IMPORTANT NOTICES

Do not begin filling out paperwork until you have read these notices!

1. If for **ANY** reason (high deductible, accident, etc.) you DO NOT want your insurance company to be billed for the services rendered by our clinic, please DO NOT provide us with your insurance information. In the event we obtain insurance information from you, we are required by law to submit the charges to your insurance company.

2. We **MUST** have an official job description sent to us from your employer or Human Resources representative. If your employer cannot immediately fax (815-459-3990) or email (info@strelcheckchiro.com) this information to us, please identify your official job description at www.occupationalinfo.org and print a copy for our file.
If you are unemployed, retired, work out of your home or your job duties are not accurately listed on this website, please notify us and we will assist you in completing this requirement.

Strelcheck Chiropractic and Massage Clinic
10 N. Virginia Street · Crystal Lake · Illinois · 60014
Tel: 815-459-3860
Fax: 815-459-3990
Email: Info@Strelcheckchiro.com

MUST USE GUIDE

This chart MUST be used when referencing any questions related to pain scales. Do NOT fill out this form. It is for reference purposes only.



10 **Worst imaginable pain**. Causes you to be completely incapacitated and barely able to talk. Requires immediate emergency hospitalization.

8-9 Pain that causes disability between levels 7 and 10. Nearing need for hospitalization.

7 **Severely disabling pain**. You cannot use or move the painful area. You have difficulty talking and concentrating on anything but the pain. Needing to lie down and/or pain-related tearfulness are common at this level of pain.

6 Pain that causes disability between levels 5 and 7.

5 **Very disabling pain**. Causes great difficulty moving or applying any strength through the painful area. You are unable to complete the current activity.

4 Pain that causes disability between levels 3 and 5

3 **Functionally disabling pain**. Pain that is starting to affect your ability to perform the current activity. (i.e., decreased movement, decreased speed, and/or the need to briefly rest and/or stretch in order to continue completing the current activity)

2.75 To 0.25 Non disabling pain. The pain is present, but not yet at a level which limits you from performing the current activity.

0 **No pain or discomfort**.

Patient Summary Form

PSF-750 (Rev:2/18/2009)

Instructions
Please complete this form within the specified timeline and fax to the specified fax number as indicated on Plan Summary or plan information previously provided.

*Fax number may vary by plan.

Patient Information

Patient name: Last | First | MI

○ Female ○ Male

Patient date of birth

Patient address | City | State | Zip code

Patient insurance ID# | Health plan | Group number

Referring physician (if applicable) | Date referral issued (if applicable) | Referral number (if applicable)

Provider Information

1. Name of the billing provider or facility (as it will appear on the claim form)

2. Federal tax ID(TIN) of entity in box #1

3. Name and credentials of the individual performing the service(s)

1 MD/DO 2 DC 3 PT 4 OT 5 Both PT and OT 6 Home Care 7 ATC 8 MT 9 Other ____

4. Alternate name (if any) of entity in box #1

5. NPI of entity in box #1

6. Phone number

7. Address of the billing provider or facility indicated in box #1

8. City

9. State

10. Zip code

Provider Completes This Section:

Date you want *THIS* submission to begin:

Patient Type

1. New to your office
2. Est'd, new injury
3. Est'd, new episode
4. Est'd, continuing care

Cause of Current Episode

1. Traumatic
2. Unspecified
3. Repetitive
4. Post-surgical →
5. Work related
6. Motor vehicle

Date of Surgery

Type of Surgery

1. ACL Reconstruction
2. Rotator Cuff/Labral Repair
3. Tendon Repair
4. Spinal Fusion
5. Joint Replacement
6. Other _____

Diagnosis (ICD code)
Please ensure all digits are entered accurately

1° 2° 3° 4°

Nature of Condition

1. Initial onset (within last 3 months)
2. Recurrent (multiple episodes of < 3 months)
3. Chronic (continuous duration > 3 months)

DC ONLY
Anticipated CMT Level

○ 98940 ○ 98942 ○ 98941 ○ 98943

Current Functional Measure Score

Neck Index | DASH | (other)

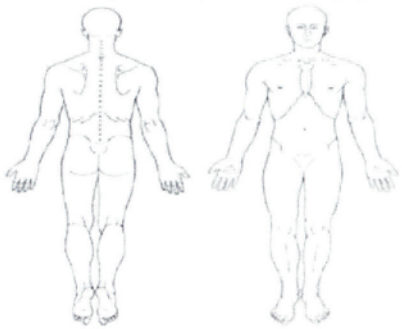
Back Index | LEFS

Patient Completes This Section:

(Please fill in selections completely)

Symptoms began on:

Indicate where you have pain or other symptoms:



1. Briefly describe your symptoms:

2. How did your symptoms start?

3. Average pain intensity:

Last 24 hours: **no pain** 0 1 2 3 4 5 6 7 8 9 10 **worst pain**

Past week: **no pain** 0 1 2 3 4 5 6 7 8 9 10 **worst pain**

4. How often do you experience your symptoms?

1. Constantly (76%-100% of the time)
2. Frequently (51%-75% of the time)
3. Occasionally (26% - 50% of the time)
4. Intermittently (0%-25% of the time)

5. How much have your symptoms interfered with your usual daily activities? (including both work outside the home and housework)

1. Not at all
2. A little bit
3. Moderately
4. Quite a bit
5. Extremely

6. How is your condition changing, since care began at *this* facility?

0. **N/A — This is the initial visit**
1. Much worse
2. Worse
3. A little worse
4. No change
5. A little better
6. Better
7. Much better

7. In general, would you say your overall health right now is...

1. Excellent
2. Very good
3. Good
4. Fair
5. Poor

Patient Signature: X _____ **Date:** _____

United Health Care Patient Summary Form

Patient Name _____ Date of Birth: _____
Address _____ Home Phone _____
Email Address _____ Cell Phone _____
Previous Address (if less than 2yrs) _____
Emergency Contact Name and Phone No. _____
Occupation: _____ How long _____ Work Phone _____
Employer Name and Address _____
Spouse Name _____ Spouse Employer _____
Insurance Subscriber's Name and Date of Birth _____
Insurance Subscriber's Social Security # _____ Policy # _____
Primary Care Physician _____ Phone _____
Referred By _____ Phone _____

Describe your current problem and how it began _____
_____

Is this □ work related injury □ auto related injury - If so, date of incident _____

Have you been treated previously for this condition? Y / N
If yes, by whom? (Doctor or hospital) _____ Release Date _____

Have you had X-Rays, MRI, CT Scan or other treatment for this injury prior to your visit today?
If so, list treatment rendered, location and date _____
_____

Have you had any previous surgeries, trauma, accidents, falls, etc.? If so, please explain: _____
_____

Are you currently on any medication? Y/N If so, please list _____
What is the medication for? _____

Do you have a family history of any of the following: □ Rheumatoid Arthritis
□ Cancer □ Diabetes □ High Blood Pressure □ Heart Problems/Stroke

For each of the conditions listed below, place a check in the "past" column if you have had the condition in the past. If you presently have a condition listed below, place a check in the "present" column.

Check box if none of the conditions apply □

Past	Present		Past	Present		Past	Present	
[ ]	[ ]	Headaches	[ ]	[ ]	High Blood Pressure	[ ]	[ ]	Diabetes
[ ]	[ ]	Neck Pain	[ ]	[ ]	Heart Attack	[ ]	[ ]	Excessive Thirst
[ ]	[ ]	Upper Back Pain	[ ]	[ ]	Chest Pains	[ ]	[ ]	Frequent Urination
[ ]	[ ]	Mid Back Pain	[ ]	[ ]	Stroke	[ ]	[ ]	Smoking/Tobacco Use
[ ]	[ ]	Low Back Pain	[ ]	[ ]	Angina	[ ]	[ ]	Drug/Alcohol Dependence
[ ]	[ ]	Shoulder Pain	[ ]	[ ]	Kidney Stones	[ ]	[ ]	Allergies _____
[ ]	[ ]	Elbow/Upper Arm Pain	[ ]	[ ]	Kidney Disorders	[ ]	[ ]	Depression
[ ]	[ ]	Wrist Pain	[ ]	[ ]	Bladder Infection	[ ]	[ ]	Systemic Lupus
[ ]	[ ]	Hand Pain	[ ]	[ ]	Painful Urination	[ ]	[ ]	Epilepsy
[ ]	[ ]	Hip Pain	[ ]	[ ]	Loss of Bladder Control	[ ]	[ ]	Dermatitis/Eczema/Rash
[ ]	[ ]	Upper Leg Pain	[ ]	[ ]	Prostate Problems	[ ]	[ ]	HIV/AIDS
[ ]	[ ]	Knee Pain	[ ]	[ ]	Abnormal Weight Gain/Loss	[ ]	[ ]	Loss of Appetite
[ ]	[ ]	Ankle/Foot Pain	[ ]	[ ]	Abdominal Pain	[ ]	[ ]	Ulcer
[ ]	[ ]	Jaw Pain	[ ]	[ ]	Liver/Gall Bladder Disorder	[ ]	[ ]	Hepatitis
[ ]	[ ]	Joint Pain/Stiffness	[ ]	[ ]	General Fatigue	[ ]	[ ]	Muscular Incoordination
[ ]	[ ]	Arthritis	[ ]	[ ]	Visual Disturbances	[ ]	[ ]	Hormonal Replacement
[ ]	[ ]	Rheumatoid Arthritis	[ ]	[ ]	Dizziness	[ ]	[ ]	Pregnancy
[ ]	[ ]	Cancer	[ ]	[ ]	Tumor	[ ]	[ ]	Birth Control Pills
[ ]	[ ]	Asthma	[ ]	[ ]	Chronic Sinusitis			

Please check all of the following that apply to you. **Check box if none of the conditions apply.** □

□ Alcohol/Drug Dependence	□ Tobacco Use (Type/Freq.) _____
□ Urinary Problems	□ Prostate Problems
□ Recent Fever	□ Menstrual Problems
□ Diabetes	□ Currently Pregnant, # Weeks _____
□ High Blood Pressure	□ Taking Birth Control Pills
□ Stroke (Date) _____	□ Abnormal Weight □ Gain □ Loss
□ Marked Morning Pain/Stiffness	□ Corticosteroid Use (Cortisone, Prednisone, etc.)
□ Pain at Night	□ Pain Unrelieved by Position or Rest
□ Dizziness/Fainting	□ Numbness in Groin/Buttocks
□ Visual Disturbances	□ Osteoporosis
□ Epilepsy/Seizures	□ Cancer/Tumor (Explain) _____
□ Heart Problems	□ Other Health Problems (Explain) _____

Strelcheck Chiropractic and Massage Clinic Policies

1. Payment is due at the time of service, or in accordance with my financial agreement.
2. I understand that an insurance contract is between the patient and the patient's insurance company. Coverage for Chiropractic care varies from company to company and policy to policy. SCC, Inc. as a courtesy and in an effort to serve our patients to the best of our ability will file the insurance claims on behalf of the patient, however. It is the patient's ultimate responsibility to keep the account current. SCC, Inc. cannot accept responsibility for collecting your insurance claim or for negotiating a settlement on a disputed claim.
3. Patients involved in litigation (lawsuits) are, as others, ultimately responsible for their treatment charges.
4. We reserve the right to bill for missed appointments.
5. I agree to pay all amounts due for services rendered by the Strelcheck Chiropractic Clinic, Inc. (SCC, Inc.) upon rendering of services and further agree to reimburse said clinic for all fees and costs incurred in the collection of such amounts, including, but not limited to reasonable attorney fees. I understand that if my bill is not paid, my information will be given to a collection agency.
6. I authorize release of my medical information necessary to process my claims. I authorize payment of benefits to Strelcheck Chiropractic Clinic for services rendered to me.
7. X-rays are the property of Strelcheck Chiropractic Clinic.

My signature is an acknowledgement that I have read the policies above and agree to abide by the same.

Patient Signature: _____ Date: _____

Our professional and personal concern is with just two things; your health and our reputation. Therefore, we accept only those patients whom we sincerely believe we can help. Thank you for your time and effort in providing us with this information.

Strelcheck Chiropractic and Massage Clinic
10 N. Virginia Street · Crystal Lake · Illinois · 60014
815-459-3860

CARDIAC SCREENING QUESTIONNAIRE

Name: _____ Date: _____

Check box if all answers below are No ☐

		Y	N
1.	Have you ever had any of the following?		
	a. Episodes of passing out	[ ]	[ ]
	b. Unusual shortness of breath	[ ]	[ ]
	c. Unexplained fatigue	[ ]	[ ]
	d. Frequent dizziness or lightheadedness	[ ]	[ ]
2.	Do you ever experience chest tightness, heaviness, pressure, or pain?	[ ]	[ ]
3.	Are you currently taking any of the following medications? (please circle)		
	a. Anti-Anginals? (Nitroglycerin, Nitro-Bid, Isordil, Isosorbide Dinitrate, Nitro-patch)	[ ]	[ ]
	b. Calcium Channel Blockers? (Cardizem, Ditiazem, Isoptin,Calan, Verapamil, Nifedipine, Procardia, Adalat)	[ ]	[ ]
	c. Beta Blockers? (Corgard, Lopressor, Tenormin, Metaprolol, Propanolol, Inderal, Visken, Timolol, Atenolol)	[ ]	[ ]
	d. Anti-arrhythmics? (Quindine, Quinaglute, Norpace, Pronestyl, Procan-SR, Procainamide, Tambacor, Amiadarone, Mexitil, Tocainide, Encainide, Tonocard, Enkaid)	[ ]	[ ]
	e. Digitalis? (Lanoxin, Digoxin)	[ ]	[ ]
	f. Diuretics (water pills)? (Lasix, Oretic, Esidrex, Spironciactone, Aldactone)	[ ]	[ ]
	g. Anti-hypertensives (blood pressure pills)? (Aldomet, Capropril, Capoten, Apresoline, Minipress, Maxide, Dyazide, Vasotec, Minoxidil, Indapamide, Lozol, Methyl Dopa, Catapres)	[ ]	[ ]
4.	Have you ever had palpitations, skipped beats an irregular beat, or slow beat?	[ ]	[ ]
5.	Do you have a family history of cardiac sudden death? (brothers, sisters, parents grandparents, children)	[ ]	[ ]

		Y	N
6.	Are you a heart patient currently under the care of a doctor?	[ ]	[ ]
7.	Do you have a history of rheumatic fever?	[ ]	[ ]
8.	Do you have mitral valve prolapse?	[ ]	[ ]
9.	Do you have a history of heart murmer?	[ ]	[ ]
10.	Are you over 70?	[ ]	[ ]
11.	Do you have high blood pressure?	[ ]	[ ]
12.	Do you have a pacemaker? Type: _____ Rate: _____	[ ]	[ ]
13.	Have you ever had a MI (heart attack)? If so, when? _____	[ ]	[ ]
14.	Do you have chronic lung disease, bronchitis, emphysema, wheezing or asthma?	[ ]	[ ]
15.	Have you ever had heart surgery? If so, when? _____	[ ]	[ ]
16.	Have you ever had an abnormal exercise test? (e.g., treadmill)	[ ]	[ ]
17.	Have you ever had an abnormal EKG?	[ ]	[ ]
18.	Do you have a history of any of the following:		
	a. High cholesterol	[ ]	[ ]
	b. Smoking more than one pack of cigarettes per day	[ ]	[ ]
	c. Diabetes	[ ]	[ ]
	d. High blood pressure	[ ]	[ ]
	e. Family history of heart attacks	[ ]	[ ]
	f. Being more than 30 lbs. overweight	[ ]	[ ]

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815-459-3860

NAME:_____ **DATE:**_____

WORKING TOGETHER TO ACHIEVE MORE

As we strive to create mutually beneficial relationships for our patients, please share with us your health care providers name, address and phone number. We would like to invite him/her to be a part of our Strelcheck Preferred & Valued Physician Program.

Patient Referral Name _____#_____Town Located _____
Family Physician _____#_____Town Located _____
OB-GYN _____#_____Town Located _____
Dentist _____#_____Town Located _____
Specialist _____#_____Town Located _____
Other Health Care Professionals _____#_____Town Located _____

HEALTH CONTINUUM

SEVERE SYMPTOMS	MODERATE SYMPTOMS	MILD SYMPTOMS	REPORTING SOME RELIEF	FEELING BETTER	SYMPTOMS GONE	FEELING GREAT	ENJOYING OPTIMUM HEALTH
/	/	/	/	/	/	/	

Please mark "A" on Health Continuum showing how you feel today and mark "B" showing where you want to be.

Please check any boxes below that you are interested in or feel you would benefit from in achieving your health goals. The doctor will review and make recommendations.

☐ **I am not interested in any of these at this time**

MASSAGE THERAPY
- ☐ Stress Relief
- ☐ Deep Tissue/Therapeutic
- ☐ Increase circulation
- ☐ Energy work
- ☐ Lymph draining
- ☐ Other _____

PHYSICAL THERAPY
- ☐ Increase strength/energy
- ☐ Increase range of motion/Stretching
- ☐ Traction/De-compression/Flexion-Distraction
- ☐ Pain control/E-stim
- ☐ Scar tissue/adhesion breakdown
- ☐ Physiotape/Kinesotaping
- ☐ Therapeutic ultrasound
- ☐ Stability/Proprioceptive/Balance training
- ☐ Posture correction
- ☐ Other _____

SUPPORTS
- ☐ Orthotics
- ☐ Lumbo/Sacral Belt
- ☐ Extremity Brace
- ☐ Topical Analgesic/Liquid Ice & Liquid Heat
- ☐ Ice Packs
- ☐ Leg Spacer
- ☐ Lumbar Support
- ☐ Other _____

NUTRITION
- ☐ Weight loss issues
- ☐ Energy issues
- ☐ Sugar handling/Diabetes issues
- ☐ Digestion issues
- ☐ Allergy issues
- ☐ Immune system issues
- ☐ Detox
- ☐ Sleep issues
- ☐ Hormonal/Reproductive issues
- ☐ Other _____

NUTRITION CURRENTLY TAKING ☐NONE
1. _____
2. _____
3. _____
4. _____
5. _____
6. _____

GENERALIZED HEALTH
- ☐ Blood Testing/Urine Analysis
- ☐ MRI/CT Scan
- ☐ Yoga/Pilates/Cross-training/Aerobics
- ☐ Natural Childbirth Classes
- ☐ Post X-rays

LOW BACK PAIN DAILY FUNCTION STATEMENTS

Name: _____ Date: _____

When your back hurts, you may find it difficult to do some of the things you normally do. This list contains sentences that people have used to describe themselves when they have back pain. When you read a sentence that describes the way you are feeling ***today***, mark the box next to it. If the sentence does not describe you, then leave the space blank and go on to the next one.

Check this box if **all** of the answers below apply to you ☐
Check this box if **none** of the answers below apply to you ☐

Because of the pain in my back, I :

- ☐ Stay at home most of the time
- ☐ Stay in bed most of the time
- ☐ Lie down to rest more often.
- ☐ Only stand up for short periods of time
- ☐ Sit down for most of the day
- ☐ Sleep less
- ☐ Go up stairs more slowly than usual
- ☐ Use a handrail to get upstairs
- ☐ Find it difficult to turn over in bed
- ☐ Only walk short distances
- ☐ Walk more slowly than usual
- ☐ Change position frequently to try and make my back comfortable
- ☐ Get dressed more slowly than usual
- ☐ Get dressed with help from someone else
- ☐ Have trouble putting on my socks (or stockings)
- ☐ Find it difficult to get out of a chair
- ☐ Have to hold on to something to get out of a reclining chair
- ☐ Try not to bend or kneel down.
- ☐ Am not doing any of the jobs that I usually do around the house
- ☐ Ask other people to do things for me
- ☐ Avoid heavy jobs around the house
- ☐ Am more irritable and bad tempered with people
- ☐ Do not have a very good appetite

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Back Index

Form BI100

rev 3/27/2003

Patient Name _____ ***Date*** _____

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

Pain Intensity

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

Sleeping

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

Sitting

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

Standing

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

Walking

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

Personal Care

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

Lifting

⓪ I can lift heavy weights without extra pain.
① I can lift heavy weights but it causes extra pain.
② Pain prevents me from lifting heavy weights off the floor.
③ Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned (e.g., on a table).
④ Pain prevents me from lifting heavy weights off the floor, but I can manage light to medium weights if they are conveniently positioned.
⑤ I can only lift very light weights.

Traveling

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

Social Life

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

Changing degree of pain

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

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

Back Index Score

Neck Index

Form N1-100

rev 3/27/2003

Patient Name _____ **Date** _____

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

Pain Intensity

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

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 the time.

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

Neck Index Score