Taylor County Chiropractic Rehabilitation, LLC.

Patient Information Form

Please Print

Patient Information

Electronic access to your health information is available upon request

Full Name _____ **Date** ___/___/___

Language _____ Race ☐ American Indian or Alaska Native ☐ Asian

Ethnicity ☐ Not Hispanic or Latino ☐ Black or African American ☐ White

☐ Hispanic or Latino ☐ Native Hawaiian or Other Pacific Islander

Date of Birth ___/___/___ Sex: ☐ Male ☐ Female Social Security # _____

Home Address _____

Street City State Zip Code

Preferred Method of Contact ☐ Home Phone ☐ Mobile Phone ☐ Email ☐ Letter

Home Phone (___) _____ Work Phone (___) _____ Mobile Phone (___) _____

Home Email _____ Fax # (___) _____

☐ Student ☐ Employed ☐ Unemployed

Employer/School _____

☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

Does your current address match your insurance policy address? ☐ Yes ☐ No

If No: _____

Street City State Zip Code

Primary Care Physician _____ Office # (___) _____

How did you hear about us? _____

Were you referred by a patient? Yes No If yes, please list name _____

Providing this information constitutes your permission for Taylor County Chiropractic and Rehabilitation, LLC to contact you regarding related information via mail, e-mail, fax, and phone.

Consent for Treatment

Authorization expires 3 years from date signed

I request and consent to the performance of chiropractic, examination, adjustment/manipulation and any and all other chiropractic procedures permitted by our State law, including medical records review, various modes of physiotherapy and necessary diagnostic x-rays on myself (or on the patient named below, for whom I am legally responsible) by any of the treating doctors of chiropractic on staff and/or any licensed chiropractor deemed appropriate by the office. I understand that results of treatment are not guaranteed. I further understand and am informed that, as in the practice of medicine, in the practice of chiropractic there are risks associated with treatment, although rare, including, but not limited to, fracture, disc injuries, strokes, dislocations, strains, and worsening symptoms. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely on the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based on the facts then known, and is in my best interest. This consent form covers the entire course of treatment for my present condition and for any future conditions(s) for which I seek treatment.

I understand it is my responsibility to fill out my case history completely and to the best of my knowledge, and to inform the doctor of any information that is not listed on my case history. I also understand that it is my responsibility to inform the doctor of any changes that may occur once I have filled out that information. I authorize Taylor County Chiropractic & Rehabilitation, LLC to treat me.

I have read and understand the foregoing.

Signed: _____ **Date** ___/___/___

Taylor County Chiropractic Rehabilitation, LLC.

Patient Information Form

Please Print

Emergency Information

Name _____ Home Phone ( ) _____ Work Phone ( ) _____

Privacy

Receipt of Notice of Privacy Practices Written Acknowledgement
(Please Initial One)

_____ I was provided a Notice of Privacy Practices by T.C.C.R., LLC to read and keep as my own.

_____ I declined a copy that was offered to me, but I am aware of my rights.

(Please Initial)

_____ I authorize the release of my medical or incidental information necessary to provide continuity of my (the patient's) medical care and to process my (the patient's) medical insurance.

_____ I will allow this office to treat me in both private and open treatment rooms

_____ I will allow this office to record my medical information, including consultation and examination, for documentation purposes, if necessary.

My Protected Health Information may be disclosed to: _____

Financial Policy

(Please Initial all notices)

_____ I understand that I am financially responsible for any balance. Our office participates with all major health plans. We will file primary and secondary claims for you. All deductible and copays are your responsibility.

_____ If your plan requires a referral, it is your responsibility to obtain that referral prior to your visit.

_____ For any services rendered, I authorize the assignment of benefits (payments) from my insurance to come directly to Taylor County Chiropractic Rehabilitation, LLC.

Insurance

Do you have health insurance? ☐ **Yes** ☐ **No**

If no, payment is expected at time of service. We accept Cash, Check, Visa or Mastercard.

Primary Insurance: _____ Secondary Insurance: _____

If yes, are you the policy holder? ☐ **Yes** ☐ **No**

If No, please provide policy holder's information: Name of Policy Holder: _____

Relationship to Patient: _____ Date of Birth: __/__/__

Address _____
Street City State Zip Code

Print Name: _____ **D.O.B.** __/__/__

Signed: _____ **Date** __/__/__

Printed Name:_____

Great News!

Taylor County Chiropractic & Rehabilitation has a great new appointment reminder system that can help you remember your upcoming appointments!

Simply check the boxes below to begin receiving text message, phone call or email reminders the day before your next scheduled appointment. Please update staff if you have a change in your cell/home # and email address.

☐ By checking this box, I hereby give permission to Taylor County Chiropractic & Rehabilitation to notify me via Phone call of my scheduled upcoming appointments. I can revoke permission at any time by notifying staff.

Home Phone Number: _____

☐ By checking this box, I hereby give permission to Taylor County Chiropractic & Rehabilitation to notify me via email of my scheduled upcoming appointments. I can revoke permission at any time by notifying staff.

Email Address: _____

☐ By checking this box, I hereby give permission to Taylor County Chiropractic & Rehabilitation to notify me via text message of my scheduled upcoming appointments. I can revoke permission at any time by notifying staff. Text message charges from my cell phone provider may apply.

Cell phone number: _____

_____ _____

Patient signature Today's date

HIPAA Notice of Privacy Practices

Taylor County Chiropractic & Rehabilitation
100 Greenbriar Drive
Campbellsville, KY 42718
(270-465-5200)

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

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

1. Uses and Disclosures of Protected Health Information

Uses and Disclosures of Protected Health Information
Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law .

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may use or disclose, as-needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

We may use or disclose your protected health information in the following situations without your authorization. These situations include: as Required By Law, Public Health issues as required by law, Communicable Diseases: Health Oversight: Abuse or Neglect: Food and Drug Administration requirements: Legal Proceedings: Law Enforcement: Coroners, Funeral Directors, and Organ Donation: Research: Criminal Activity: Military Activity and National Security: Workers' Compensation: Inmates: Required Uses and Disclosures: Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

Other Permitted and Required Uses and Disclosures Will Be Made Only With Your Consent, Authorization or Opportunity to Objec unless required by law.

You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician's practice ha taken an action in reliance on the use or disclosure indicated in the authorization.

Your Rights
Following is a statement of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information. Under federal law, however, you may not inspect or copy the following records; psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Your physician is not required to agree to a restriction that you may request. If physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively i.e. electronically.

You may have the right to have your physician amend your protected health information. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.

We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

Complaints
You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. **We will not retaliate against you for filing a complaint.**

This notice was published and becomes effective on/or before **June 1, 2019.**

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our Main Phone Number.

Signature below is only acknowledgement that you have received this Notice of our Privacy Practices:

Print Name:_____ Signature_____Date_____

Ta[illegible]County Chiropractic & Reha[illegible]ion, LLC
100 Greenbriar Drive
Campbellsville, KY 42718
(270) 465-5200
www.taylorcountychiropractic.com

Patient Health Information Consent Form

We want you to know how your Patient Health Information (PHI) is going to be used in this office and your rights concerning those records. Before we will begin any health care operations we must require you to read and sign this consent form stating that you understand and agree with how your records will be used. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your Patient Health Information we encourage you to read the HIPAA NOTICE that is available to you at the front desk before signing this consent.

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 effect 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.
11. I understand that this office treats in an open adjusting area, where privacy is limited. I understand that I can meet with the doctor privately in a closed room upon my request. Unless a request is made, it is understood that I will be treated in the open adjusting room.
12. I understand that at some point in the future that if I refer someone to this office, that my name and image may appear on a thank you board or other notation(s) throughout this office, that is in plain view of other individuals that are in this office.

I have read and understand how my Patient Health Information will be used and I agree to these policies and procedures.

Name of Patient:_____
(Please print)

Signature:_____ Date:_____
(Of patient or legal guardian)

For further information regarding this notice, please contact our Doctor at (502) 962-2277

Taylor County Chiropractic Rehabilitation, LLC.

Case History

Please Print

History of Present Illness

Approximately when did the conditions or symptoms begin to occur? _____ (date)

Is this the result of a work injury? ☐ Yes ☐ No Or an Auto Accident? ☐ Yes ☐ No

Describe the conditions, symptoms or purpose of the appointment: _____

Social

Do you smoke? ☐ Yes ☐ No Do you drink alcohol? ☐ Yes ☐ No

Number of packs (per week) _____ Number of drinks (per week) _____

Female patient: **Are you pregnant?** ☐ Yes ☐ No ☐ Unsure but could be

Date of last menstrual cycle: _____ ☐ Regular ☐ Irregular ☐ Using Birth control?

Medications

Please list any current medications:

☐ I will provide a list of medications.

1 _____ Prescribed for: _____

2 _____ Prescribed for: _____

3 _____ Prescribed for: _____

4 _____ Prescribed for: _____

Allergies

Please list any known allergies, and allergies to medications.

1 _____ 3 _____

2 _____ 4 _____

Past Medical History

List any past surgeries (including appendix, tonsils, wisdom teeth, etc)

1 _____ 2 _____

3 _____ 4 _____

List any other hospitalizations & when & for what _____

List any major or minor falls & when they occurred _____

List any cracked or broken bones & when they occurred _____

Vitals

To be filled in by the office staff.

Height	**Weight**	**Blood Pressure**		**Pulse**	
_____ ins.	____ lbs	____/____ mmHG	☐ seated?	_____ BPM	☐ **Right handed** ☐ **Left handed**

Print Name: _____ **D.O.B.** ____/____/____

Signed: _____ **Date** ____/____/____

Taylor County Chiropractic Rehabilitation, LLC.

Case History

Please Print

Additional Information Related to the Condition:

Describe your pain: ☐ Burning ☐ Sharp ☐ Dull ☐ Ache

What caused it? _____

What aggravates it? _____

What relieves it? _____

Has the patient ever had the same or similar symptoms to this condition? ☐ Yes ☐ No

When? ___/___/___

Describe _____

Please indicate any other healthcare providers who the patient has seen for the condition:

Name	Type of Licensure	Date of Last Visit
_____	_____	___/___/___
_____	_____	___/___/___

Have you missed work or school due to your injuries? ☐ Yes ☐ No

Review of Systems

Have you experienced any of the below symptoms in the past 2 weeks or since your last visit?

☐ Headache	☐ Tension	☐ Neck Stiff	☐ Pain in legs/feet
☐ Loss of Memory	☐ Loss of Smell	☐ Face flushed	☐ Sharp / shooting pain
☐ Hands Cold	☐ Burning muscle pain	☐ Nervousness	☐ Neck pain
☐ Numbness arms/hands	☐ Light bothers eyes	☐ Fainting	☐ Ears ring
☐ Coldsweats	☐ Feet cold	☐ Pain in arms/hands	☐ Back pain
☐ Irritability	☐ Tingling in legs/feet	☐ Difficulty swallowing	☐ Loss of Balance
☐ Loss of Strength - Arms	☐ Constipation	☐ Head seems too heavy	☐ Fatigue
☐ Dizziness	☐ Shortness of Breath	☐ Tingling in arms/hands	☐ Jaw pain
☐ Clumsiness	☐ Chest pain/rib pain	☐ Nausea	☐ Other _____
☐ Sleeping Problems	☐ Loss of strength - legs	☐ Numbness legs/feet	_____
☐ Buzzing in ears	☐ Diarrhea	☐ Fever	_____

Changes in Systems

Have you experienced changes to any of the following?

☐ Eyes (sight) ☐ Ears (hearing) ☐ Nose (smell) ☐ Mouth (taste) ☐ Bladder

☐ Bowels ☐ Sleep ☐ Emotion ☐ Appetite Please Explain: _____

Have you been diagnosed with or experienced any of the following?

☐ Fatigue ☐ Depression ☐ Osteopenia/Osteoporosis ☐ Heart Disease ☐ Stroke ☐ Tuberculosis

☐ Obesity ☐ Diabetes ☐ Spinal Degeneration ☐ Autoimmune Disorder (List) _____

☐ Prostate Disorder ☐ Kidney problems ☐ High blood pressure ☐ COPD ☐ Cancer (List) _____

☐ Thyroid Problems ☐ Asthma ☐ Ulcer ☐ Seizure Disorder ☐ Smoker ☐ Other (List) _____

Print Name: _____ **D.O.B.** ___/___/___

Signed: _____ **Date** ___/___/___

Taylor County Chiropractic Rehabilitation, LLC.

Pain Index Questionnaire

Please Print

Pain Index

We would like to know how much your pain presently prevents you from doing what you would normally do. Regarding each category, please indicate the overall impact your present pain has on your life, not just when the pain is at its worst.

Please circle the number which best describes how your typical level of pain affects these six categories of activities.

1. Family/Home responsibilities such as yard work, chores around the house or driving the kids to school -

0 1 2 3 4 5 6 7 8 9 10

completely able to function — totally unable to function

2. Recreation including hobbies, sports or other leisure activities -

0 1 2 3 4 5 6 7 8 9 10

completely able to function — totally unable to function

3. Social activities including parties, theater, concerts, dining-out and attending social functions with friends -

0 1 2 3 4 5 6 7 8 9 10

completely able to function — totally unable to function

4. Employment including volunteer work and homemaking tasks -

0 1 2 3 4 5 6 7 8 9 10

completely able to function — totally unable to function

5. Self-care such as taking a shower, driving or getting dressed -

0 1 2 3 4 5 6 7 8 9 10

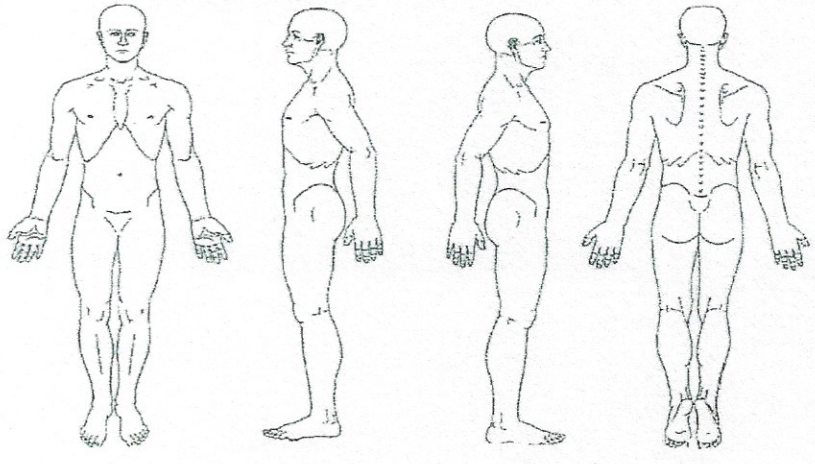
completely able to function — totally unable to function

6. Life-support activities such as eating and sleeping -

0 1 2 3 4 5 6 7 8 9 10

completely able to function — totally unable to function

Score _____ [60] Benchmark -5 = _____



Please mark the areas on the picture below that correspond to the areas of your body where you feel the described sensations. Use appropriate symbols. Mark areas of radiation. Include all affected areas.

Do Not Simply Circle The Affected Area

Numbness ---- Aching ****

Pins & Needles oooo

Burning xxxx Stabbing ////

Print Name: _____ **D.O.B.** ___/___/___

Signed: _____ **Date** ___/___/___

Back Index

Revised

Taylor County Chiropractic & Rehabilitation
100 Greenbriar Dr. Campbellsville, KY 42718
(270) 465-5200 www.taylorcountychiropractic.com

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 effect 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 selections with a statement selected X 5)} X 100

Back Index Score

Neck Index

Revised [illegible]

[illegible] County Chiropractic & Rehabilitation
100 [illegible]briar Dr, Campbellsville, KY. 42718
(270) [illegible]5-5200 www.taylorcountychiro.com

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.

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.

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).

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.

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.

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.

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.

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.

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.

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 of the time.

Index Score = {Sum of all statements selected / (# of selections with a statement selected X 5)} X 100

Neck Index Score