above information with the patient.

**(To be signed by Back Pain Relief Clinic physician)*

Physician Assistant's Signature

Physician's Signature

Food and Chemical Sensitivity Survey



Date: ___/___/___

Patient Name _____

Gender: M/F

Height: Feet ___ Inches ___

Weight: ___ lbs.

Please list all medications you are currently taking: _____

Please complete the following food and chemical sensitivity questionnaire. Score each symptom based upon your experiences over the last 60 days. This survey should be taken again after the completion of the Alcat Test, prior to reintroduction of "reactive" foods. Typically 3-6 months after initial testing. This comparison will help to assess the success of the eating modification program.

Symptom Scoring System:

- = No Symptoms (Zero Points)
- = Experience Mild Symptoms (One Point)
- = Experience Moderate Symptoms (Two Points)
- = Severe Symptoms (Three Points)

Digestive Symptoms

- Stomach Pains or Cramping
- Constipation
- Diarrhea
- Reflux or Heartburn
- Bloating
- Gas
- Nausea or Vomiting

Weight

- Inability to Lose Weight
- Food Cravings
- Binge Eating
- Water Retention

Sinus/Respiratory

- Stuffy or Runny Nose
- Asthma
- Chest Congestion
- Chronic Cough
- Wheezing
- Frequent Sneezing

Head/Ears

- Migraines
- Headaches
- Earaches
- Ear Infection
- Ringing in Ears

Eyes/Throat

- Itchy Eyes
- Watery Eyes
- Sore Throat
- Persistent Canker Sores

Emotional/Mental

- Depression
- Anxiety
- Mood Swings
- Irritability
- Poor Concentration

Energy

- Fatigue
- Hyperactivity
- Lethargy
- Restlessness
- Insomnia

Skin Disorders

- Eczema
- Dermatitis
- Excessive Sweating
- Rashes
- Hives

Other Symptoms:

- Joint Pain
- Arthritis
- Irregular Heartbeat
- Chest Pains
- Muscle Aches

Please list any symptoms not mentioned above:

Total Score: _____

NEUROLOGICAL/ MRI/ VASCULAR PATIENT QUESTIONNAIRE

NAME _____ **DATE** _____

For any YES answer, please explain under comment and notify the Doctor:

- | | | |
|--|----|-----|
| 1. Do you suffer from neck pain with pain in your shoulder, arms or hands? | NO | YES |
| Comment: _____ | | |
| 2. Do you have weakness, numbness or burning in your shoulder, arms or hands? | NO | YES |
| Comment: _____ | | |
| 3. Do your hands or arms fall asleep regularly? | NO | YES |
| Comment: _____ | | |
| 4. Do you have reduced feeling (sensation) or swelling in your hands or arms? | NO | YES |
| Comment: _____ | | |
| 5. Do you suffer from a loss of handgrip strength? | NO | YES |
| Comment : _____ | | |
| 6. Do you suffer from back pain with pain in your buttocks, legs or feet? | NO | YES |
| Comment: _____ | | |
| 7. Do you have weakness, numbness or burning in your buttocks, legs or feet? | NO | YES |
| Comment: _____ | | |
| 8. Do your legs or feet fall asleep regularly? | NO | YES |
| Comment: _____ | | |
| 9. Do you have reduced feeling (sensation) or swelling in your legs, feet? | NO | YES |
| Comment: _____ | | |
| 10. Do you suffer from cold hands or feet? | NO | YES |
| Comment: _____ | | |
| 11. Have you tried any medications such as anti-inflammatory? | NO | YES |
| If yes, what kind of medication? _____ | | |
| _____ | | |
| 12. Have you tried any Physical Therapy or Chiropractic treatments before? | NO | YES |
| If yes: When? For how long? What kind? _____ | | |
| _____ | | |
| 13. Have you had an MRI? | NO | YES |
| If yes: When? Who ordered it? What was it ordered for? _____ | | |
| _____ | | |
| 14. Have you used any splint or braces or other prescribed treatment by an MD? | NO | YES |
| If yes: When? What kind? Who ordered it? _____ | | |
| _____ | | |
| 15. If you have tried any treatment or medications, did this make your problem better? | NO | YES |
| Comment: _____ | | |

NOTE: Your health information will be kept strictly confidential. Any information that we collect about you on this form will be kept confidential in our office. If a claim is submitted to Medicare, your health information on this form may be shared with Medicare. Your health information which Medicare sees will be kept confidential by Medicare.

PATIENT NAME _____

ADDRESS _____

ATTORNEY _____

INSURANCE _____

AUTHORIZATION FOR RELEASE OF RECORDS/X-RAYS

I hereby authorize _____ (granting establishment/provider) to disclose to **Back Pain Relief Clinic** or their agent any information which he may have acquired by examination or other means of my physical or mental condition; and I hereby release him of any consequences thereof.

Dated at _____ this _____ day of _____, _____ .
(Time) (Day) (Month) (Year)

Witness:

(Signature of Patient)

Financial Policy for the State of Tennessee Insurance, Cash, Workers' Comp, and Medicare

Insurance

If you have health insurance that you believe may cover services in this office, we will verify your insurance coverage for you. Once your eligibility and coverage is determined we will file all insurance claims for you to the extent that your policy permits.

You are responsible for paying your deductible, copayment and non-covered supplements, supplies and services at the time they are rendered unless other financial arrangements are made.

Non Insured or Tenn Care

We request 100% of visits must be paid for at time of service. If your financial situation required special arrangements, please speak with the financial coordinator.

Workers' Compensation

Limited services may be covered by Workers' Compensation law, and you may be covered 100%, as long as your employer is aware you were injured on the job, you have completed the required papers with your employer, and your employer has no objection to your receiving care here, and is covered by Workers' Compensation Insurance. You are responsible for non-covered items such as supplements and supports that are not direct results of the accident. These items are to be paid for at the time they are received.

Medicare

The doctors at this clinic are participating providers with Medicare; therefore, we are required to bill Medicare for all services rendered. Medicare does not pay for everything; any services, supplies or supplements not covered by Medicare will be identified for you before you receive them. Therefore, you will be asked to pay for these services at the time you receive them unless other arrangements are made. You will also be required to pay an annual deductible and small copayment. If you have a supplemental insurance policy that covers services, we will bill them for you if Medicare does not. Medicare will send payment directly to our office. You will also be required to pay all visits in full once Medicare stops paying our office.

It must be understood:

This clinic DOES NOT promise that an insurance company will pay, nor does the clinic promise that an insurance company should or will pay the fees as charged. Therefore, this clinic will not enter into a dispute with an insurance company for reimbursement. This is the patient's obligation.

Patient Signature _____

Date _____

Authorization Notice for the Use and Disclosure of Patient's Protected Health Information

1. I am authorizing BACK PAIN RELIEF CLINIC and staff to use my name out loud in order to call me back to a room for treatment.
2. I understand that in this practice open bay adjusting and open bay therapy are used. If at any time I need to speak with the doctor in private, I can make this request and set up a special consultation time with the receptionist.
3. I understand that if the practice intends to use my name for advertising purpose or for testimonial purposed they must further get my permission.
4. I understand that this authorization is voluntary.
5. I am authorizing BACK PAIN RELIEF CLINIC and staff to use and/or disclose my protected health information (PHI) **to insurance companies, lawyers, and doctors** for all health care delivery purposes, which are known as treatment, payment, and health care operation (TPO).
6. I understand that this office will not receive financial or in-kind compensation in exchange for using or disclosing any of my health information.
7. I understand that I may request a copy of this form at any time for any reason, and it will be provided for me.
8. This form and the Notice of Privacy Practices for Protected Health Information were completely read and filled in by me before I signed it. I certify that all my questions were answered to my satisfaction and that I understand this authorization form and its contents.
9. I further understand that this authorization is valid from today until I ask for a change in this policy in writing.
10. Chiropractic care and medical care, like all forms of health care, while offering considerable benefit may also provide some level of risk. This level of risk is most often very minimal, yet in rare cases injury has been associated with chiropractic care. The types of complications that have been reported secondary to chiropractic care include sprain/strain injuries, irritation of a disc condition, and rarely, fractures. One of the rarest complications associated with chiropractic care, occurring at a rate between one instances per one million to one per two million cervical spine (neck) adjustments may be a vertebral artery injury that could lead to stroke.

Prior to receiving chiropractic care in our office, a health history and physical examination will be completed. These procedures are performed to assess your specific condition, your overall health and, in particular, your spine health. These procedures will assist us in determining if chiropractic care is needed. In addition, they will help us determine if there is any reason to modify your care or provide you with a referral to another health care provider. All relevant findings will be reported to you along with a care plan prior to beginning care.

I understand and accept there are risks associated with treatment and give my consent to the examinations that the doctor deems necessary, and to the chiropractic care including spinal adjustments, as reported following my assessment. I also understand all of the above procedures used by this office and give my consent to those.

Name of Individual (Printed)

Date

Signature of Individual

Date

Signature of Witness (Office Representative or someone with me)

Date

Relationship

REVISED OSWESTRY DISABILITY INDEX

Name: _____

Date: ____/____/____

File#: _____

This questionnaire has been designed to give the doctor information as to how your back pain has affected your ability to manage everyday life. Please answer every section and mark in each section **only the ONE box** that applies to you. We realize that you may consider that two of the statements in any one section relate to you, but please just mark the box that most closely describes your problem.

Section 1: Pain Intensity

- The pain comes and goes and is very mild.
- The pain is mild and does not vary much.
- The pain comes and goes and is moderate.
- The pain is moderate and does not vary much.
- The pain comes and goes and is very severe.
- The pain is severe and does not vary much.

Section 2: Personal Care

- I would not have to change my way of washing or dressing in order to avoid pain.
- I do not normally change my way of washing or dressing even though it causes some pain.
- Washing and dressing increases the pain, but I manage not to change my way of doing it.
- Washing and dressing increases the pain and I find it necessary to change my way of doing it.
- Because of the pain, I am unable to do some washing and dressing without help.
- Because of the pain, I am unable to do any washing and dressing without help.

Section 3: Lifting

- I can lift heavy weights without extra pain.
- I can lift heavy weights, but it causes extra pain.
- Pain prevents me from lifting heavy weights off the floor, but I manage if they are conveniently positioned (e.g., on a table).
- Pain prevents me from lifting heavy weights off the floor.
- Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
- I can only lift very light weights at the most.

Section 4: Walking*

- I have no pain on walking.
- I have some pain on walking, but it does not increase with distance.
- I cannot walk more than one mile without increasing pain.
- I cannot walk more than 1/2 mile without increasing pain.
- I cannot walk more than 1/4 mile without increasing pain.
- I cannot walk at all without increasing pain.

Section 5: Sitting

- I can sit in any chair as long as I like.
- I can only sit in my favorite chair as long as I like.
- Pain prevents me from sitting more than one hour.
- Pain prevents me from sitting more than 1/2 hour.
- Pain prevents me from sitting more 10 minutes.
- I avoid sitting because it increases pain right away.

Section 6: Standing

- I can stand as long as I want without pain.
- I have some pain on standing, but it does not increase with time.
- I cannot stand for longer than one hour without increasing pain.
- I cannot stand for longer than 1/2 hour without increasing pain.
- I cannot stand for longer than 10 minutes without increasing pain.
- I avoid standing because it increases the pain right away.

Section 7: Sleeping

- I get no pain in bed.
- I get pain in bed, but it does not prevent me from sleeping well.
- Because of pain, my normal night's sleep is reduced by less than 1/4.
- Because of pain, my normal night's sleep is reduced by less than 1/2.
- Because of pain, my normal night's sleep is reduced by less than 3/4.
- Pain prevents me from sleeping at all.

Section 8: Social Life

- My social life is normal and gives me no pain.
- My social life is normal, but increases the degree of pain.
- Pain has no significant effect on my social life apart from limiting my more energetic interests, e.g., dancing, etc.
- Pain has restricted my social life and I do not go out very often.
- Pain has restricted my social life to my home.
- I have hardly any social life because of the pain.

Section 9: Traveling

- I get no pain while travelling.
- I get some pain while travelling, but none of my usual forms of travel makes it any worse.
- I get extra pain while travelling, but it does not compel me to seek alternative forms of travel.
- I get extra pain while travelling, which compels me to seek alternative forms of travel.
- Pain restricts all forms of travel.
- Pain prevents all forms of travel except that done lying down.

Section 10: Changing Degree of Pain

- My pain is rapidly getting better.
- My pain fluctuates, but is definitively getting better.
- My pain seems to be getting better, but improvement is slow at present.
- My pain is neither getting better nor worse.
- My pain is gradually worsening.
- My pain is rapidly worsening.

Patient Signature _____

NECK DISABILITY INDEX

Name: _____

Date: _____

File# _____

This questionnaire has been designed to give the doctor information as to how your neck pain has affected your ability to manage everyday life. Please answer every section and mark in each section only the ONE box that applies to you. We realize that you may consider that two of the statements in any one section relate to you, but please just mark the box that most closely describes your problem.

Section 1: Pain Intensity

- I have no pain at the moment.
- The pain is very mild at the moment.
- The pain is moderate at the moment.
- The pain is fairly severe at the moment.
- The pain is very severe at the moment.
- The pain is the worst imaginable at the moment.

Section 2: Personal Care (Washing, Dressing, etc.)

- I can look after myself normally, without causing extra pain.
- I can look after myself normally, but it causes extra pain.
- It is painful to look after myself and I am slow and careful.
- I need some help, but manage most of my personal care.
- I need help every day in most aspects of self care.
- I do not get dressed; I wash with difficulty and stay in bed.

Section 3: Lifting

- I can lift heavy weights without extra pain.
- I can lift heavy weights, but it gives extra pain.
- Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned, for example, on a table.
- Pain prevents me from lifting heavy weights off the floor, but I can manage light to medium weights if they are conveniently positioned.
- I can lift very light weights.
- I cannot lift or carry anything at all.

Section 4: Reading

- I can read as much as I want to, with no pain in my neck.
- I can read as much as I want to, with slight pain in my neck.
- I can read as much as I want to, with moderate pain in my neck.
- I can't read as much as I want, because of moderate pain in my neck.
- I can hardly read at all, because of severe pain in my neck.
- I cannot read at all.

Section 5: Headaches

- I have no headaches at all.
- I have slight headaches that come infrequently.
- I have moderate headaches that come infrequently.
- I have moderate headaches that come frequently.
- I have severe headaches that come frequently.
- I have headaches almost all the time.

Section 6: Concentration

- I can concentrate fully when I want to, with no difficulty.
- I can concentrate fully when I want to, with slight difficulty.
- I have a fair degree of difficulty in concentrating when I want to.
- I have a lot of difficulty in concentrating when I want to.
- I have a great deal of difficulty in concentrating when I want to.
- I cannot concentrate at all.

Section 7: Work

- I can do as much work as I want to.
- I can do my usual work, but no more.
- I can do most of my usual work, but no more.
- I cannot do my usual work.
- I can hardly do any work at all.
- I can't do any work at all.

Section 8: Driving

- I can drive my car without any neck pain.
- I can drive my car as long as I want, with slight pain in my neck.
- I can drive my car as long as I want, with moderate pain in my neck.
- I can't drive my car as long as I want, because of moderate pain in my neck.
- I can hardly drive at all, because of severe pain in my neck.
- I can't drive my car at all.

Section 9: Sleeping

- I have no trouble sleeping.
- My sleep is slightly disturbed (less than 1 hr sleepless).
- My sleep is mildly disturbed (1-2 hrs sleepless).
- My sleep is moderately disturbed (2-3 hrs sleepless).
- My sleep is greatly disturbed (3-5 hrs sleepless).
- My sleep is completely disturbed (5-7 hrs sleepless).

Section 10: Recreation

- I am able to engage in all my recreation activities, with no neck pain at all.
- I am able to engage in all my recreation activities, with some neck pain at all.
- I am able to engage in most, but not all, of my usual recreation activities, because of pain in my neck.
- I am able to engage in few of my recreation activities, because of pain in my neck.
- I can hardly do any recreation activities, because of pain in my neck.
- I can't do any recreation activities at all.

Patient Signature _____