STRELCHECK
CHIROPRACTIC CLINIC
Est. 1958

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.

Filling Out The Paperwork

Option 1 - Print form, fill out and bring to your appointment

Option 2 - Download form, use fillable function, print and bring to your appointment

Strelcheck Chiropractic Clinic

10 North Virginia Street | Crystal Lake, Illinois 60014

Tel: 815-459-3860 | Fax: 815-459-3990 | Email: Info@Strelcheckchiro.com

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GENERAL PAIN INDEX QUESTIONNAIRE

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/AT-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

(0)COMPLETELY ABLE TO FUNCTION (10)TOTALLY UNABLE TO FUNCTION

2. **RECREATION** including hobbies, sports or other leisure activities -

0 1 2 3 4 5 6 7 8 9 10

(0)COMPLETELY ABLE TO FUNCTION (10)TOTALLY UNABLE TO FUNCTION

3. **SOCIAL ACTIVITIES** including parties, theater, concerts, dining -out and attending other social functions -

0 1 2 3 4 5 6 7 8 9 10

(0)COMPLETELY ABLE TO FUNCTION (10)TOTALLY UNABLE TO FUNCTION

4. **EMPLOYMENT** including volunteer work and homemaking tasks -

0 1 2 3 4 5 6 7 8 9 10

(0)COMPLETELY ABLE TO FUNCTION (10)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

(0)COMPLETELY ABLE TO FUNCTION (10)TOTALLY UNABLE TO FUNCTION

6. **LIFE-SUPPORT ACTIVITIES** such as eating and sleeping -

0 1 2 3 4 5 6 7 8 9 10

(0)COMPLETELY ABLE TO FUNCTION (10)TOTALLY UNABLE TO FUNCTION

PATIENT NAME _____ DATE _____

SCORE _____ [60] BENCHMARK =5 _____

Patient Summary Form

PSF-750 (Rev: 7/1/2015)

Instructions
Please complete this form within the specified timeframe. All PSF submissions should be completed online at www.myoptumhealthphysicalhealth.com unless otherwise instructed.

Please review the Plan Summary for more information.

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

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

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

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 codes)
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 FOM)
Back Index | LEFS

Patient Completes This Section:

(Please fill in selections completely)

Symptoms began on:

1. Briefly describe your symptoms:

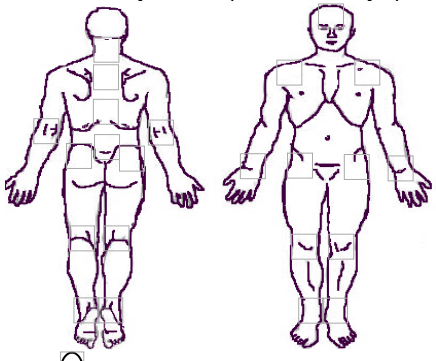
2. How did your symptoms start?

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**

Indicate where you have pain or other symptoms:



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 _____ Phone _____

Email Address _____ Cell Phone _____

Previous Address (if less than 2yrs) _____

Emergency Contact _____ Relation _____ Phone _____

Occupation _____ How Long _____ Work Phone _____

Employer Name _____ Employer Address _____

Spouse Name _____ Spouse Employer _____

Insurance Subscriber's Name _____ Insurance Subscriber's DOB _____

Insurance Subscriber's SS# _____ 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? ☐ Yes ☐ No

If yes, by whom? (Doctor or Hospital) _____ Release Date _____

_____

Have you X-Rays, MRI, CT Scan or any other treatment for this injury prior to your visit today? ☐ Yes ☐ No

If so, list treatments rendered _____

Location _____ Date _____

Have you had any previous surgeries, trauma, accidents, falls, etc.? ☐ Yes ☐ No

If so, please explain: _____

Are you currently on any medication? ☐ Yes ☐ No If so, please list _____

What is the medication for? _____

Do you have a ***family history*** of any for the following?

☐ Rheumatoid Artritis ☐ 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	
☐	☐	Headaches
☐	☐	Neck Pain
☐	☐	Upper Back Pain
☐	☐	Mid Back Pain
☐	☐	Low Back Pain
☐	☐	Shoulder Pain
☐	☐	Elbow/Upper Arm Pain
☐	☐	Wrist Pain
☐	☐	Hand Pain
☐	☐	Hip Pain
☐	☐	Upper Leg Pain
☐	☐	Knee Pain
☐	☐	Ankle/Foot Pain
☐	☐	Jaw Pain
☐	☐	Joint Pain/Stiffness
☐	☐	Arthritis
☐	☐	Rheumatoid Arthritis
☐	☐	Cancer
☐	☐	Asthma

Past	Present	
☐	☐	High Blood Pressure
☐	☐	Heart Attack
☐	☐	Chest Pains
☐	☐	Stroke
☐	☐	Angina
☐	☐	Kidney Stones
☐	☐	Kidney Disorders
☐	☐	Bladder Infection
☐	☐	Painful Urination
☐	☐	Loss of Bladder Control
☐	☐	Prostate Problems
☐	☐	Abnormal Weight Gain/Loss
☐	☐	Abdominal Pain
☐	☐	Liver/Gall Bladder Disorder
☐	☐	General Fatigue
☐	☐	Visual Disturbances
☐	☐	Dizziness
☐	☐	Tumor
☐	☐	Chronic Sinusitis

Past	Present	
☐	☐	Diabetes
☐	☐	Excessive Thirst
☐	☐	Frequent Urination
☐	☐	Smoking/Tobacco Use
☐	☐	Drug/Alcohol Dependence
☐	☐	Allergies _____
☐	☐	Depression
☐	☐	Systemic Lupus
☐	☐	Epilepsy
☐	☐	Dermatitis/Eczema/Rash
☐	☐	HIV/AIDS
☐	☐	Loss of Appetite
☐	☐	Ulcer
☐	☐	Hepatitis
☐	☐	Muscular Incoordination
☐	☐	Hormonal Replacement
☐	☐	Pregnancy
☐	☐	Birth Control Pills

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

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

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 check all that apply)
   a. Anti-Anginals? ☐ ☐
      ☐ Nitroglycerin ☐ Nitro-Bid ☐ Isordil
      ☐ Isosorbide Dinitrate ☐ Nitro-patch
   b. Calcium Channel Blockers? ☐ ☐
      ☐ Cardizem ☐ Ditiazem ☐ Isoptin
      ☐ Calan ☐ Verapamil ☐ Nifedipine
      ☐ Procardia ☐ Adala
   c. Beta Blockers? ☐ ☐
      ☐ Corgard ☐ Lopressor ☐ Tenormin
      ☐ Metaprolol ☐ Propanolol ☐ Inderal
      ☐ Visken ☐ Timolol ☐ Atenolo
   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)

Y N

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) ☐ ☐

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)? ☐ ☐

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 ☐ ☐

WORKING TOGETHER TO ACHIEVE MORE

Name: _____ Date: _____

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 _____

Specialis _____ # _____ 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 GENERALIZED HEALTH
- ☐ 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. _____

SUPPORTS 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

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.

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).

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.

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.

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.

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.

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.

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 _____

OPTUM®
MN010-W120, PO Box 1459 | Minneapolis, MN 55440-1459 | Toll Free: (800) 873-4575 | Telephone: (763)595-3200 | Fax (763) 595-3333

The Keele STarT Back Screening Tool

Patient name: _____ Date: _____

Thinking about the **last 2 weeks** tick your response to the following questions:

		No 0	Yes 1
1	Has your back pain spread down your leg(s) at some time in the last 2 weeks?	☐	☐
2	Have you had pain in the shoulder or neck at some time in the last 2 weeks?	☐	☐
3	Have you only walked short distances because of your back pain?	☐	☐
4	In the last 2 weeks, have you dressed more slowly than usual because of back pain?	☐	☐
5	Do you think it's not really safe for a person with a condition like yours to be physically active?	☐	☐
6	Have worrying thoughts been going through your mind a lot of the time?	☐	☐
7	Do you feel that your back pain is terrible and it's never going to get any better?	☐	☐
8	In general have you stopped enjoying all the things you usually enjoy?	☐	☐

9. Overall, how **bothersome** has your back pain been in the last 2 weeks?

Not at all	Slightly	Moderately	Very much	Extremely
☐	☐	☐	☐	☐
0	0	0	1	1

Total score (all 9): _____ Sub Score (Q5-9):_____

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