Located at 3888 NW Randall Way, Silverdale. On the **SECOND FLOOR** in **SUITE 202.** If you have any question, call the office at (360) 698-4411.

Kitsap Spine and Wellness

VRC _____ **Reviewed w/Patient:** _____/_____

(Complete with blue ink pen) **(**Doctor's Signature and Date)

Last Name _____ First Name _____ **Date** ____/____/____

Address _____ City_____ Zip _____

Home Phone _____Cell Phone _____Email _____

Birthday ___/____/____ Sex: M/F Marital Status: _____ Spouse's or Significant Other's Name _____

Occupation:_____Employer: _____

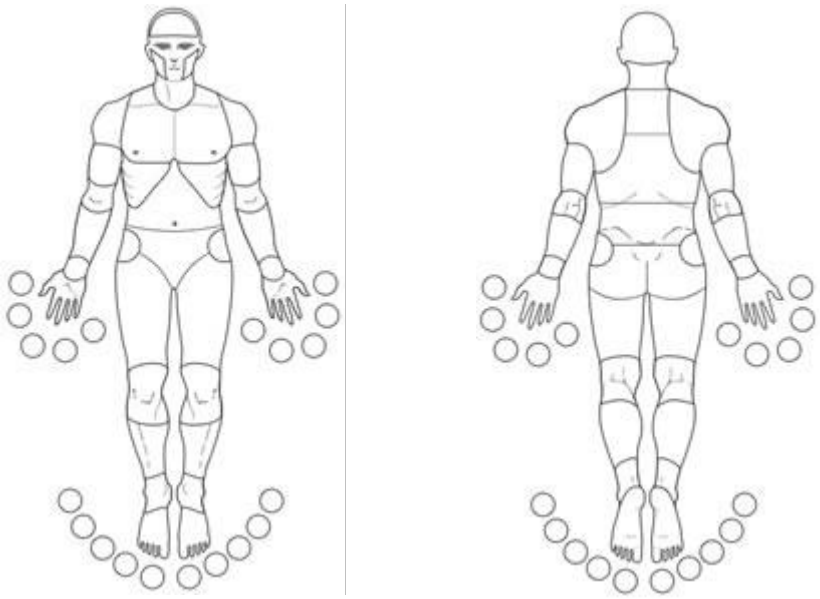
Emergency Contact (name) _____ (phone) _____ (relationship) _____

How did you hear about our clinic? _____

How would you like to receive appointment reminders? □ E-mail □Text (Cellular Carrier _____) □None

On the diagrams to the right, please mark where you are experiencing any symptoms:

<u>Use the following as a guide:</u>
P = Pain
T = Tingling
N = Numbness
B = Burning
W = Weakness



Please rate each of your symptoms individually on a scale of 0-10. (0 = no pain, 10 = worst pain you've ever had)

Symptom #1:_____ □0 □1 □2 □3 □4 □5 □6 □7 □8 □9 □10

Symptom #2:_____ □0 □1 □2 □3 □4 □5 □6 □7 □8 □9 □10

Symptom #3:_____ □0 □1 □2 □3 □4 □5 □6 □7 □8 □9 □10

Symptom #4:_____ □0 □1 □2 □3 □4 □5 □6 □7 □8 □9 □10

Symptom #5:_____ □0 □1 □2 □3 □4 □5 □6 □7 □8 □9 □10

When did your symptoms begin? _____

Are your symptoms getting progressively worse? □Yes □No □Unknown

How often do you have this pain? _____

Is it constant or does it come and go? _____

How would you characterize your pain? (Check all that apply): □Dull □Sharp □Achy □Shooting □Burning
□Stabbing □Throbbing □Stiffness □Other_____

What makes your condition <u>worse</u>? □Coughing □Sneezing □Bearing Down □Lifting □Bending □Pushing
□Pulling □Sitting □Standing □Lying Down □Walking □Moving Your Head □Other_____

What makes your condition better? □Rest □Movement □Sitting □Standing □Lying Down □Bracing □Heat □Ice
□Massage □Stretching □"Popping" □Aspirin □Ibuprofen □Tylenol/Acetaminophen □Prescribed Medication
□Other_____

What time of the day are your symptoms worse? □Morning □Afternoon □Evening □ Sleeping □At Work
□Other_____

What time of the day are your symptoms better? □Morning □Afternoon □Evening □ Sleeping □At Work
□Other_____

Is there any known cause of your symptoms? □Auto Accident □Work Injury □Lifting □Slip/Fall □Overexertion
□Strenuous Position □Unknown □Other_____

If known cause, how soon did the symptoms start? □Immediately □Hours Later □Next Day □Days Later □Week Later
□Other: _____

Have you experienced symptoms like these before? □No □Yes (when?) _____

Have you missed any work due to this condition? □No □Yes (dates?) _____

Have you had to modify or restrict your activities at work? □No □Yes

When your symptoms are at their worst, describe what happens: _____

_____

Previous Testing:

Have you had any of the following testing?

X-ray: Y/N Area: _____ Date: _____ MRI: Y/N Area: _____ Date: _____

CT Scan: Y/N Area: _____ Date_____ EMG/NCV: Y/N Area: _____ Date: _____

Was there a previous diagnosis for your condition? i.e. Have you been told what is causing your problem? _____

_____

Previous Treatment:

Have you ever seen anyone else for this condition? □Yes □No

If Yes, who and when? _____

_____

Treatment Options:

Is there any type of treatment that you would not consider at this time? _____

_____

What is your most important treatment objective? (Reduce pain, increase function, correct cause, prevent Progression) _____

Prescription Medications	**Supplements**	**Allergies**
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
□ See attached list	□ See attached list	

Previous/Current Conditions:

Do you currently have or have you ever had any of the following? (Check all that apply)

□Alcoholism	□Diabetes	□HIV/AIDS	□Rash/Lesion
□Aneurysm	□Dislocated Joints	□Thyroid Hyper/Hypo	□Rheumatic Fever
□Anemia	□Easily Bruised	□Insomnia	□Scoliosis
□Arthritis_____	□Emphysema	□Kidney Trouble	□Spinal Disc Disease
□Asthma	□Epilepsy/Seizures	□Liver Trouble	□STD
□Bone Fractures	□Erectile Dysfunction	□Mental/Emotional	□Stroke
_____	□Fatigue/weakness	Difficulty: _____	□Tinnitus/Ears Ringing
□ Blood Pressure	□Frequent Nose	□Multiple Sclerosis	□Tuberculosis
HIGH/LOW	Bleeds	□Osteoporosis/	□Ulcer
□Cancer/Tumor	□Hearing Changes	Osteopenia	□Other
□Carotid Artery	□Heart Disease	□Pacemaker	_____
Disease or Blockage	□Heart Palpitation	□Polio	□ **None of the above**
□Change in Appetite	□Hernia	□Prostate Trouble	

Have you had any of the following in the last 3 months? (Check all that apply)

□Neck Pain	□Upper Back Pain	□Mid Back Pain	□Low Back Pain	
□Neck Stiffness	□Upper Back Stiffness	□Mid Back Stiffness	□Low Back Stiffness	
□Shoulder Pain	□Hip Pain	□Leg Pain	□Ankle Pain	□Foot Pain

Vascular Screening:

Have you <u>recently</u> experienced any of the following? (Mark all that apply):

□ Double Vision / Sudden Onset of Vision Problems	□ Dizziness, Vertigo or Light-headedness
□ Sudden Numbness/Weakness of Face, Arms or Legs	□ Difficulty Speaking
□ Difficulty Swallowing	□ Difficulty Walking
□ Nausea, Vomiting or Queasiness	□ Numbness or Loss of Sensation on one side
□ Involuntary Rapid Eye Movements (nystagmus)	□ **None of the above**

If you are experiencing Headaches or Neck Pain, have you experienced pain like this before?

□Yes, I have had headaches / neck pain like this before.

□No, this pain is <u>different</u> than I have experienced in the past.

Did your headache or neck pain start suddenly? Y / N

Women Only:

Is there any chance that you may be PREGNANT? Y/N Date of last menstrual period ____/____/____

Lifestyle & Habits:

Smoking (packs per day): □Never □1 □2 □3 □4+ □Quit_____ years ago.

Caffeinated drinks (cups per day): □0 □1 □2 □3 □4 □5 □6+

Alcohol consumption (drinks per day): □0 □1 □2 □3 □4 □5 □6+

Drug/Substance use: □Yes □No

Exercise (times per week): □0 □1 □2 □3 □4 □5 □6 □7 Type of exercise: _____

Average amount of sleep per night (hours): □0 □1 □2 □3 □4 □5 □6 □7 □8 □9 □10 □11 □12

What do you feel your stress level is currently? (0 being no stress and 10 being maximal stress)

□1 □2 □3 □4 □5 □6 □7 □8 □9 □10

Previous Accidents/Injuries/Hospitalizations/Surgeries:

(Please inform us of any/all recent injuries that could have contributed to your current condition.)

Do you have a history of any of the following? □Work Injury □Auto Accident □Slip & Fall Accident

If so please list approximate dates and incident:

1. Date____/____/____Incident _____

2. Date____/____/____Incident _____

Have you ever been hospitalized? □Yes □No If so, when and for what condition?

1. Date____/____/____Condition _____

2. Date____/____/____Condition _____

Have you had any surgeries? □Yes □No If so, when and for what condition?

1. Date____/____/____Surgery _____

2. Date____/____/____Surgery _____

Family History:

Has any member of your family been diagnosed with any of the following?

□Cancer □Diabetes □High Blood Pressure □Stroke □Heart Disease □Other: _____

If yes, what is their relation to you? _____

Have you tried any of the following?				**Results of treatment: (circle one for each)**		
Anti-Inflammatory Meds:	YES	NO	►►	No Relief	Temporary Relief	Worse
Muscle Relaxers (Prescription):	YES	NO	►►	No Relief	Temporary Relief	Worse
Pain Medications (Prescription):	YES	NO	►►	No Relief	Temporary Relief	Worse
Massage Therapy:	YES	NO	►►	No Relief	Temporary Relief	Worse
Physical Therapy:	YES	NO	►►	No Relief	Temporary Relief	Worse
Acupuncture:	YES	NO	►►	No Relief	Temporary Relief	Worse
Chiropractic:	YES	NO	►►	No Relief	Temporary Relief	Worse
Injections (including epidurals):	YES	NO	►►	No Relief	Temporary Relief	Worse
Spinal Surgery:	YES	NO	►►	No Relief	Temporary Relief	Worse

Have you been told you need an injection? YES NO By whom? _____

Have you been told you need spinal surgery? YES NO By whom? _____

What three things has this condition caused you to miss out on the most?

1) _____ 2) _____ 3) _____

What is your biggest concern if you are unable to find a solution to your main problem?

_____

Please indicate how important it is for you to improve your current condition, or stop it from progressing:

Not Important *Very Important*

0 1 2 3 4 5 6 7 8 9 10

Activities of Daily Living

This next series of questions are about the effect your condition has had on your activities of daily life. We also will use this information to measure your progress and the results of your treatment if we are able to accept you for care.

Work:

How do your health problems make it harder to do your job? _____

_____

Are you less productive on your job because of your health problems? □Yes □No

Do you enjoy work less? □Yes □No

Do you have to take more breaks? □Yes □No

Are you concerned about your ability to do your job or the security of your job? □Yes □No

Please explain: _____

Social:

How do your health problems affect your relationships with your family and friends? For example: Are you less fun to be with? Do you help less around the house? Are there things you do less? _____

_____

Recreational Activities:

What hobbies or interests do you have outside of work? _____

_____

When your problems are at their worst, do they affect how you do or enjoy your hobby/interest? □Yes □No

If you didn't have this condition how would it affect how you do your hobbies/interests? _____

_____

Is there anything else you would do more of or just enjoy more if it wasn't for these conditions? _____

_____

_____

Sleep Habits:

Do you have trouble falling asleep due to being uncomfortable? Y/N

How long does it take to fall asleep? _____

Do you wake during the night? Y/N Approximately how many times? _____ Can you get back to sleep? Y/N

How old is the mattress you currently sleep on? _____

What position do you sleep in most? _____

Additional Information & Resources

If you are interested in receiving additional information about any of the following, please check the boxes below:

Conditions

- ☐ Peripheral Neuropathy
- ☐ Sciatica
- ☐ Chronic Headaches
- ☐ Dizziness/ Balance Disorders
- ☐ Whiplash Injuries
- ☐ Mild Traumatic Brain Injury
- ☐ Chronic Back/Neck Pain
- ☐ Joint Pain (Hip, Knee, Foot, Shoulder, Elbow, Hand)

Treatments

- ☐ Non-Surgical Spinal Decompression
- ☐ Cold Laser
- ☐ Massage Therapy
- ☐ Clinical Nutrition
- ☐ Functional Neurology
- ☐ Vitamins/ Supplements
- ☐ Infrared Therapy
- ☐ Whole Body Vibration
- ☐ Interactive Metronome

FINANCIAL POLICY

As a courtesy to you, we will bill your insurance company for you. In order for us to do this for you, we will need you to provide us with the following information: the name of the company, the address to which claims are to be billed, your policy identification number, your group number (if applicable), and a phone number. It is your responsibility to provide any required information (referrals, authorization numbers, claim forms, accident information). It is also your responsibility to follow the policy guidelines of your insurance company. We will bill your secondary insurance as well, provided you have given us complete insurance information as noted above for your secondary company.

Policies vary widely on which procedures, services or items an insurance company will cover. Because policies are often customized, we cannot be sure what your policy covers. In order to maximize your health insurance benefits, it is very important that you familiarize yourself with the policies and benefits outlined in your health insurance handbook or contact the customer service number on the back of your card.

Insurance Company & Phone:_____

Member ID _____ Group #:_____ Name & Date of Birth of ***Policy Holder***: _____

AUTHORIZATION OF RELEASE, ASSIGNMENT OF BENEFITS, STATEMENT OF RESPONSIBILITY

I hereby authorize release of any medical information necessary to process this claim and request payment of insurance benefits either to myself or to the party who accepts assignment. I authorize payment of any medical benefit from third-parties for benefits submitted for my claim to be paid directly to this office. I authorize the direct payment to this office of any sum I now or hereafter owe this office by my attorney, out of proceeds of any settlement of my case and by any insurance company contractually obligated to make payment to me or you based upon the charges submitted for products and services rendered.

I understand and agree that health and accident policies are an arrangement between an insurance carrier and me. Furthermore, I understand that this office will prepare any necessary reports and forms to assist in making collection from the insurance company and that any amount authorized to be paid directly to this office will be credited to my account upon receipt. However, I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment, I also understand that if I suspend or terminate my care and treatment, any fees for products or professional services rendered will be immediately due and payable. I understand that if I have insurance, the fees for services I receive will be billed to my insurance company. I also understand that I am responsible for coinsurance or copays at the time I receive the service, unless prior arrangements have been made.

I have read and understand the terms and conditions stated above.

Patient Name or Responsible Party:

_____Date:_____

(Signature)

Kitsap Spine and Wellness

FINANCIAL DISCLAIMER

The following is an explanation of what to expect and be aware of when it comes to the financial aspect of your treatment at Kitsap Spine and Wellness.

You are legally responsible for your bill at the time you receive services from the clinic. You are ultimately responsible for ensuring that the clinic is reimbursed for the services that we provided to you.
Co-pays are due at time of service. Payment options for a treatment plan will be presented to you after your clinical Report of Findings.

If you have insurance we are not contracted with, we reserve the right to not bill it.

If you have insurance we are contracted with, we will bill it for covered services. Because policies are often customized per plan, we cannot always be sure what your insurance requires of you, which is why we will also verify coverage and benefits as a courtesy to you. Please note that insurance companies consistently issue the disclaimer that quoted benefits are not a guarantee of payment. Please be sure to provide all current insurance info that you would like to be billed. Kitsap Spine and Wellness is responsible for submitting an accurate bill to your insurance company. We recommend that you make yourself aware of what your insurance covers. If you would like a template for questions to ask your insurance, we will provide one upon request. Please note: *Non-covered services, services that do not meet your insurance's criteria of medical necessity, or services that exceed the benefit maximum, will be your financial responsibility*.

We do our best to make our patients aware when an insurance company doesn't process claims the way we were told; however, it is the patient's responsibility to make sure his/ her insurance is processing claims correctly. Your insurance company is responsible for sending you an explanation of benefits (EOB) when it processes claims. If you have any questions regarding information on the EOB, please call your insurance company for details. Your insurance company is responsible for acting in your best interests by paying or declining to pay within a certain number of days from when claims were billed.

It is your responsibility to provide any required information (referrals, authorization numbers, claim forms, accident information). It is also your responsibility to follow the policy guidelines of your insurance company. Policies vary widely on which provider types, procedures, services, or items an insurance company will cover.

If your insurance changes, or if you are involved in an automobile or work accident, please inform us immediately. This allows the clinic to bill correctly, and to follow the required directions of your insurance. If you do not tell us about a change to your insurance within two weeks of the change, a $20 charge will be added to your account for additional administrative work.

Due to the large number of patients and treatments performed, we do not provide monthly statements. If you would like a monthly statement, please make the request with the Front Desk staff. If your insurance company pays your account in full, you will not receive a bill from us unless you specifically request a copy. If our records indicate that you have a balance after your insurance pays, you will receive a statement indicating your account balance. It is Kitsap Spine and Wellness policy to send statements for up to 12 months after your last date of service. This can be due to the time it takes for all claims to be processed accurately.

The consultation and initial exam fees range from $95.00 to $443.00, X-Ray fees range from $80.00 to $279.00, and individual treatment fees range from $55.00-$375.00.

Cancellation/ Missed Appointment Policy: We require 24 hours' business day notice for any physical rehabilitation appointments or you will incur a missed appointment fee of $50.

The patient is responsible for paying an administrative fee for any extra reports and/ or medical records not requested by the insurance company (For example: disability forms, work restriction reports, etc.). Since these reports are not required to process your insurance claim, they are not billable to insurance and the financial responsibility is yours.

AUTHORIZATIONS:

I hereby authorize release of any medical information necessary to prepare and submit claims. I authorize payment of any medical benefits from third parties for claim submitted to be paid directly to this office. I authorize the direct payment to this office of any sum I now or hereafter owe this office by my attorney out of proceeds of any settlement of my case and by any insurance company contractually obligated to make payment to me or you based upon the charges submitted for products and services rendered.

I understand and agree that health and accident policies are an arrangement between an insurance carrier and myself. I understand that if I have insurance, the fees for services I receive will be billed to my insurance company. Furthermore, I understand that this office will prepare any necessary reports and forms to assist in making collection from the insurance company, and that any amount authorized to be paid directly to this office will be credited to my account upon receipt. I clearly understand and agree that I am personally responsible for payment of all services rendered to me. I also understand that if I suspend or terminate my care and treatment, any fees for products or professional services rendered will be due and payable.

I have read and understood all statements on this document.

I, _____, have read and understand the terms and conditions
Signature
stated above.

****

Office

Patient Name: _____Date: _____ ID: _____
Printed Office

Kitsap Spine & Wellness PLLC
Consent for Treatment

I am presenting myself for treatment at *Kitsap Spine & Wellness PLLC*. I voluntarily consent to the rendering of medical care which is determined to be necessary or beneficial in the professional judgment of my practitioner. This includes routine diagnostic procedures and medical treatment by authorized agents and employees of the healthcare facility. I acknowledge that no guarantees have been made to me as to the effect of such examination or treatment on my condition. _____ **(Initial)**

All first visit charges are payable when services are rendered, since it is impossible to determine what Insurance covers without a diagnosis of severity. _____ **(Initial)**

"Time of service" discount for services paid ***PRIOR*** to treatment, otherwise, billed Insurance Prices. In order to keep our prices low for our patients; we are forced to apply an interest charge on any existing balances. _____ **(Initial)**

A **NO SHOW/LATE CANCELLATION FEE** will be charged **$50** ***Adjustment appointments, $100 for Physical Rehabilitation or Trigetics*** *that* are rescheduled /cancelled **without 24 hours' notice.** _____ **(Initial)**

In consideration of the services received or to be received during treatment at *Kitsap Spine and Wellness PLLC*, I assign all insurance benefits due me. I further warrant that *Kitsap Spine and Wellness PLLC* shall be entitled to the full amount of its charges. Any credit balance resulting for any reason will be applied to other existing accounts. **I authorize** *Kitsap Spine and Wellness PLLC to* **bill my insurance company if applicable for services rendered to me, unless otherwise indicated in writing.** I hereby agree to pay any and all charges that exceed or that are not covered by my insurance coverage. THIS ASSIGNMENT SHALL BE IRREVOCABLE. _____ **(Initial)**

I understand and agree that all charges for services rendered to me are ultimately my responsibilities. _____ **(Initial)**

If your payment is made via e-check, paper check, debit/credit card and is returned from the bank as dishonored a $25 returned fee will apply. _____ **(Initial)**

I understand that this information will be used to carry out treatment, payment activities and health care operation. I fully understand that I may revoke my consent in writing at any time and that doing so will be responsible for insurance claims and remittance. _____ **(Initial)**

By signing this form you acknowledge that you had the opportunity to review our Notice of Privacy Practices and that you consent to the use and disclosure of protected health information. I understand that this information can and will be used to:

- Provide and coordinate a treatment plan among a number of health care providers who may be involved in that treatment directly or indirectly.
- Obtain payment from third-party payers for health care services.
- Conduct normal health care operations such as quality assessment and improvement activities.

I have read and fully understand the above statements. All questions regarding the doctor's objectives pertaining to my care in this office have been answered to my complete satisfaction.

_____ _____ _____

Printed Name of Patient | Signature of Patient | Date

I, _____ being the **parent or legal guardian of the aforementioned child h**ave read and fully understand the above terms of acceptance and hereby grant permission for my child to receive care.

_____ _____

Signature of Parent /Guardian | Date

Back Index

ACN Group, Inc. Form BI-100

ACN Group, Inc. Use Only rev 3/27/2003

Patient Name _____ **Date** _____

This questionnaire will give your provider information about how your back condition affects your everyday life. Please answer every section by marking the one statement that applies to you. If two or more statements in one section apply, please mark the one statement that most closely describes your problem.

Pain Intensity

⓪ The pain comes and goes and is very mild.
① The pain is mild and does not vary much.
② The pain comes and goes and is moderate.
③ The pain is moderate and does not vary much.
④ The pain comes and goes and is very severe.
⑤ The pain is very severe and does not vary much.

Sleeping

⓪ I get no pain in bed.
① I get pain in bed but it does not prevent me from sleeping well.
② Because of pain my normal sleep is reduced by less than 25%.
③ Because of pain my normal sleep is reduced by less than 50%.
④ Because of pain my normal sleep is reduced by less than 75%.
⑤ Pain prevents me from sleeping at all.

Sitting

⓪ I can sit in any chair as long as I like.
① I can only sit in my favorite chair as long as I like.
② Pain prevents me from sitting more than 1 hour.
③ Pain prevents me from sitting more than 1/2 hour.
④ Pain prevents me from sitting more than 10 minutes.
⑤ I avoid sitting because it increases pain immediately.

Standing

⓪ I can stand as long as I want without pain.
① I have some pain while standing but it does not increase with time.
② I cannot stand for longer than 1 hour without increasing pain.
③ I cannot stand for longer than 1/2 hour without increasing pain.
④ I cannot stand for longer than 10 minutes without increasing pain.
⑤ I avoid standing because it increases pain immediately.

Walking

⓪ I have no pain while walking.
① I have some pain while walking but it doesn't increase with distance.
② I cannot walk more than 1 mile without increasing pain.
③ I cannot walk more than 1/2 mile without increasing pain.
④ I cannot walk more than 1/4 mile without increasing pain.
⑤ I cannot walk at all without increasing pain.

Personal Care

⓪ I do not have to change my way of washing or dressing in order to avoid pain.
① I do not normally change my way of washing or dressing even though it causes some pain.
② Washing and dressing increases the pain but I manage not to change my way of doing it.
③ Washing and dressing increases the pain and I find it necessary to change my way of doing it.
④ Because of the pain I am unable to do some washing and dressing without help.
⑤ Because of the pain I am unable to do any washing and dressing without help.

Lifting

⓪ I can lift heavy weights without extra pain.
① I can lift heavy weights but it causes extra pain.
② Pain prevents me from lifting heavy weights off the floor.
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).
④ Pain prevents me from lifting heavy weights off the floor, but I can manage light to medium weights if they are conveniently positioned.
⑤ I can only lift very light weights.

Traveling

⓪ I get no pain while traveling.
① I get some pain while traveling but none of my usual forms of travel make it worse.
② I get extra pain while traveling but it does not cause me to seek alternate forms of travel.
③ I get extra pain while traveling which causes me to seek alternate forms of travel.
④ Pain restricts all forms of travel except that done while lying down.
⑤ Pain restricts all forms of travel.

Social Life

⓪ My social life is normal and gives me no extra pain.
① My social life is normal but increases the degree of pain.
② Pain has no significant affect on my social life apart from limiting my more energetic interests (e.g., dancing, etc).
③ Pain has restricted my social life and I do not go out very often.
④ Pain has restricted my social life to my home.
⑤ I have hardly any social life because of the pain.

Changing degree of pain

⓪ My pain is rapidly getting better.
① My pain fluctuates but overall is definitely getting better.
② My pain seems to be getting better but improvement is slow.
③ My pain is neither getting better or worse.
④ My pain is gradually worsening.
⑤ My pain is rapidly worsening.

Index Score = [Sum of all statements selected / (# of sections with a statement selected x 5)] x 100

Back Index Score _____

Neck Index

ACN Group, Inc. Form NI-100

ACN Group, Inc. Use Only rev 3/27/2003

Patient Name _____ **Date** _____

This questionnaire will give your provider information about how your neck condition affects your everyday life. Please answer every section by marking the one statement that applies to you. If two or more statements in one section apply, please mark the one statement that most closely describes your problem.

Pain Intensity

⓪ I have no pain at the moment.
① The pain is very mild at the moment.
② The pain comes and goes and is moderate.
③ The pain is fairly severe at the moment.
④ The pain is very severe at the moment.
⑤ The pain is the worst imaginable at the moment.

Sleeping

⓪ I have no trouble sleeping.
① My sleep is slightly disturbed (less than 1 hour sleepless).
② My sleep is mildly disturbed (1-2 hours sleepless).
③ My sleep is moderately disturbed (2-3 hours sleepless).
④ My sleep is greatly disturbed (3-5 hours sleepless).
⑤ My sleep is completely disturbed (5-7 hours sleepless).

Reading

⓪ I can read as much as I want with no neck pain.
① I can read as much as I want with slight neck pain.
② I can read as much as I want with moderate neck pain.
③ I cannot read as much as I want because of moderate neck pain.
④ I can hardly read at all because of severe neck pain.
⑤ I cannot read at all because of neck pain.

Concentration

⓪ I can concentrate fully when I want with no difficulty.
① I can concentrate fully when I want with slight difficulty.
② I have a fair degree of difficulty concentrating when I want.
③ I have a lot of difficulty concentrating when I want.
④ I have a great deal of difficulty concentrating when I want.
⑤ I cannot concentrate at all.

Work

⓪ I can do as much work as I want.
① I can only do my usual work but no more.
② I can only do most of my usual work but no more.
③ I cannot do my usual work.
④ I can hardly do any work at all.
⑤ I cannot do any work at all.

Personal Care

⓪ I can look after myself normally without causing extra pain.
① I can look after myself normally but it causes extra pain.
② It is painful to look after myself and I am slow and careful.
③ I need some help but I manage most of my personal care.
④ I need help every day in most aspects of self care.
⑤ I do not get dressed, I wash with difficulty and stay in bed.

Lifting

⓪ I can lift heavy weights without extra pain.
① I can lift heavy weights but it causes extra pain.
② Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned (e.g., on a table).
③ Pain prevents me from lifting heavy weights off the floor, but I can manage light to medium weights if they are conveniently positioned.
④ I can only lift very light weights.
⑤ I cannot lift or carry anything at all.

Driving

⓪ I can drive my car without any neck pain.
① I can drive my car as long as I want with slight neck pain.
② I can drive my car as long as I want with moderate neck pain.
③ I cannot drive my car as long as I want because of moderate neck pain.
④ I can hardly drive at all because of severe neck pain.
⑤ I cannot drive my car at all because of neck pain.

Recreation

⓪ I am able to engage in all my recreation activities without neck pain.
① I am able to engage in all my usual recreation activities with some neck pain.
② I am able to engage in most but not all my usual recreation activities because of neck pain.
③ I am only able to engage in a few of my usual recreation activities because of neck pain.
④ I can hardly do any recreation activities because of neck pain.
⑤ I cannot do any recreation activities at all.

Headaches

⓪ I have no headaches at all.
① I have slight headaches which come infrequently.
② I have moderate headaches which come infrequently.
③ I have moderate headaches which come frequently.
④ I have severe headaches which come frequently.
⑤ I have headaches almost all the time.

Index Score = [Sum of all statements selected / (# of sections with a statement selected x 5)] x 100

Neck Index Score _____