

West Bradenton- Pediatric New Patient Intake Form for 12 and under

Name _____ Preferred Name (if applicable) _____

Parent(s)/Guardian Name(s): _____

Address _____ City _____

State _____ Zip Code _____ Preferred Number: Home Cell Work

Home Phone (____) _____ - _____ Cell Phone (____) _____ - _____

Email _____ (for appointment reminders)

Date of Birth: _____ Sex: Male Female Social Security Number: _____ - _____ - _____

Preferred Language: English Other _____ Race/Ethnicity: _____

How were you referred to our office? _____

Pediatrician/Family Medical Doctor I was referred by this physician

Name _____ Phone Number _____

Date of last visit: _____ Reason for last visit: _____

When doctors work together, it benefits you. Do we have your permission to update your medical doctor regarding your care in our office? Y N

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.

Please list who we may speak with regarding you chiropractic care and account (please note, we cannot speak with or release any information to anyone not listed): _____

Guardian's Signature Authorizing Care: _____ Date: _____

Authorization for Care of Minor

I hereby authorize Harbor Chiropractic, its Doctor(s) and Staff, to administer chiropractic care to my Son/Daughter as they deem necessary. I clearly understand and agree that I am personally responsible for payment of all fees at the time services are rendered.

Parent/Guardian Name: _____ Date: _____

Guardian's Signature Authorizing Care: _____ Date: _____

Harbor Chiropractic Office and Financial Policy

Our recommendations are based on a desire to see you get well and stay well. Chiropractic care is covered under many insurance plans. Most of our patients that have health or accident insurance will fall under one of the plans discussed in this policy. Regardless of your coverage, we'll suggest the chiropractic care we think you need. We ask that you read and understand our policy as it applies to your particular situation.

1 Doctor's Initials _____

SCHEDULING

While we do schedule appointments in order to reduce waiting time for you and others, patients are welcome to stop in anytime. Please be aware, however, that walk-in patients will be seen after all regularly scheduled patients have been seen. Although we do not charge for missed or cancelled appointments, we do request 24 hours' notice when possible. In consideration of our other patients, we will be unable to schedule further appointments if three (3) consecutive appointments are missed without notification.

PATIENTS WITHOUT INSURANCE

We request that 100% of the first visit be paid at the time of the visit. For future visits, we will discuss payment options to make you chiropractic care more affordable.

GROUP OR INDIVIDUAL INSURANCE

Your insurance is an agreement between you and your insurance company, not between your insurance company and our office. We cannot be certain if your insurance covers Chiropractic, although most policies do provide coverage. The amount they pay varies from one policy to another. When possible, we will call to verify benefits on your insurance; however, **the benefits quoted to us by your insurance company are not a guarantee of payment.** As a courtesy to you, our office will complete any necessary insurance forms at no additional charge, and file them with your insurance company to help you collect. It is to be understood and agreed that any services rendered are charged to you directly and **you are personally responsible for payment of any non-covered services, deductibles or co-pays.** You may also pay the full amount due each day thereby qualifying for our Time of Service Reduction in fees. You may then submit the bill to your insurance carrier for reimbursement.

PERSONAL INJURY OR AUTOMOBILE ACCIDENTS

Please present your auto insurance card, your health insurance card, and tell us if you have retained an attorney. There are a few options available to the PI patient:

1. Pay cash for your care and we will submit reports whenever necessary.
2. We will bill (accept assignment) from the Med Pay/PIP portion of your auto insurance.
3. We will accept a Letter of Protection or Doctor's Lien from an attorney and await payment at the time of settlement as long as you remain an active patient.

Although you are ultimately responsible for your bill, we will wait for settlement of your claim for up to six months after your care is completed. Once the claim is settled or if you suspend or terminate care, any fees for services are due immediately.

MEDICARE

We do accept assignment from Medicare. The check is usually sent directly to our office in payment of the services that Medicare will cover which for Chiropractors is ONLY manual manipulation of the spine. Medicare pays 80% of the allowable fee once the deductible has been met. You are required to pay the deductible and the remaining 20%. All other services we provide are NON-COVERED. These services include, but are not limited to, x-rays, examinations, therapies, orthotics, supports, and/or nutritional supplements. Medicare patients are fully responsible for charges of non-covered services. Secondary insurance may or may not pay for these non-covered services. Our office completes and files the forms for Medicare at no charge.

SECONDARY INSURANCE

Please inform us of any secondary insurance you may have. We will assist you if you need help in filing but are unable to speak directly.

MANAGED CARE PLANS

We are preferred providers for most insurance companies. Some plans require you to pay a co-pay at the time of service. Other plans may have a deductible amount to be met first. After that deductible has been satisfied, you and your insurance company will share a percentage of the cost that varies from plan to plan. A referral from your primary care physician may also be necessary. Out of network benefits are usually available if a referral is not obtained.

FLEX PLANS/MEDICAL SAVINGS ACCOUNTS

Please inform us if you have a medical savings account, sometimes known as a 'flex plan'. We will be happy to provide you with a statement of your charges for reimbursement.

INSURANCE FORMS/PAYMENT

If you receive any correspondence from your insurance carrier pertaining to the care you have received at this office or a request of more information regarding your care, please bring it in as soon as possible. It is very important that we keep your file as up to date as possible. Occasionally, either by mistake, or due to provisions in your policy, the check issued by the insurance company for payment of services rendered in our office, may come to you instead of the office. If you should receive any unexpected check in the mail, please contact us to see if it does represent payment of your bill here.

I have read and understand the payment/office policy of Harbor Chiropractic. **I understand that my insurance is an arrangement between me and my insurance company, and NOT between Harbor Chiropractic and my insurance company.** I request that Harbor Chiropractic prepare the customary forms at no charge so that I may obtain insurance benefits. I also understand that if my insurance does not respond within 60 days, or if I suspend or terminate my schedule of care as prescribed by the doctors of Harbor Chiropractic that fees will be due and payable immediately.

Guardian's Signature Authorizing Care: _____ Date: _____

Informed Consent

Please read and understand the entire document prior to signing. Should you have any questions, please ask.

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.

As with any healthcare procedure, there are certain complications that can occur as a result of a spinal manipulation. These complications include, but are not limited to: muscle strain, cervical myelopathy, disc and vertebral injury, fractures, strains and dislocations, Bernard-Horner's Syndrome (aka oculosympathetic 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. We are aware of these complications, and in order to minimize their occurrence we 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.

Other treatment options for your condition may include self-administered, over the counter analgesics and rest; medical care and prescription drugs such as anti-inflammatory, muscle relaxants, and pain killers; hospitalization; surgery. Please be aware that there are risks and benefits to the "other treatment options" and you may wish to discuss them with your primary medical physician.

Remaining untreated may allow the formation of adhesions and reduce mobility which may set up a pain reaction further reducing mobility. Over time this process may complicate treatment making it more difficult and less effective the longer it is postponed.

I have read or have had read to me the above explanation of the chiropractic adjustment and related treatment. I have discussed it with Harbor Chiropractic and have had my questions answered to my satisfaction. Having been informed the risks, I hereby give my consent to the treatment.

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.

Guardian's Signature Authorizing Care: _____ Date: _____

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 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.

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/Medical Facility/Hospital: _____

Address: _____

Phone Number: _____ Fax Number: _____

Information to be disclosed include copies of:

- | | |
|---------------------------|-----------------------|
| _____ Entire Record | _____ X-ray Reports |
| _____ Progress Notes | _____ X-ray Films |
| _____ Physical Exam forms | _____ Other, specify: |
| _____ Daily chart notes | _____ |

This authorization will be effective after the date signed, unless cancelled in writing. I understand that the cancellation will have no effect on information released prior to receiving the cancellation. A copy of this authorization is as valid as the original.

Patient's Signature Date: _____

Guardian/Parent/Legal Representative Signature Date: _____

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

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.

Patient's Name: _____ Date: _____

Purpose for Contacting our office: _____

Have Other Doctors Been Seen for this Condition? Yes No

If Yes, List Doctor Name(s) and Prior Treatments: _____

Check Any of the Following Conditions Your Child Has Experienced During the Past Six Months:

- Ear Infections Digestive Problems Car Accident Headaches Asthma / Allergies Bed Wetting
- Chronic Colds Growing / Back Pains Colic Seizures Recurring Fevers Autism Scoliosis
- ADD/ADHD Temper Tantrums Other: _____

Social History: Activity Level: None Light Moderate Vigorous

Hospitalizations: None If yes, list: _____

Surgeries: None If yes, list: _____

Prior Accidents/Injuries/Car Accidents: None If yes, list: _____

According to the National Safety Council, approximately 50% of children fall head-first from a high place during their first year of life (for example: a bed, changing table, stairs, etc.).

Has your child had a head-first fall? Yes No

Is/has your child been involved in any high impact or contact sports (i.e., Soccer, Football, Gymnastics, Baseball, Cheerleading, Martial Arts, etc.)? Yes No List: _____

Childhood Diseases: Please mark all that apply. Chicken Pox Age: _____ Mumps Age: _____
 Rubella Age: _____ Whooping Cough Age: _____ Rubeola Age: _____ Other(s) List: _____

Past Medical History/Current Conditions (Check all that apply to your child) None

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

Current Medications/Supplements: If yes, List: _____

Allergies: None If yes, List: _____

Family History: None

(check if applicable and indicate **F**ather, **M**other, **S**ister, **B**rother)

Arthritis: _____ Cancer: _____ Diabetes: _____ Heart Disease: _____ Hypertension: _____ Stroke: _____

Other: _____

Check if applicable to your child: _____ As an adopted child, little is known of birth parents or family.

Previous Chiropractic Care: Yes No Date of last adjustment: _____

Preferred Method of Adjusting (if applicable): Manual Instrument

Previous Tests: None MRI X-Rays CT Region, Date, and Results: _____

Patient's Name: _____ Date: _____

HISTORY OF PRESENT ILLNESS:

Please answer each section for each individual symptom. (i.e.: Low back pain and neck pain would be completed separately) If only one symptom, only complete region #1. If more than 2 regions of complaint, please request an additional sheet.

#1: Location on body: _____ R / L 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) Intermittently (26-50% of the day) Occasionally (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: _____ R / L 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) Intermittently (26-50% of the day) Occasionally (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.

Patient's Name: _____ Date: _____

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								

Patient's Name: _____ Date: _____

Permission to Examine and Treat a Minor

I _____ hereby give my consent to Harbor Chiropractic/Harbor
(Name of parent or guardian)

Chiropractic of Palmetto, its Doctor(s) and Staff, for Chiropractic examination and treatment of

(Name of minor)

I understand that a guardian shall be aware of/present during all procedures being performed at Harbor Chiropractic/Harbor Chiropractic of Palmetto.

Parent or Guardian Signature

Date

Witness Signature

Date

Patient's Name: _____ Date: _____

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: _____

Patient's Name: _____ Date: _____

Oswestry Disability Index for LOWER BACK PAIN (if applicable)

This questionnaire has been designed to give information as to how your lower back 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 please 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 is very painful.
- 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 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 extra pain.
- Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned (i.e. 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 only very light weights.
- I cannot lift or carry anything at all.

Section 4 – Walking

- Pain does not prevent me walking any distance.
- Pain prevents me walking more than 1mile.
- Pain prevents me walking more than 1/2 of a mile.
- Pain prevents me 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 sit in my favorite chair as long as I like.
- Pain prevents me from sitting for more than 1 hr.
- Pain prevents me from sitting for more than 30 min.
- Pain prevents me from sitting for more than 10 min.
- 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 min.
- Pain prevents me from standing for more than 10 min.
- Pain prevents me from standing at all.

Section 7 – Sleeping

- My sleep is never disturbed by pain.
- My sleep is occasionally 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.

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 cause 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.
- Pain has restricted my social life and I do not go out as often.
- Pain has restricted 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 extra pain.
- Pain is bad but I manage journeys of over 2 hours.
- Pain restricts me to short necessary journeys under 30 min.
- Pain prevents me from traveling except to receive treatment.

Patient's Name: _____ Date: _____

NECK Disability Index for NECK PAIN (if applicable)

This questionnaire has been designed to give 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 please just mark the box which 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 (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, 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 neck pain.
- I can read as much as I want to 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 can hardly read at all because of severe neck pain.
- 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 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 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 any neck pain.
- I can drive my car as long as I want with slight neck pain.
- I can drive my car as long as I want with moderate pain.
- I cannot drive my car as long as I want because of moderate pain in my neck.
- I can hardly drive at all because of severe neck pain.
- I cannot drive my car at all.

Section 9 – Sleeping

- I have no trouble sleeping.
- My sleep is slightly disturbed (< 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 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 cannot do any recreation activities at all.