



# CONFIDENTIAL HEALTH INFORMATION

Afford A Care Chiropractic, Inc.  
1223 Brookfield Rd  
P.O. Box 233  
Hubbard, OH 44425  
Phone 330.448.0111  
Fax 330.448.0544

**Please provide your driver's license and insurance card(s) for us to copy**  
We comply with all HIPPA & all federal privacy standards.  
All information supplied is strictly confidential.

\_\_\_\_\_  
Full name including middle initial      SS# \_\_\_\_\_       Male  Female      \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
Gender      Birth date

\_\_\_\_\_  
Address      City \_\_\_\_\_      State \_\_\_\_\_      Zip \_\_\_\_\_

Single  Married  Divorced  Widowed ( ) \_\_\_\_\_ ( ) \_\_\_\_\_ ( ) \_\_\_\_\_  
Marital status      Home phone      Cell phone      Work phone

\_\_\_\_\_  
Email address       Yes  No  
Okay to contact me with this info

\_\_\_\_\_  
Emergency contact – name      Relation      Cell      Home      Work

Home phone  Cell  Work  Email       Insurance  Self-pay  Other \_\_\_\_\_ If work or auto related – inform front desk  
Preferred method of contact      Who is responsible for this bill

Caucasian  African American  Asian  Native American  Latin American  Other \_\_\_\_\_  
Race

Hispanic  Latino  Non-Hispanic/Non-Latino  Other \_\_\_\_\_  
Ethnicity

\_\_\_\_\_  
Who may we thank for referring you to our office?      Primary Care Physician's Name      Primary Care Physician's City & State

Employed full time  Employed part time  Unemployed  Retired  Full time student  Part time student \_\_\_\_\_  
Your employment status

Yes  No      \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
Ever involved in an auto accident?      When?       Yes  No      Any Injuries? If yes, describe

Yes  No \_\_\_\_\_  
Any problems remaining from the above accident? If yes, describe

\_\_\_\_\_  
Patient employed by      Occupation       Yes  No  
Have you missed work due to this problem? If yes, list dates

\_\_\_\_\_  
Address of patient's employer      City \_\_\_\_\_      State \_\_\_\_\_      Zip \_\_\_\_\_

\_\_\_\_\_  
Name of spouse      Spouse employed by      Occupation      \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
DOB of spouse

I have NO insurance      \_\_\_\_\_  
Insurance Carrier      Insured's name      \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
DOB of insured

How important is your health to you (1 = very little; 10 = extremely important):      1    2    3    4    5    6    7    8    9    10

*Please read each statement and initial your agreement to the following:*

\_\_\_\_\_ I hereby authorize Afford A Care Chiropractic, Inc., to furnish information concerning my present illness and DIRECT the insurer to pay without equivocation, directly to them, any and all benefits due him as a result of this claim. I hereby authorize this office to release all information necessary, including diagnosis and the records of any exam or treatment rendered to me, in order to secure the payment of benefits. I am also aware that I am personally responsible for charges &/or balances not covered by my insurance. I understand that it is my personal responsibility to know the coverage of my insurance and if there are any special requirements, such as but not limited to: referral by a primary physician or prior authorization. A copy or scan of this form is as legally acceptable as the original.

\_\_\_\_\_ I authorize Afford A Care Chiropractic, Inc./Clarence L. Wray, Jr., D.C., to send copies of my records to my family physician stated on this form (or later informed to them) as they see fit.

\_\_\_\_\_ To the best of my knowledge, the information I have supplied is complete and truthful. I have not misrepresented the presence, severity, or cause of my concern.

\_\_\_\_\_  
If the patient is a child, print the child's full name      Signature of patient / parent / legal guardian      \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
Date

## Informed Consent to Care

A patient coming to the doctor gives him/her permission and authority to care for them in accordance with appropriate test, diagnosis, and analysis. The clinical procedures performed are usually beneficial and seldom cause any problem. In rare case, underlying physical defects, deformities or pathologies may render the patient susceptible for injury. The doctor, of course, will not provide specific healthcare, if he/she is aware that such care may be contraindicated. It is the responsibility of the patient to make it known or to learn through health care procedures from whatever he/she is suffering from: latent pathological defects, illnesses, or deformities, which would otherwise not come to the attention of the physician. This office does not perform breast, pelvic, prostate, rectal, or full skin evaluations. These examinations should be performed by your family physician, GYN, and dermatologist to exclude cancers, abnormal skin lesions that should undergo biopsy/removal or other treatments. This clinic does not provide care for any condition (such as high blood pressure, diabetes, high cholesterol) other than those addressed in your physical medicine care plan. We also do not prescribe or refill ANY controlled substances. All prescriptions should be refilled by your original prescriber and any new prescriptions should be issued by your primary care provider.

The patient assumes all responsibility/liability if the patient does not report on health forms any past medical history, illnesses, medicines, or allergies.

I agree to settle any claim or dispute I may against or with any of these persons or entities, whether related to the prescribed care or otherwise, will be resolved by binding arbitration under the current malpractice terms which can be obtained by written request.

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
*Patient's Signature*                      *Date*

Chiropractic care, like all forms of health care, while offering considerable benefit may also provide some level of risk. This level of risk is most often very minimal, yet in rare cases injury has been associated with chiropractic care. The types of complications that have been reported secondary to chiropractic care include sprain/strain injuries, irritation of a disc condition, and rarely, fractures. One of the rarest complications associated with chiropractic care, occurring at a rate between one instance per one million to one per two million cervical spine (neck) adjustments may be a vertebral artery injury that could lead to stroke.

Prior to receiving chiropractic care in this Chiropractic office, a health history and physical examination will be completed. These procedures are performed to assess your specific condition, your overall health and, in particular, your spine health. These procedures will assist us in determining if chiropractic care is needed, or if any further examinations or studies needed. In addition, they will help us determine if there is any reason to modify your care or provide you with a referral to another health care provider. All relevant findings will be reported to you along with a care plan prior to beginning care. I understand and accept that there are risks associated with chiropractic care and give consent to the examinations that the doctor deems necessary, and to the chiropractic care including spinal adjustments, as reported following my assessment.

This notice is effective as of the date it is signed and will expire seven years after the date on which you last received services from us.

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
*Patient's Signature*                      *Date*

### ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I have reviewed the Notice of Privacy Practices of Jones Integrated Physical Medicine & Afford A Care Chiropractic, Inc.  
(Please initial one of the following options and sign below.)

\_\_\_\_\_ I wish to receive a paper copy of Privacy Notice.

\_\_\_\_\_ I do not request a copy of the Privacy Notice at this time. I acknowledge that I can request a copy at any time and the Privacy Notice is posted in the office. If I should have a problem or question in regard to my rights, I may speak with the Privacy Officer about my concerns.

I acknowledge that it is the policy of this office to leave reminder messages on my answering machine or with another person in my home. I may make a request of an alternative means of communication (within reason) in writing.

X \_\_\_\_\_  
**Signature of Patient/Guardian**                      **Date**

\_\_\_\_\_  
**Witness (Office Staff)**                      **Date**

# RED FLAG QUESTIONNAIRE

Name \_\_\_\_\_

DATE \_\_\_\_/\_\_\_\_/\_\_\_\_

Age \_\_\_\_

Please check the appropriate response. If "yes", please explain. If you are not sure, check the "?" box.

- | NO                       | YES                      | ?                        |  |
|--------------------------|--------------------------|--------------------------|--|
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Do you have a past history of cancer?                                  |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Have you had any unexplained weight loss?                              |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Does your pain improve with rest?                                      |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Are you over 50 years old?   |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Failure to respond to a course of conservative care (4-6 weeks)?       |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Have you had spinal pain greater than 4 weeks?                         |
|                          |                          |                          |  |
| NO                       | YES                      | ?                        |  |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Prolonged use of corticosteroids (such as organ transplant Rx)?        |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Intravenous drug use?  |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Current or recent urinary tract, respiratory tract or other infection  |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Immunosuppression medication &/or condition                            |
|                          |                          |                          |  |
| NO                       | YES                      | ?                        |  |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | History of significant trauma?   |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Minor trauma in person > 50 years old?                                 |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Do you have osteoporosis (weak bones)?                                 |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Are you over 70 years old?   |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Any history of prolonged use of corticosteroids?                       |
|                          |                          |                          |  |
| NO                       | YES                      | ?                        |  |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Acute onset urinary retention or overflow incontinence (wet underwear) |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Loss of anal sphincter tone or fecal incontinence (bowel accidents)    |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Saddle anesthesia (numbness in the groin region)                       |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Global or progressive muscle weakness in the legs (legs give out)      |

## COMMENTS:

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**Current Conditions:**

- |                                    |  |  |  |  |   |
|------------------------------------|--|--|--|--|---|
| <input type="checkbox"/> Aids      | <input type="checkbox"/> Cancer              | <input type="checkbox"/> Multiple Sclerosis  | <input type="checkbox"/> Spinal Disc Disease         | <input type="checkbox"/> STD's           | <input type="checkbox"/> Ulcer          |
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Bone Fracture       | <input type="checkbox"/> Heart Problem       | <input type="checkbox"/> Low Blood Pressure          | <input type="checkbox"/> Sinus Trouble   | <input type="checkbox"/> Polio          |
| <input type="checkbox"/> Anemia    | <input type="checkbox"/> Cirrhosis/Hepatitis | <input type="checkbox"/> HIV/ARC             | <input type="checkbox"/> Mental/Emotional Difficulty | <input type="checkbox"/> Epilepsy        | <input type="checkbox"/> Scoliosis      |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Diabetes            | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Prostate Trouble            | <input type="checkbox"/> Thyroid Trouble | <input type="checkbox"/> Diverticulitis |
| <input type="checkbox"/> Asthma    | <input type="checkbox"/> Dislocated Joints   | <input type="checkbox"/> Kidney Trouble      | <input type="checkbox"/> Rheumatic Fever             | <input type="checkbox"/> Tuberculosis    |   |

Other – list: \_\_\_\_\_

**Family History of Illness:** *Please check the box if you have a family member with one of the following.*

*In the comment section at the bottom, list the condition and put **M** for mother, **F** for father, or **S** for sibling.*

- |                                    |  |  |  |  |   |
|------------------------------------|--|--|--|--|---|
| <input type="checkbox"/> Aids      | <input type="checkbox"/> Cancer              | <input type="checkbox"/> Multiple Sclerosis  | <input type="checkbox"/> Spinal Disc Disease         | <input type="checkbox"/> STD's           | <input type="checkbox"/> Ulcer          |
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Bone Fracture       | <input type="checkbox"/> Heart Problem       | <input type="checkbox"/> Low Blood Pressure          | <input type="checkbox"/> Sinus Trouble   | <input type="checkbox"/> Polio          |
| <input type="checkbox"/> Anemia    | <input type="checkbox"/> Cirrhosis/Hepatitis | <input type="checkbox"/> HIV/ARC             | <input type="checkbox"/> Mental/Emotional Difficulty | <input type="checkbox"/> Epilepsy        | <input type="checkbox"/> Scoliosis      |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Diabetes            | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Prostate Trouble            | <input type="checkbox"/> Thyroid Trouble | <input type="checkbox"/> Diverticulitis |
| <input type="checkbox"/> Asthma    | <input type="checkbox"/> Dislocated Joints   | <input type="checkbox"/> Kidney Trouble      | <input type="checkbox"/> Rheumatic Fever             | <input type="checkbox"/> Tuberculosis    |   |

Other – list: \_\_\_\_\_

List any past tests and diagnosis for the condition(s) you have come this office for: <input type="checkbox"/> None	
Past treatments (list doctors and hospitals) for this condition and your response: <input type="checkbox"/> None	
List current medications & over-the-counter drugs and dosage (or include a copy): <input type="checkbox"/> None	
List all vitamins/herbs/minerals you are taking: <input type="checkbox"/> None	
List all surgeries and dates: <input type="checkbox"/> None	
List allergies: <input type="checkbox"/> None	
Do you drink alcohol? <input type="checkbox"/> No <input type="checkbox"/> Yes Drinks per week ____	Cigarettes? <input type="checkbox"/> Current every day smoker <input type="checkbox"/> Former smoker <input type="checkbox"/> Current some days smoker <input type="checkbox"/> Never smoked <input type="checkbox"/> Heavy tobacco smoker <input type="checkbox"/> Light tobacco smoker
Caffeine? <input type="checkbox"/> No <input type="checkbox"/> Yes Drinks per day? ____	Exercise? <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Light <input type="checkbox"/> Moderate <input type="checkbox"/> Strenuous Hours per week? ____
Additional Comments:	

Signature \_\_\_\_\_

Date \_\_\_\_/\_\_\_\_/\_\_\_\_

# Review of Systems

Name \_\_\_\_\_

Date \_\_\_\_/\_\_\_\_/\_\_\_\_

## CONSTITUTIONAL

- Appetite change
- Fatigue

## NONE OF BELOW

- Fever
- Weakness

- Weight loss
- Trouble Sleeping

- Night sweats
- Chills

- Weight gain
- Restlessness

## EYES

- Blurry
- Pain
- Cataracts

## NONE OF BELOW

- Double vision
- Sensitivity to light
- Other \_\_\_\_\_

- Vision loss
- Glaucoma

- Tearing
- Flashing lights

- Redness
- Specks

## EAR/NOSE/THROAT

- Ringing in ears
- Mouth/throat irritation
- Sore throat
- Altered taste/smell
- Thrush

## NONE OF BELOW

- Ear pain
- Tooth problem
- Hoarseness
- Voice change
- Neck lumps

- Nasal congestion
- Sinus pain
- Decreased hearing
- Swollen glands in neck
- Other \_\_\_\_\_

- Nasal drainage
- Sore tongue
- Bleeding gums
- Earaches

- Nose bleeds
- Dry mouth
- Bad breath
- Ear drainage

## CARDIOVASCULAR

- Chest pain/pressure
- High blood pressure
- Swelling

## NONE OF BELOW

- Heart racing
- Low blood pressure
- Difficulty breathing lying down

- Palpitations
- Tightness
- Sudden awakening shortness of breath

- Sweating
- Shortness of breath
- Other \_\_\_\_\_

- Leg swelling
- Anemia

## RESPIRATORY

- Cough
- Painful breathing

## NONE OF BELOW

- Yellow/green sputum
- Asthma

- Blood in sputum
- Recurrent respiratory infection

- Shortness of breath
- Other \_\_\_\_\_

- Wheezing

## GASTROINTESTINAL

- Swallowing difficulties
- Pain
- Change in bowel Habits

## NONE OF BELOW

- Nausea
- Blood in stool
- Rectal bleeding

- Vomiting
- Blood in vomitus
- Stomach pain or Cramping

- Diarrhea
- Heartburn
- Other \_\_\_\_\_

- Constipation
- Change in appetite

## GENITOURINARY

- Incontinence
- Pain
- Urgency
- Change in urinary strength

## NONE OF BELOW

- Abnormal bleeding
- Impotence
- Uterine fibroids

- Abnormal discharge
- Sexual problem
- Ovarian cysts
- Other \_\_\_\_\_

- Urinary frequency
- Infection
- Cancer

- Urinary hesitancy
- Urinary retention
- Prostate problems

## MUSCULOSKELETAL

- Muscle or joint pain
- Trauma
- Rheumatoid arthritis

## NONE OF BELOW

- Stiffness
- Arthritis
- Chronic pain

- Back pain
- Weakness
- Other \_\_\_\_\_

- Redness of joints
- Muscle wasting

- Swelling of joints
- Sprain/fracture

## INTEGUMENTARY

- Rashes
- Hair and nail changes
- Other \_\_\_\_\_

## NONE OF BELOW

- Lumps
- Eczema

- Itching
- Excessive sweating

- Dryness
- Easy bruising

- Color changes
- Increased bleeding

## NEUROLOGICAL

- Headache
- Change in hearing
- Shaking

## NONE OF BELOW

- Dizziness
- Loss/change sensation
- Speech problem

- Change in voice
- Trouble walking
- Seizures

- Change in taste
- Balance problem
- Migraines

- Change in vision
- Coordination problem
- Other \_\_\_\_\_

## MENTAL

- Nervousness
- Irritability

## NONE OF BELOW

- Stress
- Confusion

- Depression
- Anxiety

- Memory loss
- Other \_\_\_\_\_

- Mood swings

## ENDOCRINE

- Cold intolerance
- hot flashes/sweats
- Change in appetite

## NONE OF BELOW

- Heat intolerance
- Change in body hair
- Inability to lose weight

- Blood sugar problem
- Change in libido
- Weight loss for no reason

- Weight gain
- Increased thirst
- Other \_\_\_\_\_

- Missed periods
- Increased urination

## HEMATOLOGIC

- Bruising easily
- Other \_\_\_\_\_

## NONE OF BELOW

- Bleed easily

- Swelling

- Anemia

- Enlarge lymph node

## ALLERGIC/IMMUNOLOGIC

- Itch
- Other \_\_\_\_\_

## NONE OF BELOW

- Post-nasal drip

- Watery/itchy eyes

- Nasal drainage

- Immunosuppressed

# **BACK INDEX**

Patient Name \_\_\_\_\_

Date \_\_\_\_/\_\_\_\_/\_\_\_\_

*This questionnaire will give your provider information about how your back condition affects your everyday life. Please answer every section by **circling** the number for the one statement that applies to you. If two or more statements apply, circle 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

## ***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 or 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

## ***Walking***

- 0 I have not 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

## ***Sitting***

- 0 I can sit in any chair for as long as I like
- 1 I can only sit in my favorite chair for 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

## ***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

## ***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

## ***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

## ***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

***If you have been involved in an accident or if you have had something happen (example: you lifted something or slipped) please tell the doctor)***

*This questionnaire will give your provider information about how your back condition affects your everyday life. Please answer every section by **circling** the number for the one statement that applies to you. If two or more statements apply, circle 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

**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

**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

**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

**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 severe 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

**Sleeping**

- 0 I have no difficulty sleeping
- 1 My sleep is slight 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)

**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 of my usual recreation activities because of neck pain
- 3 I am only able to engage in a few of my usual recreating 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

***If you have been involved in an accident or if you have had something happen (example: you lifted something or slipped) please tell the doctor)***