Patient Name_____ **Date** _____ **Patient Number**_____

CONFIDENTIAL PATIENT CASE HISTORY

Please complete this questionnaire. This confidential history must be completed before treating in our office and will be part of your permanent records. Please answer questions completely and to the best of your knowledge. THANK YOU.

Name _____ Birthday ___/___/___ Soc Sec #___-___-____
Last First MI

Address _____
Street City State Zip

Home Phone (___) ___-_____ Work (___) ___-_____ Cell (___) ___-_____

Sex ☐M ☐F Marital Status: ☐M ☐S ☐D ☐W Chief Complaint_____

Occupation _____ Employer_____

Insurance Company_____ Name/Relationship of Insured_____

ID/Member #_____ Insurance Phone #_____

Who may we thank for referring you? How did you hear about us?_____

Would you like us to send you monthly health topics by email? NO / YES (email_____)

Spouse/Parent Name_____ Birthday___/___/_____ Soc Sec #___-___-____

Spouse/Parent Employer_____ Emergency Phone# (___) ___-_____.

Do you have any children? NO / YES (Names & Ages_____)

Are your present symptoms or conditions related to or the result of an auto accident, work related injury or other personal injury someone else might be responsible for? NO / YES (If yes, date of injury___/___/___)
Have you been in any auto accidents, work injuries, falls or had any other significant personal injury?
NO / YES (Give Explanation &Dates) _____

_____

_____

What is the condition/problem you are concerned with? _____

_____

When did it start? _____ What caused it?_____
Have you had the same/similar conditions in the past? NO / YES (When_____)
Type of Pain: Dull / Sharp / Numbness / Tingling / Stiffness / Burning / Throbbing / Shooting / Achy
Does the Pain: Come and Go/Constant/Other _____ Is the condition: Improved/Unchanged/Getting Worse
Has your condition affected your daily activities? NO / YES (Explain_____)
Do any positions/activities make it feel better?_____
What have you tried to alleviate symptoms?_____
Other doctors or therapists who have treated THIS condition _____
Are you currently taking any medications for this condition? NO / YES (_____)

Have you had any surgeries in the past or are you scheduled for any surgeries in the future?
NO / YES (Give Procedure & Dates) _____

_____

Date of Last Spinal X-Ray _____ Taken at _____ ☐ Normal ☐ Abnormal
Any Known Allergies? NO / YES _____

Family Physician_____ Hospital/Clinic_____

SOCIAL HISTORY Check the boxes and fill in.

Current Weight _____ Have you recently lost or gained weight? _____

Mental Work ☐ Heavy ☐ Moderate ☐ Light Hours per day _____

Physical Work ☐ Heavy ☐ Moderate ☐ Light Hours per day _____

Exercise ☐ Heavy ☐ Moderate ☐ Light Hours per week _____ Type _____

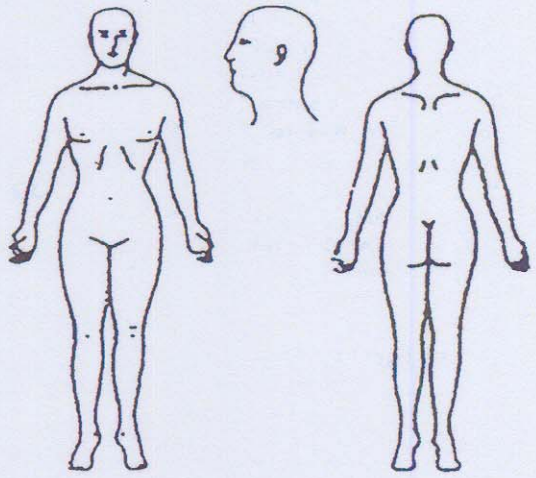
Smoking ☐ Current ☐ Previous Packs/Day _____ No. of years _____

Alcohol Beer/Week _____ Liquor/Week _____ Wine/Week _____ No. of Years _____

Caffeine *(Coffee, Tea, Cola)* Cups/Day _____ No. of Years _____

Aspirin No./Day _____ No. of Years _____ Others _____

MARK THE AREAS OF YOUR SYMPTOMS ON THE FIGURE TO THE RIGHT.



Use the appropriate letter shown for each symptom:

Aches–A Burning-B Pins/Needles-P

Cramps-C Stabbing -S Numbness-N

Rate the severity of your pain on a scale of 1 (least pain) to 10 (severe pain)_____

Legal Assignment & Financial Responsibility

I, the undersigned certify that I (or my dependent) have provided A. Unruh Chiropractic with any and all information necessary to bill all insurance claims for myself, and not providing this information forfeits my ability to have claims sent on to my insurance. I understand that I am financially responsible for all charges whether or not paid by insurance. I will notify A. Unruh Chiropractic of any and all changes to my insurance company or plan before I receive treatment after the time that this information has changed. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I also authorize the use of this signature on all insurance submission. I also assign to A. Unruh Chiropractic all medical benefits and/or insurance reimbursement, if any, otherwise payable to me for services from such doctor and clinic. I hereby authorize any plan administrator or fiduciary, insurer and my attorney to release to such doctor and clinic any and all plan documents, insurance policy and/or settlement information upon written request from such doctor and clinic in order to claim such medical benefits, reimbursement or any applicable remedies. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original. I have read and fully understand this agreement.

After evaluation by Dr. Allen Unruh, he and his staff have explained to me that some of the services that have been prescribed to me and I might choose to receive, may not be a covered benefit as defined by my health insurance policy or certificate. I understand that insurance companies do not pay for services that are not deemed medically necessary. However, I may still choose to receive these services (ex. Hydro, laser, supplements, and supplies). I understand and acknowledge that if I do choose to receive such items, I will be responsible for these items as well as any applicable deductible, co-pay, or coinsurance at the time of service unless prior arrangements were made.

_____ _____

Signature of Patient/Insured/Guardian Date

CHECK ONLY THE ONES YOU HAVE NOW OR HAVE HAD IN THE PAST!!

GENERAL	Now	Past
Weakness	☐	☐
Fatigue	☐	☐
Fever	☐	☐
Chills	☐	☐
Night Sweats	☐	☐
Fainting	☐	☐
SKIN		
Color Changes	☐	☐
Nail Changes	☐	☐
Hair Changes	☐	☐
Moles	☐	☐
Rashes	☐	☐
Sores	☐	☐
Weakness	☐	☐
HEAD		
Headaches	☐	☐
Injuries	☐	☐
Bumps	☐	☐
Last Eye Exam	_____	
Glasses	☐	☐
Contacts	☐	☐
Cataracts	☐	☐
EARS		
Hard of Hearing	☐	☐
Deafness	☐	☐
Ringing	☐	☐
Discharge	☐	☐
Earache	☐	☐
Itching	☐	☐
Dizziness	☐	☐
Room Spins	☐	☐
NOSE		
Decreased Smell	☐	☐
Bleeding	☐	☐
Pain	☐	☐
Discharge	☐	☐
Obstruction	☐	☐
Post Nasal Drip	☐	☐
Deviated Septum	☐	☐
Runny Nose	☐	☐
Sinus Congestion	☐	☐
MOUTH		
Bleeding Gums	☐	☐
Sores	☐	☐
Dental Problems	☐	☐
Bad Breath	☐	☐
Loss of Taste	☐	☐
Dry Mouth	☐	☐
Ulcers	☐	☐
Blisters	☐	☐

THROAT	Now	Past
Soreness	☐	☐
Bad Tonsils	☐	☐
Hoarseness	☐	☐
Pain	☐	☐
Trouble Swallowing	☐	☐
Recurrent Infections	☐	☐
NECK		
Neck Enlargement	☐	☐
Stiff Neck	☐	☐
Soreness	☐	☐
Lumps	☐	☐
Masses	☐	☐
BREASTS		
Discharge	☐	☐
Lumps	☐	☐
Pain	☐	☐
Bleeding	☐	☐
Nipple Changes	☐	☐
Skin Changes	☐	☐
Bloated	☐	☐
LUNGS		
Cough	☐	☐
Phlegm	☐	☐
Blood	☐	☐
Short of Breath	☐	☐
Wheezing	☐	☐
Pain	☐	☐
Congestion	☐	☐
Inhalant Exposure	☐	☐
HEART		
Murmur	☐	☐
Palpitations	☐	☐
Rapid Heartbeat	☐	☐
Swollen Extremities	☐	☐
Cold Extremities	☐	☐
Chest Pain/Pressure	☐	☐
Varicose Veins	☐	☐
Blood Clots	☐	☐
Blue Extremities	☐	☐
BLOOD		
Anemia	☐	☐
Low Blood Iron	☐	☐
Easy Bruising	☐	☐
Easy Bleeding	☐	☐
Swollen Nodes	☐	☐
Painful Nodes	☐	☐
Sugar in Blood	☐	☐
Red Spots	☐	☐

GASTROINTESTINAL	Now	Past
Abdominal Pain	☐	☐
Nausea	☐	☐
Bloated	☐	☐
Belching	☐	☐
Heartburn	☐	☐
Indigestion	☐	☐
Irregular Bowel Habits	☐	☐
Constipation	☐	☐
Diarrhea	☐	☐
Gas	☐	☐
Hemorrhoids	☐	☐
Poor Appetite	☐	☐
Food Intolerance	☐	☐
Bloody Stools	☐	☐
Black Stools	☐	☐
GENITOURINARY		
Urgency	☐	☐
Incontinence	☐	☐
Straining	☐	☐
Back Pain	☐	☐
Frequent Voiding	☐	☐
Stones	☐	☐
Burning	☐	☐
Bed Wetting	☐	☐
Small Stream	☐	☐
Discharge	☐	☐
Impotence	☐	☐
Dribbling	☐	☐
Cloudy Urine	☐	☐
Spotting Between Periods	☐	☐
Menstrual Cramps	☐	☐
Discharge	☐	☐
Itching	☐	☐
Painful Intercourse	☐	☐
Irregular Periods	☐	☐
Hot Flashes	☐	☐
Contraception Type _____		
Menstrual Flow ☐Hvy ☐Lt ☐Mod		
Last Period _____		
Last Pap Smear _____		
Last Mammogram _____		
Last Prostate Exam _____		

NEUROLOGIC	Now	Past
Seizures	☐	☐
Vertigo	☐	☐
Dizziness	☐	☐
Hand Trembling	☐	☐
Incoordination	☐	☐
Loss of Sensation	☐	☐
Loss of Facial Control	☐	☐
Weak Grip	☐	☐
Paralysis	☐	☐
Difficulty Speaking	☐	☐
Tingling	☐	☐
Loss of Memory	☐	☐
Numbness	☐	☐
ENDOCRINE		
Weight Loss	☐	☐
Weight Gain	☐	☐
Extremely Thin	☐	☐
Heat Intolerance	☐	☐
Cold Intolerance	☐	☐
Hair Changes	☐	☐
Breast Changes	☐	☐
MUSCULOSKELETAL		
Muscle Pain	☐	☐
Muscle Weakness	☐	☐
Muscle Cramps	☐	☐
Muscle Twitching	☐	☐
Joint Stiffness	☐	☐
Joint Pain	☐	☐
PSYCHIATRIC		
Hyperventilation	☐	☐
Insecurity	☐	☐
Depression	☐	☐
Troubled Sleep	☐	☐
Undecidedness	☐	☐
Irritable	☐	☐
Extreme Worry	☐	☐
Hallucinations	☐	☐
Loss of Memory	☐	☐
Alcoholism	☐	☐
Drug Addiction	☐	☐
Drug Dependent	☐	☐
Suicidal Thoughts	☐	☐

PAST MEDICAL HISTORY-Check if you've had in the PAST!

Allergies	☐	Heart Trouble	☐	Dysentery	☐	Stroke	☐
Alcoholism	☐	Blood Disease	☐	Hepatitis	☐	Cancer	☐
Depression	☐	Varicose Veins	☐	Gallstones	☐	Ulcers	☐
Epilepsy	☐	Kidney Stones	☐	Leukemia	☐	Polio	☐
Paralysis	☐	Kidney Infections	☐	Liver Trouble	☐	Mumps	☐
Angina	☐	Nervous Breakdown	☐	Diabetes	☐	Tumor	☐
Migraine	☐	Bladder Trouble	☐	Hypertension	☐	Jaundice	☐
Phlebitis	☐	Prostate Problems	☐	Mental Illness	☐	Parasites	☐
Hay Fever	☐	Rheumatic Fever	☐	Skin Trouble	☐	Gout	☐

FEMALES ONLY: I understand that if I'm pregnant and have x-rays taken which expose my lower torso to radiation, it is possible to injure the fetus. I have been advised that the 10 days following onset of a menstrual period are generally considered safe for x-ray exams.

- I am currently Pregnant YES / NO - I could be Pregnant YES / NO -I am late with my menstrual period YES / NO

With Full understanding of the above, and believing that I am not currently at risk, I wish to have an X-ray examination performed now.

Signature_____ **Date**_____

VEHICLE ACCIDENT INFORMATION

PATIENT INFORMATION

Date_____

Patient Name_____

Date of Accident_____ Time of Accident_____ ☐ a.m. ☐ p.m.

Please describe the accident in your own words:_____

_____

_____

_____

Were you the: ☐ Driver ☐ Front Passenger ☐ Rear Passenger ☐ Pedestrian

How many people were in the accident vehicle?_____

ACCIDENT SITE

Road/Street Name_____

City/State_____

Nearest intersection with road/street_____

Driving conditions ☐ Dry ☐ Wet ☐ Icy ☐ Other _____

Which direction were you headed?_____

Speed you were traveling?_____

VEHICLE

Make and model of vehicle you were in:

_____

Were you wearing a seatbelt? ☐ Yes ☐ No

If yes, what type? ☐ Lap ☐ Shoulder

Was vehicle equipped with airbags? ☐ Yes ☐ No

If yes, did it/they inflate properly? ☐ Yes ☐ No

Did your seat have a headrest? ☐ Yes ☐ No

If yes, what was the position of the headrest?

☐ Low ☐ Midposition ☐ High

IMPACT

Did your car impact another vehicle? ☐ Yes ☐ No

Did your car impact a structure? ☐ Yes ☐ No

If yes, explain_____

_____

Did any part of your body strike anything in the vehicle?

☐ Yes ☐ No If yes, explain_____

Was impact from :

☐ Front ☐ Rear ☐ Left ☐ Right ☐ Other_____

At the time of impact were you:

☐ Looking straight ahead ☐ Looking to the right

☐ Looking to the left ☐ Looking down

☐ Looking up

Were both hands on the steering wheel? ☐ Yes ☐ No

If no, which hand was on the wheel? ☐ Right ☐ Left

Was your foot on the brake? ☐ Yes ☐ No

If yes, which foot was on the brake? ☐ Right ☐ Left

Were you: ☐ Surprised by impact ☐ Braced for impact

OTHER VEHICLE

(if applicable)

Make and model of other vehicle_____

Which direction was other vehicle headed?_____

Speed other vehicle was traveling_____

POLICE

Did the police come to the accident site? ☐ Yes ☐ No

Were there any witnesses? ☐ Yes ☐ No

Was a police report filed? ☐ Yes ☐ No

Was a traffic violation issued? ☐ Yes ☐ No

If yes, to whom?_____

– OVER –

#20546 Medical Arts Press 1-800-328-2179

PATIENT CONDITION

Were you unconscious immediately after the accident? ☐ Yes ☐ No If yes, for how long?_____

Please describe how you felt immediately after the accident:

_____

_____

_____

TREATMENT

Did you go to the hospital? ☐ Yes ☐ No

When did you go? ☐ Immediately after accident ☐ Next day ☐ 2 days or more after the accident

How did you get to the hospital? ☐ Ambulance ☐ Private transportation

Name of hospital_____ Name of doctor_____

Diagnosis_____

_____

Treatment received_____

_____

X-rays taken_____

SYMPTOMS/INJURIES

Have you been able to work since this injury? ☐ Yes ☐ No How many work days have you missed?_____

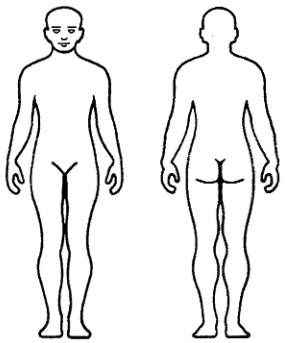
Prior to the injury were you able to work on an equal basis with others your age? ☐ Yes ☐ No

If you have had any of the following symptoms since your injury, please ☑ check:

- ☐ Arm/shoulder pain
- ☐ Back pain
- ☐ Back stiffness
- ☐ Chest pain
- ☐ Dizziness
- ☐ Ear buzzing
- ☐ Ear ringing
- ☐ Fatigue
- ☐ Feet/toe numbness
- ☐ Hand/finger numbness
- ☐ Headaches
- ☐ Irritability
- ☐ Jaw problems
- ☐ Leg pain
- ☐ Memory loss
- ☐ Nausea
- ☐ Neck pain
- ☐ Neck stiff
- ☐ Shortness of breath
- ☐ Sleep difficulty
- ☐ Stomach upset
- ☐ Tension
- ☐ Vision blurred

Is this condition getting progressively worse? ☐ Yes ☐ No ☐ Unknown

Mark an X on the picture where you continue to have pain, numbness, or tingling.



Rate the severity of your pain on a scale from 1 (least pain) to 10 (severe pain)_____

Type of pain:
- ☐ Sharp ☐ Dull ☐ Throbbing ☐ Numbness
- ☐ Aching ☐ Shooting ☐ Burning ☐ Tingling
- ☐ Cramps ☐ Stiffness ☐ Swelling ☐ Other_____

How often do you have this pain?_____

Is it constant or does it come and go?_____

Does it interfere with your: ☐ Work ☐ Sleep ☐ Daily Routine ☐ Recreation

Activities or movements that are painful to perform: ☐ Sitting ☐ Standing ☐ Walking ☐ Bending ☐ Lying Down

I certify that the above information is correct to the best of my knowledge.

Patient Signature_____ Date_____

REVISED OSWESTRY DISABILITY

Name _____ **Date**____/____/_____ **File #**_____

(Please Print)

This questionnaire helps us to understand how much your low back pain has affected your ability to perform everyday activities. Please check the one box in each section that most clearly describes your problem right now.

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 severe.
- ☐ The pain is severe and does not vary much.

SECTION 2 - Personal Care (Washing, Dressing, etc.)

- ☐ 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 gives extra pain.
- ☐ Pain prevents me from lifting heavy weights off the floor.
- ☐ Pain prevents me from lifting heavy weights off the floor, but I can 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 without pain.
- ☐ I can sit only in my favorite chair as long as I like.
- ☐ Pain prevents me from sitting more than 1 hour.
- ☐ Pain prevents me from sitting more than 1/2 hour.
- ☐ Pain prevents me from sitting for more than 10 minutes.
- ☐ I avoid sitting because it increases pain immediately.

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 immediatley.

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 nights sleep is reduced by less than 3/4.
- ☐ Pain prevents me from sleeping at all.

SECTION 8 - Social Life

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

SECTION 9 - Traveling

- ☐ I get no pain while traveling.
- ☐ I get some pain while traveling, but none of my usual forms of travel make it any worse.
- ☐ I get extra pain while traveling, but it does not compel me to seek alternative forms of travel.
- ☐ I get extra pain while traveling 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.
- ☐ My pain is neither getting better nor getting worse.
- ☐ My pain is gradually worsening.
- ☐ My pain is rapidly worsening.

Form by N. Hudson- Cook, K. Tomes-Nicholson, A. Breen. In Roland MO, Jenner JR. Eds. Back Pain.
Manchester University Press 1989: 187-204

ROLAND MORRIS DISABILITY INDEX

Name _____ **Date** ____/____/____ **File#**_____
(Please Print)

When your back hurts, you may find it difficult to do some of the things you normally do. Check the box before each sentence that describes you today. Leave the box blank if the sentence does not describe you.

- ❑ I stay home most of the time because of my back.
- ❑ I change positions frequently to try and get my back comfortable.
- ❑ I walk more slowly than usual because of my back.
- ❑ Because of my back , I am not doing any of the jobs that I usually do around the house.
- ❑ Because of my back, I use a handrail to get upstairs.
- ❑ Because of my back, I lie down to rest more.
- ❑ Because of my back , I have to hold on to something to get out of an easy chair.
- ❑ Because of my back, I try to get other people to do things for me.
- ❑ I get dressed more slowly because of my back.
- ❑ I only stand up for short periods of time because of my back.
- ❑ Because of my back, I try not to bend or kneel.
- ❑ I find it difficult to get out of a chair because of my back.
- ❑ My back is painful almost all of the time.
- ❑ I find it difficult to turn over in bed because of my back.
- ❑ My appetite is not very good because of my back.
- ❑ I have trouble putting on my socks (stockings) because of my back.
- ❑ I only walk short distances because of my back pain.
- ❑ I sleep less well because of my back pain.
- ❑ Because of my back pain, I get dressed with help from someone else.
- ❑ I sit down for most of the day because of my back.
- ❑ I avoid heavy jobs around the house because of my back.
- ❑ Because of my back pain, I am more irritable and bad tempered with people than usual.
- ❑ Because of my back, I go upstairs more slowly than usual.
- ❑ I stay in bed most of the time because of my back.

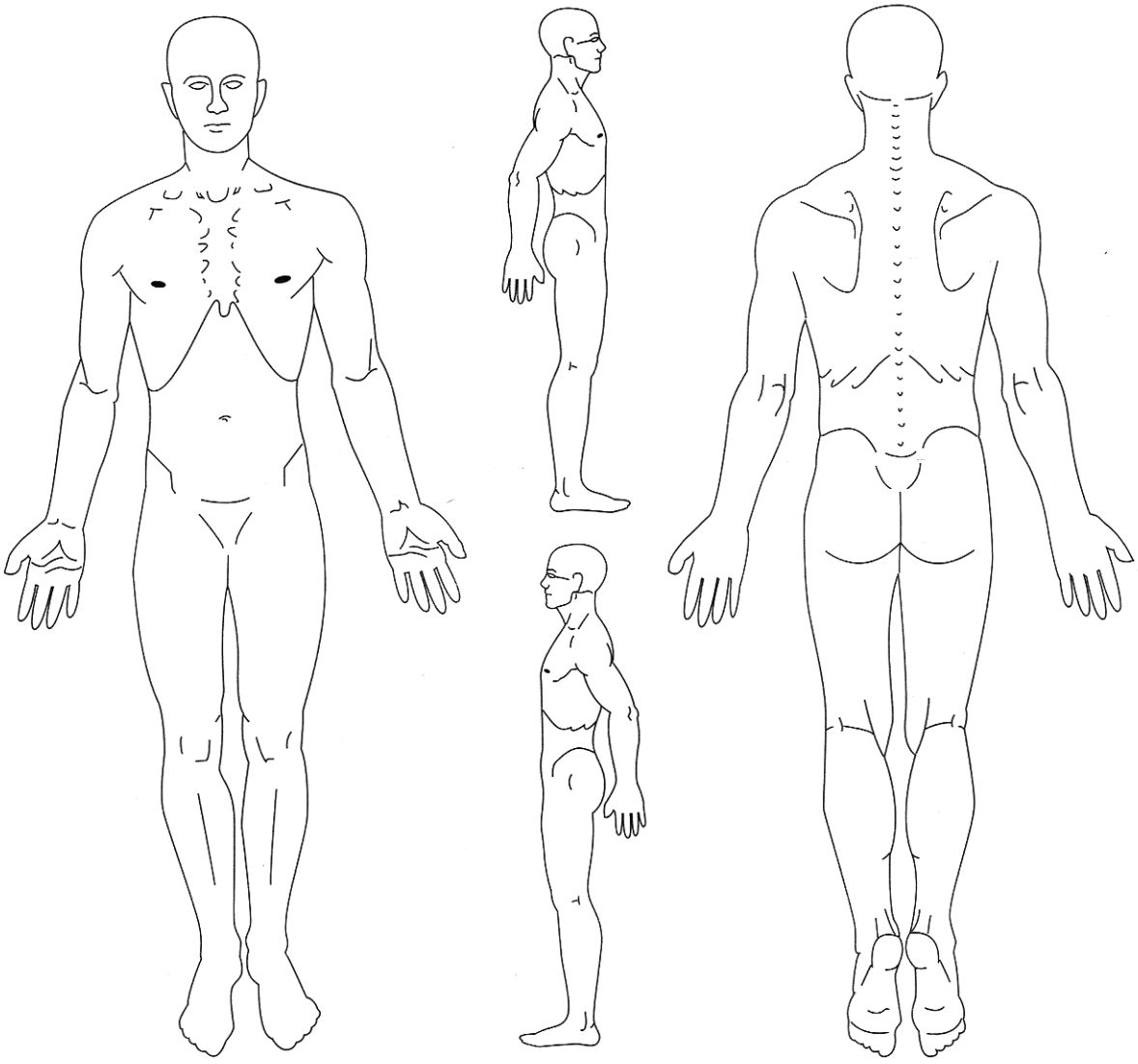
Form by Roland M, Morris R. Spine 1983;8(2):141-144. Lippincott-Raven Publishers

Patient Name(Print)_____ Date_____

Patient ID #_____

Please draw the location of your pain or discomfort on the images below. Use the symbols shown to represent the type(s) of pain:

D = Dull
B = Burning
N = Numb
S = Stabbing/Cutting
T = Tingling (Pins & Needles)
C = Cramping



On the scales below, please draw a vertical line representing your pain or discomfort:

Rate the pain you have right **now:**

No Pain Unbearable Pain

Rate your pain at its **best** in the past week:

No Pain Unbearable Pain

Rate your **average** pain in the past week:

No Pain Unbearable Pain

Rate your **worst** pain in the past week:

No Pain Unbearable Pain

This questionnaire helps us to understand how much your neck pain has affected your ability to perform everyday activities. Please check the one box in each section that most clearly describes your problem right now.

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 coveniently 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.

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SECTION 6 - Concentration

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

SECTION 7- Work

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

SECTION 8 - Driving

- ☐ I can drive my car without 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.