ALL COUNTY CHIROPRACTIC CENTER
Mark Schneiderman, D.C.
4 Walter Foran Blvd., Suite 304
Flemington, NJ 08822
Tel. (908) 788-3624

ALIGNIS Clinical Records System

Patient Health Assessment

Please PRINT or WRITE Clearly

General Information

Patient Name:_____ Date:_____

Provider Name:_____

Primary Care Physician's Name:_____

Patient Sex: M_____ F_____ Date of Birth:_____ Social Security #:_____

Patient Address:_____

Home Phone:_____ Work Phone:_____

Patient Employer:_____ Patient Occupation:_____

Subscriber Name:_____ Relation to Patient:_____

Subscriber Employer:_____ Subscriber Social Security #:_____

Referred for Treatment by:_____

Health Insurance Plan:_____ Group #:_____ Member #:_____

Complaint History

1. Describe your current complaint and how the problem began: _____

How long have you had this condition?_____ **Date of onset:**_____

2. How would you describe pain?

☐ Sharp ☐ Soreness ☐ Throbbing ☐ Tingling ☐ Dull ☐ Stiffness
☐ Spasm ☐ Burning ☐ Ache ☐ Weakness ☐ Numbness ☐ Shooting

ACTIVITIES OF DAILY LIVING PATIENT WOULD LIKE TO DO, BUT CAN'T

DAILY LIVING ACTIVITY
- ☐ FAMILY –RELATED
- ☐ SPORTS –RELATED
- ☐ WORK –RELATED
- ☐ OTHER

4. How often is the pain present?

☐ Constant (81-100%) ☐ Frequent (51-80%) ☐ Occasional (26-50%) ☐ Intermittent (25% or less)

5. Since your problem began is the pain:

☐ Getting worse ☐ Getting better ☐ Staying the same

6. How did your problem begin?

☐ An auto accident ☐ Work related accident ☐ Other type of accident
☐ Gradual ☐ Sudden ☐ No specific reason

Explain: _____

7. What makes your problem better?

☐ Nothing ☐ Walking ☐ Standing ☐ Sitting ☐ Moving around/exercise ☐ Lying down ☐ Inactivity

8. What makes your problem worse?

☐ Nothing ☐ Walking ☐ Standing ☐ Sitting ☐ Moving around/exercise ☐ Lying down ☐ Inactivity

9. Are you currently taking any medications? ☐ Yes ☐ No

If yes, please describe _____

10. Were you previously treated for an earlier occurrence of this *same* condition? ☐ Yes ☐ No

If yes, by whom? ☐ MD ☐ Chiropractor ☐ Physical therapist ☐ Other_____

What were the approximate dates, type of treatment and the results? _____

11. What is your physical activity at work?

☐ Mostly sitting ☐ Light manual labor ☐ Moderate manual labor ☐ Heavy manual labor

ALIGNIS Clinical Records System

Patient Health Assessment (cont.)

12. Do you exercise?

☐ No regular exercise ☐ 1-2 times a week ☐ 3-4 times a week ☐ 5-7 times a week
☐ Cardiovascular ☐ Stretching ☐ Weight Machine ☐ Free Weights ☐ Sports _____ Type

13. What is your present general stress level:

☐ No stress ☐ Minimal stress ☐ Moderate stress ☐ Greatly stressed

14. Is your problem affecting your ability to work or do other routine daily activities?

☐ No effect ☐ Have some limited physical restrictions, but can function
☐ Need some assistance with daily activities ☐ Cannot work
☐ Cannot function without assistance ☐ Totally disabled

Past Or Present Symptoms, Conditions Or Habits

Below is a listing of symptoms, conditions or habits. Please check the box indicating whether this applies to past or present.

Symptom	Past	Present	Symptom	Past	Present
Neck pain	☐	☐	High blood pressure	☐	☐
Shoulder pain	☐	☐	Heart condition	☐	☐
Arm/elbow pain	☐	☐	Respiratory condition	☐	☐
Hand pain	☐	☐	Digestive problems	☐	☐
Upper back pain	☐	☐	Kidney/bladder problem	☐	☐
Lower back pain	☐	☐	Menstrual problems	☐	☐
Pain in upper leg or hip	☐	☐	Breast soreness/lump	☐	☐
Pain in lower leg or knee	☐	☐	Sinus conditions	☐	☐
Pain in ankle or foot	☐	☐	Allergies/asthma	☐	☐
Jaw pain	☐	☐	Cancer	☐	☐
Swelling/stiffness of joints	☐	☐	Stroke	☐	☐
Headaches	☐	☐	Excessive weight loss/gain	☐	☐
Dizziness	☐	☐	Skin condition	☐	☐
Fainting spells	☐	☐	Arthritis	☐	☐
Convulsions	☐	☐	Diabetes	☐	☐
General prolonged fatigue	☐	☐	Prostate condition	☐	☐
Condition of uterus/ovaries	☐	☐			

Tobacco use:
☐ Past ☐ Present
☐ Occasional ☐ Moderate ☐ Heavy

Alcohol use:
☐ Past ☐ Present
☐ Occasional ☐ Moderate ☐ Heavy

Caffeine use: *(Coffee, tea, soft drinks)*
☐ Past ☐ Present
☐ Occasional ☐ Moderate ☐ Heavy

Pregnancy: ☐ Past ☐ Present

Surgical Procedure:
☐ Past ☐ Present

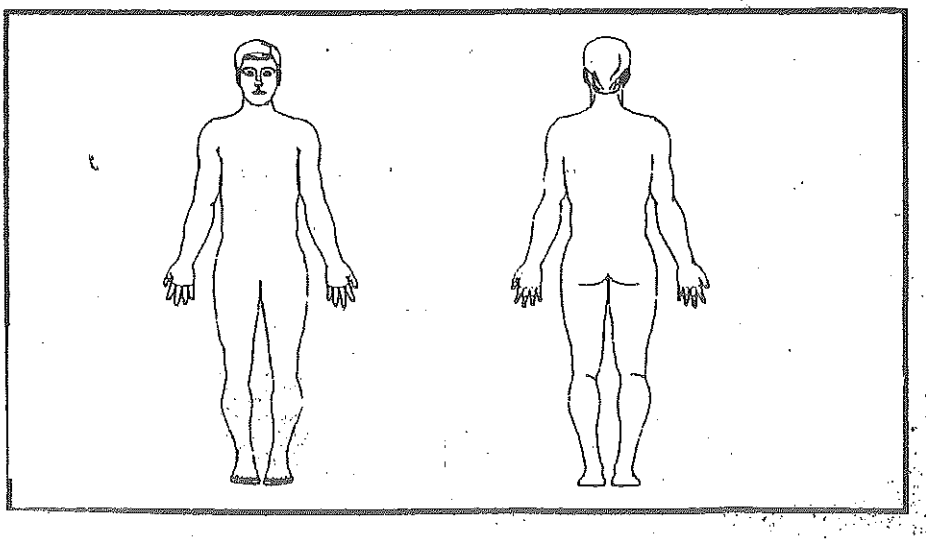
Please list: _____

_____

Comments: _____

_____

Please shade in the figures below where you have pain, or other symptoms:



I have reviewed the information contained on this form with the patient.

_____
Patient Name

_____
Provider Initials

_____
Date

QUADRUPLE VISUAL ANALOGUE SCALE

Patient Name _____ Date _____

Please read carefully:

Instructions: Please circle the number that best describes the question being asked.

Note: If you have more than one complaint, please answer each question for each individual complaint and indicate the score for each complaint. Please indicate your pain level right now, average pain, and pain at its best and worst.

Example:

	Headache				Neck				Low Back		
No pain	0	1	(2)	3	4	(5)	6	7	(8)	9	10	worst possible pain

---

1 – What is your pain RIGHT NOW?

No pain	0	1	2	3	4	5	6	7	8	9	10	worst possible pain

2 – What is your TYPICAL or AVERAGE pain?

No pain	0	1	2	3	4	5	6	7	8	9	10	worst possible pain

3 – What is your pain level AT ITS BEST (How close to "0" does your pain get at its best)?

No pain	0	1	2	3	4	5	6	7	8	9	10	worst possible pain

4 – What is your pain level AT ITS WORST (How close to "10" does your pain get at its worst)?

No pain	0	1	2	3	4	5	6	7	8	9	10	worst possible pain

Other Comments: _____

PATIENT NAME _____ PATIENT SIGNATURE _____

EXAMINER _____ DATE _____

Score: Total all scores; divide by number of regions x 10 = _____ (< 50 LI / > 50 HI)

Reprinted from *Spine*, 18, Von Korff M, Deyo RA, Cherkin D, Barlow SF, Back pain in primary care: Outcomes at 1 year, 855-862, 1993, w/ permission from Elsevier Science.

PATIENT INFORMATION FORM

NAME _____ HOME PHONE _____ WORK PHONE _____ x ____

HOME ADDRESS _____ CITY _____ ZIP CODE _____

SPOUSE'S NAME _____ WORK PHONE _____ x _____

NEAREST RELATIVE NOT LIVING WITH YOU _____ PHONE _____

NEAREST FRIEND NOT LIVING WITH YOU _____ PHONE _____

PHYSICIAN _____ PHONE _____

DENTIST _____ PHONE _____

LANDLORD _____ PHONE _____

WHOM MAY WE CONTACT IN THE CASE OF AN EMERGENCY? _____ PHONE _____

WHOM MAY WE THANK FOR REFERRING YOU TO US? _____ PHONE _____

SOC. SECURITY # _____ D.O.B. _____

WHO IS FINANCIALLY RESPONSIBLE FOR THIS BILL? _____

I WILL BE PAYING TODAY BY CASH _____ CHECK _____

I understand and agree that, (regardless of my insurance status), I am ultimately responsible for the balance on my account for any professional services rendered. I have read all the information on both sides of this sheet and have completed the above answers. I certify this information is true and correct to the best of my knowledge. I will notify you of any changes in my health status or the above information.

_____ Date _____
Signature

_____ Date _____
Parent (if minor)

All County Chiropractic Center
4 Walter Foran Blvd, Suite 304
Flemington NJ 08822
908-788-3624

ABOUT FINANCIAL ARRANGEMENTS AND MEDICAL INSURANCE

We are committed to providing you with the best possible care. If you have medical insurance we are anxious to help you receive your maximum allowable benefits. In order to achieve these goals, we need your assistance, and your understanding of our payment policy.

Payment for services is due at the time services are rendered unless payment arrangements have been made in advance by our staff. For those patients being seen more then once per week we will be happy to extend payment due until the end of each week you are still under treatment. We accept cash, checks and credit/ debit cards with exception of American Express. For those patients with medical insurance, it is very important that you know and understand your policy. We will be happy to assist you by checking with you insurance company about your benefits. Please note, however, that we do not always get the correct information over the telephone with many customer service reps. Since the insurance company will not usually give us anything in writing, should they give us incorrect information, it is ultimately your responsibility as you have the written policy documentation in your possession. It has happened in the past that their computers are not always up to date and if you have changed policies recently we may be given obsolete or incorrect information or even incorrect information concerning precerts and referrals.

If this is an automobile accident please let us know immediately as a separate precert requirement is needed.

At the present time we are not contracted with any insurance companies. Unfortunately it is not possible, at this time, to contract directly with the most popular ones, Aetna, Cigna, United, Oxford and Blue Shield NJ. The reason for this is that they either do not reimburse us, or reimburse us at such a low level for many of the procedures we utilize, that we would not be able to do them. In addition, many of them have recently lowered their fee schedule even further, to a level that we could not possibly even consider them. **WE WOULD JUST NOT BE ABLE TO GIVE YOU THE TIME AND ATTENTION YOU DESERVE AND NEED, AND WE WILL NOT COMPROMISE YOUR HEALTH.** As a result we feel that it is best for you to utilize any out of network benefits you may have. This will allow us to be committed to giving you the time and attention you need for your particular problem. Please also be aware that it is illegal for us to waive any co-pays or deductibles or to have a different fee schedule for patients with or without insurance. The only exception to this rule would be financial hardship. If you feel that this may apply to you please talk to us privately and we will tell you what documentation will be required to qualify for any reduced

fees.

We must emphasize that as a medical provider, our relationship is with you, not your insurance company. We will do our best to verify your benefits and follow whatever rules your managed plan requires. **PLEASE KNOW YOUR BENEFITS.** Any incorrect information we may be given will ultimately be your responsibility.

Please remember that we are always here to help you. We want us to have a good relationship with you and we want you to be comfortable with our treatment and office procedures. If you have any question or concerns, or if temporary financial problems occur please contact us promptly so that we can better assist you.

I have read **"ABOUT FINANCIAL ARRANGEMENTS AND MEDICAL INSURANCE"** and a copy has been given to me if requested.

Signature of Patient

INFORMED CONSENT TO CHIROPRACTIC TREATMENT

Based on your medical history, physical examination and diagnostic studies, All County Chiropractic Center is recommending a course of chiropractic therapy. This may include chiropractic manipulation, physical therapy, and traction treatment for your spinal or extremity pain.

While All County Chiropractic Center believes this recommended therapy to be reasonable and necessary and the anticipated benefits to far outweigh the risks, some patient understandably wonder what complications might occur. Thus, All County Chiropractic thinks that you should be made aware of these risks before you begin your treatment.

For the vast majority of patients, there are few, if any, risks; and most of the risks are minimal, such as spinal or extremity pain, rib or nose fractures. However, in some patients, more serious complications,such as a disc becoming larger by further rupture, paralysis of the legs or organs, or vascular accident, may occur. While none of these complications has ever occurred in our office, should they occur in your case, for your protection, you would be referred immediately to another physician for surgery or other treatment.

This consent is designed to inform rather than to frighten you. Thus, if you have any questions, All County Chiropractic Center will be glad to discuss them with you before beginning treatment.

Sincerely,

All County Chiropractic Center
Dr. Mark I. Schneiderman

I have read and understand the above consent form and understand the risks of the recommended treatment as the treatment and risks of treatment have also been verbally explained to me by my doctor I understand and consent to the treatment being delivered by Dr. Mark Schneiderman. I consent for All County chiropractic Center to provide the recommended chiropractic therapy. No guarantee or assurances of results has been made.

_____ Date

_____ Patient's Signature

HIPAA HAPPENINGS

ALL-COUNTY CHIROPRACTIC

Patient Authorization for contact regarding chiropractic care, related health services and/or related health products.

It is our desire for our staff to use your name, address and/or telephone number for the purpose of contacting you to remind you about scheduled appointments, appointment related issues, advise you about health related meetings, workshops, and products.

The use of this information is intended to make your experience with our office more efficient, productive and to further enhance your access to quality health care.
If you choose not to authorize this use of your information, your decision will have no adverse effect on your care from All-County Chiropractic or on your relationship with our staff.

Your signature indicates your authorization of this activity.

_____ _____ _____

Name (printed) Signature Date

This authorization may be revoked by you at any time. Revocation may be accomplished by advising us in writing of your desire to withdraw your authorization. Please allow a reasonable processing time for the change in our system to be completed.

ALL COUNTY CHIROPRACTIC

THIS NOTICE DESCRIBES HOW CHIROPRACTIC AND MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

In the course of your care as a patient, we may use or disclose personal and health related information about you in the following ways:

*Your personal health information, including of your clinical records, may be disclosed to another health care provider or hospital if it is necessary to refer you for further diagnosis, assessment or treatment.
*Your health care records as well as your billing records may be disclosed to another party, such as an insurance carrier, an HMO, a PPO, or your employer, if they are or may responsible for the payment of your services.
*Your name, address, phone number, and your health care records may be used to contact you regarding appointment reminders, information about alternatives to your present care, or other health related information that may be of interest to you.

If you are not at home to receive an appointment reminder, a message may be left on your answering machine. Further, you have the right to inspect or obtain a copy of the information we will use for these purposes. You also have the right to refuse to provide authorization for this office to contact you regarding these matters. If you do not provide us with this authorization it will not affect the care provide to you or the reimbursement avenues associated with your care.

Under federal law, we are also permitted or required to use or disclose your health information without your consent or authorization in these following circumstances:

*If we are providing health care services to you based on the orders of another health care provider.
*If we provide health care services to you in an emergency.
*If we are required by law to provide care to you and we are unable to obtain your consent after attempting to do so.
*If there are substantial barriers to communicating with you, but in our professional judgement we believe that you intend for us to provide care.
*If we are ordered by the courts or another appropriate agency

Any use or disclosure of your protected health information, other than as outlined above, will only be made upon your written authorization.

We normally provide information about your health to you in person at the time you receive chiropractic care from us. We may also mail information to you regarding your health care or about the status of your account. If you would like to receive this information at an address other than your home or, if you would like the information in a different form please advise us in writing as to your preferences.

You have the right to inspect and/or copy your health information for seven years from the date that the record was created or as long as the information remains in our files. In addition you have the right to request an amendment to your health information. Requests to inspect, copy or amend your health related information should be provided to us in writing.

We are required by state and federal law to maintain the privacy of your patient file and the health protected health information therein. We are also required to provide you with this notice of our privacy practices with respect to your health information.

We are further required by law to abide by the terms of this notice while it is in effect. We reserve the right to alter or amend the terms of this privacy notice. If changes are made to our privacy notice we will notify you in writing as soon as possible following the changes. Any change in our privacy notice will apply for all of your health information in our files.

Information that we use or disclose based on this privacy notice may be subject to re-disclosure by the person to whom we provide the information and may no longer be protected by the federal privacy rules.

If you have a complaint regarding our privacy notice, our privacy practices or any aspect of our privacy activities you should direct your complaint to: Department of Health & Human Services – Office of the Patient Advocate.

If you would like further information about our privacy policies and practices please ask our staff.

This notice is effective as of April 14, 2003. This notice, and any alterations or amendments made hereto will expire seven years after the date upon which the record was created. My signature acknowledges that I have received a copy of this notice.

Name (Printed please) _____ Signature _____ Date _____

If you are a minor, or if you are being represented by another party

Personal Representative Printed _____ Personal Representative Signature _____ Date _____

Description of the authority to act on behalf of the patient. _____

All County Chiropractic Center
Mark Schneiderman, D.C.
4 Walter Foran Blvd., Suite 304
Flemington, NJ 08822

A. Notifier:

B. Patient Name: **C. Identification Number:**

Advance Beneficiary Notice of Noncoverage (ABN)

NOTE: If Medicare doesn't pay for D.Servies listed below, you may have to pay. Medicare does not pay for everything, even some care that you or your health care provider have good reason to think you need. We expect Medicare may not pay for the D.Services listed below.

D.	E. Reason Medicare May Not Pay:	F. Estimated Cost
Spinal Manipulation	Medicare does not pay for chiropractic maintenance care, only active chiropractic care.	$48.00, $58.00 $68.00
Electrotherapy	Medicare does not pay for electro-therapy performed by a chiropractor.	$30.00-$40.00
Traction	Medicare does not pay for this service	$25.00-$30.00
Exams or X-rays	Medicare does not pay for this service by a chiropractor.	Exam-$100.00 X-rays $50.00-$100 ea.

WHAT YOU NEED TO DO NOW:

Read this notice, so you can make an informed decision about your care.
Ask us any questions that you may have after you finish reading.
Choose an option below about whether to receive the D.services listed above.

Note: If you choose Option 1 or 2, we may help you to use any other insurance that you might have, but Medicare cannot require us to do this.

G. Options: Check only one box. We cannot choose a box for you.

☐ **OPTION 1.** I want the D. services listed above. You may ask to be paid now, but I also want Medicare billed for an official decision on payment, which is sent to me on a Medicare Summary Notice (MSN). I understand that if Medicare doesn't pay, I am responsible for payment, but **I can appeal to Medicare** by following the directions on the MSN. If Medicare does pay, you will refund any payments I made to you, less co-pays or deductibles.

☐ **OPTION 2.** I want the D. services listed above, but do not bill Medicare. You may ask to be paid now as I am responsible for payment. **I cannot appeal if Medicare is not billed.**

☐ **OPTION 3.** I don't want the D.services listed above. I understand with this choice I am not responsible for payment, and **I cannot appeal to see if Medicare would pay.**

H. Additional Information: Active care is care by a chiropractor that is received within 30 days of an initial injury when an examination is performed and function is measured.

This notice gives our opinion, not an official Medicare decision. If you have other questions on this notice or Medicare billing, call **1-800-MEDICARE** (1-800-633-4227/TTY: 1-877-486-2048). Signing below means that you have received and understand this notice. You also receive a copy.

I. Signature:	J. Date:

Low Back Pain and Disability Questionnaire (Revised Oswestry)

Patient Name: _____ **File #** _____ **Date:** _____

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 which applies to you. We realize you may consider that two of the statements in any one section relate to you, but please just mark the box which 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 increase the pain but I manage not to change my way of doing it.
- ☐ Washing and dressing increase 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.
- ☐ 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 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 half hour.
- ☐ Pain prevents me from sitting more than 10 minutes.
- ☐ I avoid sitting because it increases pain straight 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 straight 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 - TRAVELLING

- ☐ I get no pain whilst travelling.
- ☐ I get some pain whilst travelling but none of my usual forms of travel make it any worse.
- ☐ I get extra pain whilst travelling but it does not compel me to seek alternative forms of travel.
- ☐ I get extra pain whilst 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 overall is definitely 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.

Pain Severity Scale:

Rate the Severity of your pain by checking one box on the following scale

No pain	0	1	2	3	4	5	6	7	8	9	10	Excruciating Pain

Neck Pain and Disability Index (Vernon-Mior)

Patient Name: _____ File #_____ Date: _____

Please read instructions:

This questionnaire has been designed to give the doctor 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 which applies to you. We realize you may consider that two of the statements in any one section relate to you, but just mark the box which 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, 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 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 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 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 pain in my neck.
- ☐ 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 a few of my usual 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.

Pain Scale:

Rate the Severity of your pain by checking one box on the following scale