Harbor Chiropractic · 6220 Manatee Ave W, Ste 204, Bradenton, FL 34209 · 941-761-1100

New Patient Intake Form

Full Name ______________________________ **Preferred Name (if applicable)** __________________

Address ____ **City** ______________________

State _____ **Zip Code** _____________ **Preferred Number:** ☐ Home ☐ Cell ☐ Work

Home Phone (_____) ________-_________ **Cell Phone** (_____) ________-__________

Work Phone (_____) ________-________ **Email** ________________________ **(for appointment reminders)**

Date of Birth ______/______/_______ **Sex:** ☐ Male ☐ Female

Social Security Number: ______-______-______ **Marital Status:** ☐ Single ☐ Married ☐ Separated

Preferred Language: ☐ English ☐ Other _________ ☐ Divorced ☐ Widowed ☐ Other

Race/Ethnicity: ☐ American Indian or Alaskan Native ☐ Asian ☐ Black or African American ☐ Other

☐ Hispanic or Latino ☐ Native Hawaiian or Other Pacific Islander ☐ White

Employment Status: ☐ Employed ☐ Unemployed ☐ FT Student ☐ PT Student ☐ Other_____

Employer Data

Employer ____________________________________ Occupation _________________________

Emergency Contact Data

Name ________________________________ Phone Number ________________________

Primary Insured's Name: _________________________ Primary Insured's Date of Birth: ____/_____/______

Primary Care Physician/Family Medical Doctor ☐ **I was referred by this physician**

Name ______________________________ Phone Number _________________________

*When doctors work together it benefits you. May we have your permission to update your medical doctor regarding your care at this office? ☐ Yes ☐ No

Insurance Information: Please check any and all insurance coverage that may be applicable in this case:

☐ Major Medical ☐ Medicare ☐ Auto Accident ☐ Medical Savings Account & Flex Plans ☐ Other

Name of Primary Insurance Company: ____

Name of Secondary Insurance Company (if any):____________________________________

AUTHORIZATION AND RELEASE: I authorize payment of insurance benefits directly to the chiropractor or chiropractic office. I authorize the doctor to release all information necessary to communicate with personal physicians and other healthcare providers and payers and to secure the payment of benefits. I understand that I am responsible for all costs of chiropractic care, regardless of insurance coverage. I also understand that if I suspend or terminate my schedule of care as determined by my treating doctor, any fees for professional services will be immediately due and payable. **The patient understands and agrees to allow this chiropractic office to use their Patient Health Information for the purpose of treatment, payment, healthcare operations, and coordination of care. We want you to know how your Patient Health Information is going to be used in this office and your rights concerning those records. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your Patient Health Information we encourage you to read the HIPAA NOTICE that is available to you at the front desk before signing this consent.**

The following person(s) have my permission to receive my personal health information:________________

____

Patient's Signature: ____ Date: _______________

Guardian's Signature Authorizing Care: ______________________________ Date: _______________

 Doctor's Initials _____

Informed Consent

The use of hands or a mechanical instrument will be placed upon your body in such a way as to move your joints. This procedure is referred to as "Spinal Manipulation" or "Spinal Adjustment." As the joints in your spine are moved, you may experience a "pop" as part of the process. There are certain complications that can occur as a result of a spinal manipulation. These compilations include, but are not limited to: muscle strain, cervical myelopathy, disc and vertebral injury, fractures, strains and dislocations, Bernard-Horner's Syndrome (aka oculosympathethetic palsy), costovertebral strains and separation. Rare complications include but are not limited to stroke. The most common complication or complaint following spinal manipulation is an ache or stiffness at the site of adjustment. I am aware of these complications, and in order to minimize their occurrence I will take precautions. These precautions include but are not limited to my taking your detailed clinical history and examining you for any defect which would cause a complication. This examination may include the use of x-rays. The use of x-ray equipment may pose a risk if you are pregnant. If you are pregnant, you should inform our office while taking your clinical history.

Patient's Signature: ______________________________ Date: ____________

Guardian's Signature Authorizing Care: ______________________________ Date: ____________

Patient Health Information Consent

1. The patient understands and agrees to allow this chiropractic office to use their Patient Health Information (PHI) for the purpose of treatment, payment, healthcare operations, and coordination of care. As an example, the patient agrees to allow this chiropractic office to submit requested PHI to the Health Insurance Company (or companies) provided to us by the patient for the purpose of payment. Be assured that this office will limit the release of all PHI to the minimum needed for what the insurance companies require for payment.
2. The patient has the right to examine and obtain a copy of his or her own health records at any time and request corrections. The patient may request to know what disclosures have been made and submit in writing any further restrictions on the use of their PHI. Our office is obligated to agree to those restrictions only to the extent they coincide with state and federal law.
3. A patient's written consent need only be obtained one time for all subsequent care given the patient in this office.
4. The patient may provide a written request to revoke consent at any time during care. This would not affect the use of those records for the care given prior to the written request to revoke consent but would apply to any care given after the request has been presented.
5. Our office may contact you periodically regarding appointments, treatments, products, services, or charitable work performed by our office. You may choose to opt-out of any marketing or fundraising communications at any time.
6. For your security and right to privacy, all staff has been trained in the area of patient record privacy and a privacy official has been designated to enforce those procedures in our office. We have taken all precautions that are known by this office to assure that your records are not readily available to those who do not need them.
7. Patients have the right to file a formal complaint with our privacy official and the Secretary of HHS about any possible violations of these policies and procedures without retaliation by this office.
8. Our office reserves the right to make changes to this notice and to make the new notice provisions effective for all protected health information that it maintains. You will be provided with a new notice at your next visit following any change.
9. This notice is effective on the date stated below.
10. If the patient refuses to sign this consent for the purpose of treatment, payment, and health care operations, the chiropractic physician has the right to refuse to give care.

Patient's Signature: ______________________________ Date: ____________

Guardian's Signature Authorizing Care: ______________________________ Date: ____________

 Doctor's Initials _____

Authorization for the Release of Medical Records

Patient Name: ______________________________ Date of Birth:__________

I hereby request and authorize:

Harbor Chiropractic
6220 Manatee Ave W, Ste 204
Bradenton, FL 34209
T: (941) 761-1100 / F: (941) 761-1103

______To Disclose information to: ______To Receive Information from:

Provider: ______________________________
Address: ______________________________
City/State/Zip: ______________________________
Phone: ______________________ Fax: ________________

Information to be disclosed include copies of:

_____Entire Record
_____Progress Notes
_____Physical Exam forms
_____Daily chart notes
_____X-ray Reports
_____X-ray Films
_____Other, specify:
____

Patient's Signature: ______________________________Date: _______________

Guardian's Signature Authorizing Care: ______________________________Date: _______________

If signing for a minor patient, I hereby state that my parental rights have not been revoked by a court of law.

A copy of this authorization is as valid as the original.

Notice to recipient of information: This information has been disclosed to you from confidential records, which are protected by law. Unless you have further authorization, laws may prohibit you from making any further disclosures of this information without the specific written consent of the patient or legal representative.

Harbor Chiropractic · 6220 Manatee Ave W, Ste 204, Bradenton, FL 34209 · 941-761-1100

Patient's Name: ______________________________ Date: ____________

How did you hear about our office? ______________________________

Social History: (Check all that apply to you)

Tobacco Use: ☐ Current tobacco use ☐ Not a current tobacco user ☐ Never a tobacco user
Alcohol Use: ☐ None ☐ Light/Moderate ☐ Heavy ☐ Former Alcoholic
Activity Level: ☐ None ☐ Light ☐ Moderate ☐ Vigorous

Hospitalizations ☐ **None** **If yes, list:** ______________________________

Surgeries: (Check all that apply to you) ☐ **None**

☐ Appendectomy	☐ Cardiovascular procedure	☐ Cervical spine	☐ Hysterectomy
☐ Joint Replacement	☐ Prostate	☐ Lumbar spine	☐ Gall Bladder
☐ Brain	☐ Shoulder	☐ Thoracic spine	☐ Knee
☐ Carpal Tunnel	☐ Gastro-intestinal	☐ Uro-genital	☐ Hernia
☐ Breast Augmentation	☐ Other ____________		

Prior Accidents/Injuries: ☐ **None** **If yes, list:** ______________________________

____

Medical Conditions: (Check all that apply to you) ☐ **None**

☐ Arthritis	☐ Cancer	☐ Diabetes	☐ Heart Disease
☐ High Blood Pressure	☐ Psychiatric Illness	☐ Skin Disorder	☐ Stroke
☐ Fibromyalgia	☐ Asthma	☐ Osteoporosis/penia	☐ Other ____________

Allergies: (Check all that apply to you) ☐ **None**

☐ Mold	☐ Seasonal	☐ Milk or Lactose	☐ Animal
☐ Chemical __________	☐ Sulfites	☐ Wheat/Glutens	☐ Other ________

Current Medications/Supplements (list all): ☐ **None** ______________________________

____

Family History: ☐ **None**
(Check all that apply)

Arthritis:	☐ Parent	☐ Sibling
Cancer:	☐ Parent	☐ Sibling
Diabetes:	☐ Parent	☐ Sibling
Heart Disease	☐ Parent	☐ Sibling
Hypertension	☐ Parent	☐ Sibling
Stroke	☐ Parent	☐ Sibling
Thyroid	☐ Parent	☐ Sibling

Other: ____________

____

Previous Tests: ☐ MRI ☐ X-Rays ☐ CT
Region and Results: ____________________

Previous Chiropractic Care: ☐ Yes ☐ No
Preferred Method of Adjusting (if applicable):
☐ Manual ☐ Instrument

WOMEN: Are You Pregnant? ☐ **Yes** ☐ **No** **If yes, due date:** ______

 Doctor's Initials _____

Review of Systems – ☐ **None**(Check box if you have/have had trouble with any of the following. Leave blank if not applicable)

General	**Past**	**Present**	**HEENT**	**Past**	**Present**	**Skin/Hair**	**Past**	**Present**
Lethargy/Weakness			Headaches/Migraines			Rashes/Skin Trouble		
Recurring Fever			Eye/Vision Problem			Flushing		
Weight Loss/Gain			Nose Bleeds			Excess Acne		
Dizziness			Sore Throat			Eczema		
Fever			Hoarseness			Psoriasis		
Chills			Swollen glands			Skin Cancer		
Cardiovascular:	**Past**	**Present**	Sinus Trouble			Skin Color Change		
Chest Pain/Pressure			Ear/Hearing Problem			Change in hair/nail		
Heart Attack			Dental Problems			Easy Bruising		
Shortness of Breath			TMJ Problems			**Gastrointestinal**	**Past**	**Present**
Palpitations			**Respiratory:**	**Past**	**Present**	Loss of Appetite		
Swelling hands/feet			Chronic Cough			Nausea/Vomiting		
Hypertension (HBP)			Asthma/Wheezing			Diarrhea		
High Cholesterol			Short of Breath			Constipation		
Heart Murmur			Exercise Intolerance			Abdominal Pain		
Blood Clots			Sleep Apnea			Ulcers		
Pacemaker			Emphysema			Bloating/Cramping		
Mitral Valve Prolapse						Heartburn		
Neurologic	**Past**	**Present**	**Musculoskeletal**	**Past**	**Present**	Hemorrhoids		
Frequent Headache			Arthritis			Hepatitis		
Migraines			Joint Pain/Swell			Cirrhosis		
Dizziness			Neck Pain			Gastric Reflux		
Fainting			Back Pain			Bowel/Bladder Issues		
Memory Loss			Trauma			**Blood/Lymph**	**Past**	**Present**
Poor Balance			Osteoporosis			Anemia		
Numbness/tingling			Scoliosis			Bleeding		
Pins/Needles			Cramping			Bruising		
Muscle Weakness						Blood Clots		
Seizures			**Endocrine**	**Past**	**Present**	Past Transfusions		
Stroke			Diabetes			Leukemia		
Tremors			Thyroid Problems			Lymphoma		
Head Injury			Sweating			HIV/AIDS		
Psychiatric	**Past**	**Present**	Hot/Cold Intolerance			Sickle Cell		
Insomnia			Weight Loss			**Urinary**	**Past**	**Present**
Diff Concentrating			Weight Gain			Excess/Pain Urination		
Memory Loss/Confusion			Excess Urination			Incontinence		
Depression			Excess thirst			Urgency		
Anxiety			Appetite Change			Kidney Stones		
Agitation/Irritability						**Allergies**	**Past**	**Present**
Female	**Past**	**Present**	**Male**	**Past**	**Present**	Seasonal		
Menstrual Irregularity			Testicular Pain/Lumps			Food		
Hot Flashes			Prostate Disease			Medication		
Breast Pain/Lumps								
Menopause								

Additional Comments: ____

____

____

 Doctor's Initials ____ Patient/Guardian Initials ____ Date ____

Please answer each section for each individual symptom.
(i.e.: Low back pain and neck pain would be completed separately)

#1: Location on body: ________________ **Pain Intensity:** no pain 0 1 2 3 4 5 6 7 8 9 10 worst pain

When did your symptoms begin? __________ **How did they begin?** ______________________________

Are your symptoms a result of: ☐ Motor Vehicle Accident ☐ Work Related Accident ☐ Other_____
Current Open Insurance Claim: ☐ Yes ☐ No

How often do you experience your symptoms?
☐ Constantly: (76-100% of the day) ☐ Frequently (51-75% of the day) ☐ Occasionally (26-50% of the day) ☐ Intermittently (0-25% of the day)

Is the pain: ☐ Not applicable
☐ Unaffected by time of day? ☐ Worse in the morning? ☐ Worse in the afternoon? ☐ Worse at night

What describes the nature of your symptoms?
☐ Ache ☐ Burning ☐ Dull ☐ Sharp ☐ Stabbing ☐ Throbbing
☐ Weakness ☐ Numbness/Tingling ☐ Stiffness ☐ Other ______ ☐ Radiates into ___________

Does anything aggravate your pain? ☐ No If yes, check below
☐ Activity (circle: Heavy / Light / Moderate) ☐ Bending ☐ Lifting ☐ Standing ☐ Stress
☐ Temperature Changes ☐ Twisting ☐ Other __________

Does anything improve your pain? ☐ No If yes, check below
☐ Cold ☐ Heat ☐ Activity ☐ Lying Down ☐ OTC Medication ☐ Postural Changes
☐ Prescribed Medications ☐ Rest ☐ Stretching ☐ Support Brace ☐ Other __________

#2: Location on body: ________________ **Pain Intensity:** no pain 0 1 2 3 4 5 6 7 8 9 10 worst pain

When did your symptoms begin? __________ **How did they begin?** ______________________________

Are your symptoms a result of: ☐ Motor Vehicle Accident ☐ Work Related Accident ☐ Other_____
Current Open Insurance Claim: ☐ Yes ☐ No

How often do you experience your symptoms?
☐ Constantly: (76-100% of the day) ☐ Frequently (51-75% of the day) ☐ Occasionally (26-50% of the day) ☐ Intermittently (0-25% of the day)

Is the pain: ☐ Not applicable
☐ Unaffected by time of day? ☐ Worse in the morning? ☐ Worse in the afternoon? ☐ Worse at night

What describes the nature of your symptoms?
☐ Ache ☐ Burning ☐ Dull ☐ Sharp ☐ Stabbing ☐ Throbbing
☐ Weakness ☐ Numbness/Tingling ☐ Stiffness ☐ Other ______ ☐ Radiates into ___________

Does anything aggravate your pain? ☐ No If yes, check below
☐ Activity (circle: Heavy / Light / Moderate) ☐ Bending ☐ Lifting ☐ Standing ☐ Stress
☐ Temperature Changes ☐ Twisting ☐ Other __________

Does anything improve your pain? ☐ No If yes, check below
☐ Cold ☐ Heat ☐ Activity ☐ Lying Down ☐ OTC Medication ☐ Postural Changes
☐ Prescribed Medications ☐ Rest ☐ Stretching ☐ Support Brace ☐ Other __________

 Doctor's Initials _____ Patient/Guardian Initials _____ Date _____

#3: Location on body: _______________ **Pain Intensity:** no pain 0 1 2 3 4 5 6 7 8 9 10 worst pain

When did your symptoms begin? __________ **How did they begin?** ____________________________

Are your symptoms a result of: ☐ Motor Vehicle Accident ☐ Work Related Accident ☐ Other_____
Current Open Insurance Claim: ☐ Yes ☐ No

How often do you experience your symptoms?

☐ Constantly:	☐ Frequently	☐ Occasionally	☐ Intermittently
(76-100% of the day)	(51-75% of the day)	(26-50% of the day)	(0-25% of the day)

Is the pain: ☐ Not applicable
☐ Unaffected by time of day? ☐ Worse in the morning? ☐ Worse in the afternoon? ☐ Worse at night

What describes the nature of your symptoms?
☐ Ache ☐ Burning ☐ Dull ☐ Sharp ☐ Stabbing ☐ Throbbing
☐ Weakness ☐ Numbness/Tingling ☐ Stiffness ☐ Other _____ ☐ Radiates into __________

Does anything aggravate your pain? ☐ No If yes, check below
☐ Activity (circle: Heavy / Light / Moderate) ☐ Bending ☐ Lifting ☐ Standing ☐ Stress
☐ Temperature Changes ☐ Twisting ☐ Other _________

Does anything improve your pain? ☐ No If yes, check below
☐ Cold ☐ Heat ☐ Activity ☐ Lying Down ☐ OTC Medication ☐ Postural Changes
☐ Prescribed Medications ☐ Rest ☐ Stretching ☐ Support Brace ☐ Other _________

If there are MORE regions of complaint, please request additional sheet from one of our chiropractic assistants.

Acknowledgments

To set clear expectations, improve communication and help you get the best results in the shortest amount of time, please read each statement, and initial your agreement.

Initials ____ I instruct the chiropractor to deliver the care that, in her professional judgement, can best help me in the restoration of my health. I also understand that the chiropractic care offered in this practice is based on the best available evidence and designed to reduce or correct vertebral subluxation. Chiropractic is a separate and distinct healing art from medicine and does not proclaim to cure any named disease or entity.

Initials ____ I grant permission to use my name in your patient newsletter and on any office bulletin or social media platform for purposes such as, but not limited to, announcing births, birthdays, weddings, graduations or acknowledging my referrals.

Initials ____ I grant permission to be called, emailed, and/or contacted via text to confirm or reschedule an appointment and to be sent occasional cards, letters, texts, emails or health information to me as an extension of my care in this office.

Initials ____ To the best of my ability, the information I have supplied is complete and truthful. I have not misrepresented the presence, severity, or cause of my health concern.

Patient's Signature:____ Date: ______________
Guardian's Signature Authorizing Care:________________________________ Date: ______________

Please help us to serve you better by keeping your regular scheduled appointment. Our practice is committed to providing the best treatment to our patients. Our prices are representative of the usual and customary charges for our area.

 Doctor's Initials ____

Rate your current difficulties by placing the appropriate number in the box (below; a **1 / 2 / 3**).
NO check marks.
If an activity does not cause pain or if pain does not affect an activity, leave box **blank**.

[1] This activity causes some pain, but it is of minor annoyance.
[2] This activity causes a significant amount of pain.
[3] I cannot perform this activity due to pain and disability.

Self-Care and Personal Hygiene: ___bathing ___brushing teeth ___putting on shoes ___doing laundry ___grooming hair ___making bed ___putting on pants ___doing dishes ___washing face ___putting on shirt ___cooking ___taking out trash ___going to bathroom or sitting on toilet

Physical Activities: ___standing ___walking ___reaching ___bending right ___twisting right ___sitting ___squatting ___bending ___bending left ___twisting left ___reclining ___bending back ___kneeling ___looking left ___looking right

Functional Activities: ___carrying small objects ___lifting weight off table ___push/pull standing ___carrying large objects ___climbing stairs/incline ___exercising upper body ___exercising lower body ___carrying purse/case ___lifting objects off floor ___push/pull seated

Social & Recreational Activities: ___jogging ___biking ___swimming ___dancing ___golfing ___bowling ___hunting ___fishing ___gardening ___basketball ___soccer ___hockey ___competitive sports

Difficulties with Travel: ___driving in car ___riding as passenger ___entering and exiting vehicle ___driving for long periods of time ___riding as passenger for long period of time

Other Activities: ___concentrating ___studying ___listening ___reading ___writing ___using computer ___sleeping ___sexual relation

How does your condition interfere with the things you do every day? Please think about the 4 following areas and make notes on how these daily activities have been affected since the condition began.

HOME:

WORK:

RECREATION:

PERSONAL LIFE:

 Doctor's Initials _____ Patient/Guardian Initials _____ Date _____

Oswestry Low Back Pain Disability Questionnaire

Instructions

This questionnaire has been designed to give us information as to how your back or leg pain is affecting your ability to manage in everyday life. Please answer by checking ONE box in each section for the statement which best applies to you. We realise you may consider that two or more statements in any one section apply but please just shade out the spot that indicates the statement which most clearly 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 (e.g. washing, dressing)

- 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 can manage most of my personal care.
- I need help every day in most aspects of self-care.
- I do not get dressed, 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 me extra pain.
- Pain prevents me from lifting heavy weights off the floor I can manage if they are conveniently placed (e.g., on a table.)
- 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.
- I cannot lift or carry anything.

SECTION 4: Walking

- Pain does not prevent me walking any distance.
- Pain prevents me from walking more than 1 mile.
- Pain prevents me from walking more than 1/2 mile.
- Pain prevents me from walking more than 100 yards.
- I can only walk using a stick or crutches.
- I am in bed most of the time.

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 sitting more than 1 hour.
- Pain prevents me from sitting more than 30 minutes.
- Pain prevents me from sitting more than 10 minutes.
- Pain prevents me from sitting at all.

SECTION 6: Standing

- I can stand as long as I want without extra pain.
- I can stand as long as I want but it gives me extra pain.
- Pain prevents me from standing more than 1 hour.
- Pain prevents me from standing for more than 30 minutes.
- Pain prevents me from standing for more than 10 minutes.
- Pain prevents me from standing at all.

SECTION 7: Sleeping

- My sleep is never disturbed by pain.
- Because of pain I have less than 6 hours sleep.
- Because of pain I have less than 4 hours sleep.
- Because of pain I have less than 2 hours sleep.
- Pain prevents me from sleeping at all.
- My sleep is occasionally disturbed by pain.

SECTION 8: Sex Life (if applicable)

- My sex life is normal and causes no extra pain.
- My sex life is normal but causes some extra pain.
- My sex life is nearly normal but is very painful.
- My sex life is severely restricted by pain.
- My sex life is nearly absent because of pain.
- Pain prevents any sex life at all.

SECTION 9: Social Life

- My social life is normal and gives me no extra 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. sport.
- Pain has restricted my social life and I do not go out as often.
- Pain has restricted my social life to my home.
- I have no social life because of pain.

SECTION 10: Traveling

- I can travel anywhere without pain.
- I can travel anywhere but it gives me extra pain.
- Pain is bad but I manage journeys over 2 hours.
- Pain restricts me to journeys of less than 1 hour.
- Pain restricts me to short necessary journeys under 30 minutes.
- Pain prevents me from traveling except to receive treatment.

Patient Name: **Date:** **Score:**

Neck Disability Index

This questionnaire has been designed to give us information as to how your neck pain has affected your ability to manage in everyday life. Please answer every section and mark in each section only the one box that applies to you. We realise you may consider the two or more 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 mild at the moment.
- ○ The pain comes and goes and is moderate.
- ○ The pain is moderate and does not vary much.
- ○ The pain is very severe, but comes and goes.
- ○ The pain is severe and does not vary much.

SECTION 2: Personal Care (e.g. washing, dressing)

- ○ 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 can manage most of my personal care.
- ○ I need help every day in most aspects of self-care.
- ○ I do not get dressed, 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 me extra pain.
- ○ Pain prevents me from lifting heavy weights off the floor I can manage if they are conveniently placed (e.g., on a table.)
- ○ 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.
- ○ I cannot lift or carry anything.

SECTION 4: Reading

- ○ I can read as much as I want to with no neck pain.
- ○ I can read as much as I want with slight neck pain.
- ○ I can read as much as I want with moderate neck pain.
- ○ I cannot read as much as I want because of moderate neck pain.
- ○ I cannot read as much as I want because of severe neck pain.
- ○ I cannot read at all.

SECTION 5: Headache

- ○ I have no headaches at all.
- ○ I have slight headaches which come infrequently
- ○ I have moderate headaches which come infrequently.
- ○ I have moderate headaches which come frequently.
- ○ I have severe headaches which 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 only 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 cannot do any work at all.

SECTION 8: Driving

- ○ I can drive my car without 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 cannot drive my car as long as I want because of moderate pain in my neck.
- ○ I can hardly drive my car at all because of severe pain in my neck.
- ○ I cannot drive my car at all.

SECTION 9: Sleeping

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

SECTION 10: Recreation

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

Patient Name: **Date:** **Score:**