Date: _____

Name: Mr.☐ Mrs.☐ Miss ☐ Ms.☐ _____ Social Security #: _____

Birthdate: _____ Age: _____ Sex: M/F _____ Marital Status: M ☐ S ☐ D ☐ Sep. ☐

Address: _____ City: _____ State: _____ Zip: _____

Work Phone: _____ Home Phone: _____ Cell: _____ Email: _____

Occupation: _____ Employed by: _____

Address: _____ City: _____ State: _____ Zip: _____

Person to contact in case of an emergency: _____ Phone: _____

CODE:

ASSIGNMENT OF BENEFIT

I hereby authorize you to pay directly to Southeastern Healthcare, PC benefits due to me under the terms of my policy of insurance issued by your company. Please send such benefits to 2595 S.17th Street, Wilmington, NC 28401. Payment is authorized upon your receipt of the itemized statement for services rendered to me. Your policy was in full force and effect at the time that these services were rendered. Payment of such amounts to the above provider in whole or part, shall constitute payment as if said payment were made directly to me. I hereby authorize SEHC to endorse/sign my name on any and all checks listing me as a payee which are presented to the Office for payment of an account relating to me, my spouse, or any of my dependents.

Insured: _____ Signature of Insured: _____

Date of Birth: _____ Date: _____

Insurance Carrier: _____ Employer of Insured: _____ Policy #: _____

PRIVATE PAY

I understand fully and agree that I am personally responsible for the total amounts due to Southeastern Healthcare, PC for the services rendered. If the bill remains unpaid, and no satisfactory arrangements have been made and executed on it, the account will be reported to the credit bureau and assigned for collection.

Patient Signature: _____ Date: _____

32M-0719

INFORMED CONSENT TO CHIROPRACTIC TREATMENT

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures including various modes of physical therapy, and if necessary, diagnostic x-rays on me (or on the patient named below, for whom I am legally responsible: _____) by the chiropractic physician and/or anyone working in this office authorized by the chiropractic physician.

I further understand that such chiropractic services by the Physician of Chiropractic named here _____ and/or other licensed Physicians of Chiropractic who may treat me now or in the future of this office. I have had an opportunity to discuss with Dr. _____ and/or with other office or clinic personnel the nature and purpose of chiropractic adjustments and other procedures. I understand that results are not guaranteed.

I understand and am informed that, as in the practice of medicine and all healthcare, the practice of chiropractic carries some risks to treatment; including, but not limited to: fractures, disc injuries, strokes (CVA), dislocations, and sprains. I do not expect the physician to be able to anticipate and explain all risks and complications. Further, I wish to rely on the physician to exercise judgement during the course of the procedure which the physician feels are in my best interests at the time, based upon the facts then known.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its contents, and by signing below, I agree to the treatment recommended by my physician. I intend this consent form to cover the entire course of treatment for my present condition(s) and for any condition(s) for which I seek treatment at this facility.

To be completed by the patient:

_____
Print Patient's Name

_____
Signature of Patient

To be completed by the patient's representative, if necessary, *(e.g. if the patient is a minor or is physically or mentally incapacitated)*

_____
Print Name of Patient

_____
Print Name of Representative

_____
Signature of Representative

This form should be maintained in the patient's health record.

123M-0219

CURRENT PROBLEM

File# _____

Patient Name _____ DOB: _____ Today's Date: _____

Mark all previous care you have received relating to this current condition:

☐ Chiropractic: Who_____approximately when: _____

☐ Physical therapy: Who_____approximately when: _____

☐ Primary care: Who_____approximately when: _____

Mark all previous imaging you have had taken relating to this condition:

☐ X-Ray: Who_____approximately when: _____

☐ CT scans: Who_____approximately when: _____

☐ MRI: Who_____approximately when: _____

What do you think may have caused this condition?

☐ Sitting at a desk for long hours ☐ Lifting ☐ Bending ☐ Standing on feet for long hours ☐ Lying down

☐ Physical activity ☐ Sitting to standing ☐ Slip or fall ☐ Prior vehicle accident

When did you first notice this pain or symptoms? Date _____/_____/_____

What makes the pain or symptoms worse? (Check all that apply)

☐ Sitting ☐ Standing ☐ Physical activity ☐ Lifting ☐ Bending ☐ Lying down ☐ Sitting to standing

What does the pain or symptoms feel like? (Check all that apply)

☐ Dull ache ☐ Shooting ☐ Burning ☐ Sore ☐ Tense ☐ Sharp [constant] ☐ Sharp [once in a while]

☐ Throbbing ☐ Tingling

Does pain or tingling travels down the arms or legs? (Please indicate)

☐ Travels from my neck to the shoulder ☐ Travels from my neck to my head

☐ Travels to my fingers ☐ Travels down my leg

Overall, how severe is the pain? (0-10) ____/10 *(10 being the worst you can imagine)*

Since this pain or symptom has started it has: (Please indicate)

☐ Gotten progressively worse ☐ Gotten somewhat better ☐ Stayed about the same

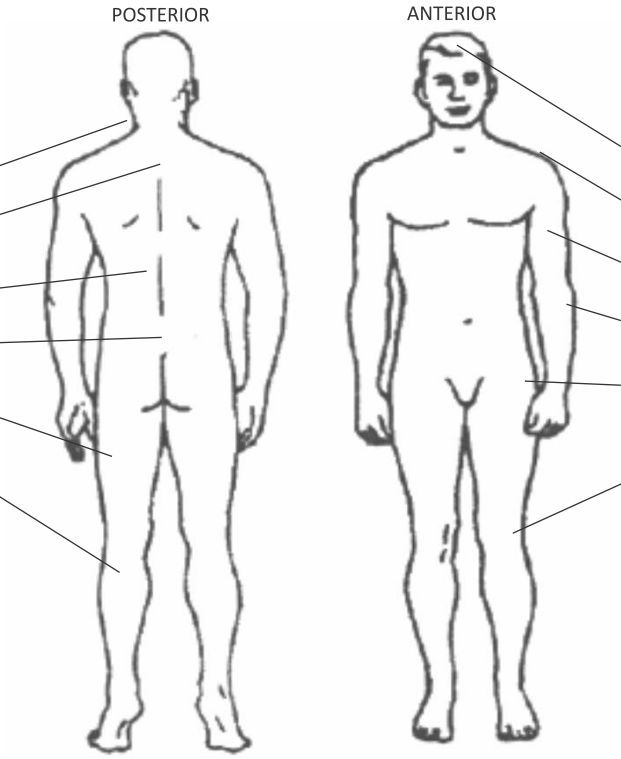
Major Complaint:

Check all that pertain to your complaint:

☐ Headache
☐ Neck pain
☐ Shoulder joint pain
☐ Numbness/tingling arm
☐ Pain down the arm
☐ Upper back pain
☐ Mid back pain
☐ Low back pain
☐ Hip joint pain
☐ Knee joint pain
☐ Pain down the leg
☐ Numbness/tingling leg
☐ Other: _____
☐ Other: _____
☐ Other: _____

PAIN DRAWING

Mark areas of pain on figures below:



Neck pain ☐
Upper back ☐
Mid back pain ☐
Low back pain ☐
Numbness/tingling legs ☐
Pain down the leg ☐
_____ Other ☐
_____ Other ☐
_____ Other ☐

☐ Headache
☐ Shoulder joint pain
☐ Numbness/tingling arm
☐ Pain down the arm
☐ Hip joint pain
☐ Knee joint pain
☐ Other _____
☐ Other _____
☐ Other _____

Women:

Is it possible you are pregnant? ☐ YES ☐ NO Date of Last Menstrual cycle: ____/____/_____

DOCTORS ONLY:

O: [Onset] Date_____/_____/_____

P: [Provocation] ☐ sitting ☐ standing ☐ physical activity ☐ lifting ☐ bending ☐ lying down ☐ sitting to standing

Q: [Quality] ☐ dull ache ☐ sharp shooting ☐ throbbing ☐ burning ☐ intermittently sharp

R: [Radiates] ☐ NO ☐ YES Radiates to: _____

S: [Severity]

1) _____/10 _____ 4) _____/10 _____
2) _____/10 _____ 5) _____/10 _____
3) _____/10 _____ 6) _____/10 _____

T: [Time] ☐ worsening ☐ same ☐ better

Other Details: _____

_____

_____

_____

_____

_____

Signature: _____ _____/_____/_____

ADVANTAGE RADIOLOGY SERVICE

(419) 269-2424 (800) 442-1202

PATIENT _____ CLINIC _____ FILM DATE _____

AGE_____ SEX M ☐ F ☐ SOCIAL SECURITY# _____/_____/_____ DATE OF BIRTH _____

PATIENT ADDRESS_____ CITY_____ STATE_____ ZIP_____

X-RAY ASSIGNMENT AGREEMENT

I understand that the services of a chiropractic radiologist are being utilized to insure the highest quality interpretation of my x-rays. I acknowledge that these services are separate from those of the clinic where I am receiving care, and that the charges for these services will be submitted to my insurance carrier, Workers' Compensation carrier or State Bureau, and/or to my attorney in the case of personal injury.

In the event that I receive payment for these services, I agree to promptly remit payment to Advantage Radiology Service (ARS).

I assign my insurance benefits and rights to payment to ARS to the extent of their charges, and authorize them, or their agents, to bill and release information to my insurance company, attorney, and/or any third-party payer. I authorize my treating physician, insurance company, attorney, and/or any third-party payer to provide ARS or their agents with any information concerning my claim, their services, and/or payment for the services provided.

By my signature below, I acknowledge that I have read, understand, and agree to the above provisions, and I assign my insurance benefits as described above.

SIGNATURE:_____ DATE:_____

WITNESS:_____

PATIENT HISTORY

PATIENT PRESENTATION_____

_____

TRAUMA? YES ☐ NO ☐ EXPLAIN_____

PAST MEDICAL HISTORY_____

_____

MALIGNANCY? YES ☐ NO ☐ DETAILS _____

DIAGNOSIS/CONCERNS/QUESTIONS[NO ICD CODES PLEASE]_____

PLEASE COMPLETE INSURANCE/BILLING INFO ON REVERSE SIDE

ADVANTAGE RADIOLOGY SERVICE

(419) 269-2424 (800) 442-1202

CASH (no insurance) _____ **MEDICARE ONLY** _____ **MEDICAID ONLY** _____

STANDARD NEED **NON-PARTICIPATING** PROVIDER INSURANCE NAME & BILLING ADDRESS

PLEASE ATTACH COPY OF FRONT AND BACK OF INSURANCE CARD(S).

INSURANCE NAME & BILLING ADDRESS (PRIMARY)			**INSURANCE NAME & BILLING ADDRESS (SECONDARY)**		
CARRIER	TELEPHONE		CARRIER	TELEPHONE	
ADDRESS			ADDRESS		
CITY	STATE	ZIP	CITY	STATE	ZIP
RELATIONSHIP TO INSURED **SELF ☐ SPOUSE ☐ CHILD ☐ OTHER**_____			**RELATIONSHIP TO INSURED** **SELF ☐ SPOUSE ☐ CHILD ☐ OTHER**_____		
INSURED NAME	INSURED DATE OF BIRTH		INSURED NAME	INSURED DATE OF BIRTH	
INSURED SOCIAL SECURITY #	INSURED ID #		INSURED SOCIAL SECURITY #	INSURED ID #	
INSURED GROUP #	BCBS 3 LTR PREFIX		INSURED GROUP #	BCBS 3 LTR PREFIX	
INSURED EMPLOYER	TELEPHONE		INSURED EMPLOYER	TELEPHONE	
IF W/C: EMPLOYER ADDRESS	CITY	ST ZIP	IF W/C: EMPLOYER ADDRESS	CITY	ST ZIP

AUTO ACCIDENT/PI/WORKERS' COMPENSATION

RELATED TO EMPLOYMENT? YES ☐ NO ☐ AUTO ACCIDENT? YES ☐ NO ☐
OTHER? YES ☐ NO ☐

CLAIM # _____ **DATE OF INJURY** _____

W/C CARRIER or AUTO INSURANCE **NAME & BILLING ADDRESS** LIST BOTH LIABILITY & MED PAY CARRIERS (USE ADDITIONAL PAPER IF NECESSARY)			**ATTORNEY NAME & BILLING ADDRESS**		
CARRIER	TELEPHONE		ATTORNEY NAME	TELEPHONE	
INSURANCE ADDRESS			ATTORNEY ADDRESS		
CITY	STATE	ZIP	CITY	STATE	ZIP
RELATIONSHIP TO INSURED SELF ☐ SPOUSE ☐ CHILD ☐ OTHER_____			*PLEASE LIST BOTH LIABILITY AND MED PAY CARRIERS (USE ADDITIONAL PAPER IF NECESSARY)		
INSURED NAME	INSURED SOC. SECURITY #				
IF PI: ADJUSTERS NAME	ADJ: TELEPHONE		IF W/C: ALLOWED DIAGNOSIS ICD-9 CODES		

PLEASE COMPLETE PATIENT HISTORY ON REVERSE SIDE

HEALTH HISTORY CONFIDENTIAL

Name _____ Today's date _____

Age _____ Birthdate _____ Date of Last Physical Exam _____

What is the reason for your visit? _____

SYMPTOMS Check ☑ symptoms you currently have or have had in the past year.

General
- ☐ Chills
- ☐ Depression
- ☐ Dizziness
- ☐ Fainting
- ☐ Fever
- ☐ Forgetfulness
- ☐ Headaches
- ☐ Loss of Sleep
- ☐ Nervousness
- ☐ Numbness
- ☐ Sweats
- ☐ Loss of weight

Skin
- ☐ Bruise easily
- ☐ Hives
- ☐ Itching
- ☐ Mole change
- ☐ Rash
- ☐ Scars
- ☐ Sore that will not heal

Gastrointestinal
- ☐ Appetite poor
- ☐ Bloating
- ☐ Bowel changes
- ☐ Constipation
- ☐ Diarrhea
- ☐ Excessive hunger
- ☐ Excessive thirst
- ☐ Gas
- ☐ Hemorrhoids
- ☐ Indigestion
- ☐ Nausea
- ☐ Rectal bleeding
- ☐ Stomach pain
- ☐ Vomiting
- ☐ Vomiting blood

Genitourinary
- ☐ Blood in urine
- ☐ Frequent urination
- ☐ Lack of bladder control
- ☐ Painful urination

Eye/Ear/Nose/Throat
- ☐ Bleeding gums
- ☐ Blurred vision
- ☐ Crossed eyes
- ☐ Difficulty swallowing
- ☐ Double vision
- ☐ Earache
- ☐ Ear discharge
- ☐ Hay fever
- ☐ Hoarseness
- ☐ Loss of hearing
- ☐ Nosebleeds
- ☐ Persistent cough
- ☐ Ringing in ears
- ☐ Sinus problems
- ☐ Vision-flashes
- ☐ Vision-halos

Muscle/Joint/Bone
- ☐ Migraines
- ☐ Headaches upon rising, wear off during day
- ☐ Splitting headaches
- ☐ Neck pain
- ☐ Pain between shoulder blades
- ☐ Low back pain
- ☐ Pain in shoulders, arms, hands, hips, legs, feet or toes
- ☐ Sciatica
- ☐ Chronic aches
- ☐ Pain on inspiration
- ☐ Pain with coughing or sneezing
- ☐ Muscle weakness
- ☐ Numbness/tingling in arms, shoulders, hands, legs, feet or toes
- ☐ Joint stiffness
- ☐ Joint pain
- ☐ Joint swelling
- ☐ Multiple tender points
- ☐ Injury from motor vehicle accident
- ☐ Other injury _____
  _____
  _____
- ☐ Tension headache

Cardiovascular
- ☐ Irregular heart beat
- ☐ Chest pain
- ☐ High blood press
- ☐ Low blood press
- ☐ Poor circulation
- ☐ Rapid heart beat
- ☐ Varicose veins
- ☐ Ankle swelling

MEN only
- ☐ Breast lump
- ☐ Erection difficulty
- ☐ Sore on penis
- ☐ Penis discharge

MEN only
- ☐ Lump in testicles
- ☐ Other _____

WOMEN only
- ☐ Abnormal pap smear
- ☐ Bleeding between periods
- ☐ Breast lump
- ☐ Extreme menstrual pain
- ☐ Hot flashes
- ☐ Nipple discharge
- ☐ Painful intercourse
- ☐ Vaginal discharge
- ☐ Other

Date of last menstrual period _____
Date of last Pap smear _____
Have you had a Mammogram? _____
Are you pregnant? _____
Number of children _____

CONDITIONS Check ☑ conditions you have or have had in the past.

- ☐ AIDS
- ☐ Alcoholism
- ☐ Anemia
- ☐ Anorexia
- ☐ Appendicitis
- ☐ Arthritis
- ☐ Asthma
- ☐ Bleeding disorder
- ☐ Breast lump
- ☐ Bronchitis
- ☐ Bulimia
- ☐ Cancer
- ☐ Cataracts
- ☐ Chemical dependency
- ☐ Chicken pox
- ☐ Diabetes
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Glaucoma
- ☐ Goiter
- ☐ Gonorrhea
- ☐ Gout
- ☐ Heart Disease
- ☐ Hepatitis
- ☐ Hernia
- ☐ Herpes
- ☐ High cholesterol
- ☐ HIV positive
- ☐ Kidney disease
- ☐ Liver disease
- ☐ Measles
- ☐ Migraine headaches
- ☐ Miscarriage
- ☐ Mononucleosis
- ☐ Multiple Sclerosis
- ☐ Mumps
- ☐ Pacemaker
- ☐ Pneumonia
- ☐ Polio
- ☐ Prostate Problems
- ☐ Psychiatric care
- ☐ Pneumonia fever
- ☐ Scarlet fever
- ☐ Stroke
- ☐ Thyroid problems
- ☐ Tonsillitis
- ☐ Tuberculosis
- ☐ Typhoid fever
- ☐ Ulcers
- ☐ Vaginal Infections
- ☐ Venereal disease

MEDICATION List medications you are currently taking.

_____
_____
_____
_____

Pharmacy Name: Phone Number:

ALLERGIES to medications or substances.

_____
_____
_____
_____

PLEASE COMPLETE THE BACK OF THIS PAGE & SIGN AT THE BOTTOM

FAMILY HISTORY Fill in health information about your family.

Relation	Age	State of Health	Age at Death	Cause of Death
Father				
Mother				
Brothers				
Sisters				

Check ✓ if your blood relative have any of the following:

✓	Disease	Relationship
	Arthritis, Gout	
	Asthma, Hay Fever	
	Cancer	
	Chemical Dependency	
	Diabetes	
	Heart Disease, Strokes	
	High Blood Pressure	
	Kidney Disease	
	Tuberculosis	
	Other	

HOSPITALIZATIONS

Year	Hospital	Reason for Hospitalization & Outcome

PREGNANCY HISTORY

Year	Sex	Complications

Have you ever had a blood transfusion:

❑ YES ❑ NO

If yes, please give approximate dates: _____

SERIOUS ILLNESS/INJURY	DATE	OUTCOME

HEALTH HABITS

Check ✓ which substance you use and describe how much you use

	Caffeine	
	Tobacco	
	Drugs	
	Other	

OCCUPATIONAL CONCERNS

Check ✓ if your work exposes you to the following:

	Stress
	Hazardous Substances
	Heavy Lifting
	Other

Your occupation:

I certify that the above information is correct to the best of my knowledge. I will not hold my doctor or any member of his/her staff responsible for any errors or omissions that I may have made in the completion of this form.

_____ Signature

_____ Date

_____ Reviewed by

_____ Date

AUTHORIZATION for USE, DISCLOSURE and/or REQUEST of PROTECTED HEALTH INFORMATION

SECTION A: Psychotherapy Notes. ☐ Check if this authorization is for psychotherapy notes.
If this authorization is for psychotherapy notes, you must *not* use it as an authorization for any other type of protected health information. Identify the psychotherapy notes by checking "Other" in Section C and describing in the space provided, do not check any other boxes or types of information.

SECTION B: The Individual (or the Individual's Personal Representative) confirming the authorization.
I authorize the use and/or disclosure of my protected health information as described in Section C below. I understand that this authorization is voluntary.

I understand that, if the persons or organizations I authorize below are not health care providers, they may further disclose the protected health information and it may no longer be protected by federal health information privacy laws.

Patient's Name: _____ Date of Birth _____ Social Security # *(last 4 digits only)* _____

Address: _____ City: _____ State: _____ Zip: _____

Phone: _____ Email: _____

SECTION C: The use, disclosure and/or request being authorized (minimum necessary).
☐ Present year only ☐ 1 year ☐ 2 years **History/Office Notes**
☐ Present year only ☐ 1 year ☐ 2 years **Labs**
☐ Last **Eye Exam** ☐ Last **Foot Exam** ☐ 2 years **Pap Smears** ☐ 2 years **Mammograms** ☐ All **Immunization** summaries
☐ All **Colonoscopy** and **EGD** procedure reports ☐ All **Pathology** reports ☐ All **Radiologic studies** ***(Bone Density, CT/CTA, MRI/MRA, US, Vascular, etc)***
☐ All **Cardiac Studies** ☐ All **Hospital Admissions, H&Ps, Consults, Operative reports, Discharges**
☐ **Other** ***(Please be specific and DO NOT request ALL Records)*** _____

*Entities Authorized to **Use or Disclose***:
Records requested **FROM**:
Name of provider/organization: _____
_____
Address _____
_____
Phone#: _____ Fax #: _____

*Entities Authorized to **Use or Disclose***:
Records requested **SENT TO**:
Name of provider/organization/person: _____
_____
Address _____
_____
Phone#: _____ Fax #: _____

SECTION D: Preference for Receipt of Records.
☐ Regular Mail ☐ Fax #_____ *(Maximum 50 pgs)*
☐ Pick up by: _____ *(2-3 day processing minimum)* Where: _____
☐ Retrieve from Website *(Personal copies only)*
☐ Electronic Copy *(disk)*

SECTION E: Purpose of Use, Disclosure and/or Request of Protected Health Information.
☐ Personal Use ***You will be charged a state regulated fee for a personal copy of your records ($10 minimum/$50 maximum)***
☐ Changing Provider/Continuity of Care ☐ Insurance ☐ Attorney
☐ Other _____

SECTION F: Expiration.
This authorization will expire ***(complete one)***:
☐ Until I revoke permission in writing ☐ 2 years after my death ☐ Future Date _____/_____/_____
☐ On the occurrence of the following event: _____

Right to Revoke: I understand that I may revoke this authorization at any time by giving written notice of my revocation to the Contact Office listed below. I understand that revocation of this authorization will *not* affect any action you took in reliance on this authorization before you received my written notice of revocation.

Contact Office: Southeastern Healthcare Privacy Officer
Address: 2595 S. 17th Street, Wilmington, NC 28401 **Phone**: 910) 392-1252 **Fax**: (910) 392-1244 **Email**: lisa@sehc.net

Inability to Condition Treatment: I understand that Southeastern Healthcare may not condition my treatment on my refusal to sign this authorization.

SECTION G: SIGNATURE
SIGNATURE–YOU MAY REFUSE TO SIGN THIS AUTHORIZATION AND THE REQUEST WILL BE CONSIDERED NULL & VOID.
PERSONAL COPIES WILL INCUR A FEE. REFER TO "SECTION E" FOR INFORMATION.

Signature: _____ **Date:** _____

If this authorization is signed by a personal representative on behalf of the individual, complete the following:

Personal Representative's Name: _____ Relationship to Individual _____

WITNESS: _____ **Date**: _____

YOU ARE ENTITLED TO A COPY OF THIS AUTHORIZATION AFTER YOU SIGN IT.
Include this authorization in the individual's medical record.

AUTHORIZATION for USE and/or DISCLOSURE of PROTECTED HEALTH INFORMATION

I authorize the use and/or disclosure of my protected health information as described in Section B below. I understand that this authorization is voluntary.

I understand that, if the persons or organizations I authorize below are not health care providers, they may further disclose the protected health information and it may no longer be protected by federal health information privacy laws.

Section A: Patient Information (please print):

Account #: _____ Patient's Name: _____ Social Security # _____

Address: _____ City: _____ State: _____ Zip: _____

Date of Birth: _____ Phone: _____

Section B: Protected Health Information to be Used and/or Disclosed:

Do you wish for us to discuss all your protected health information with your family/friends or do you prefer that only specific information be released?

☐ All medical information, except psychotherapy information.

☐ Psychotherapy notes. ***If this authorization is for psychotherapy notes, you must not use it as an authorization for any other type of protected health information.***

☐ Specific information *(please describe):* _____

Entities Authorized to Use or Disclose: Southeastern Healthcare

Families, Friends, and Other Authorized to receive and use *(please name specifically any family/friends to which we may release your protected health information either in writing or verbally)*:

_____ _____

_____ _____

Section C: Purpose of Use or Disclosure of Protected Health Information.

☐ So family member, friend or caregiver may have knowledge of or assist in my medical care or payment for medical care.

☐ At the request of the individual

☐ Other _____

Section D: Expiration.

This authorization will expire *(complete one)*:

☐ Until I revoke permission in writing ☐ 2 years after my death ☐ Future Date _____/_____/_____

☐ On the occurrence of the following event: _____

Right to Revoke: I understand that I may revoke this authorization at any time by giving written notice of my revocation to the Contact Office listed below. I understand that revocation of this authorization will *not* affect any action you took in reliance on this authorization before you received my written notice of revocation.

Contact Office: Southeastern Healthcare Privacy Officer **Address**: 2595 S. 17th Street, Wilmington, NC 28401
Phone: (910) 392-1252 **Fax**: (910) 392-1244 **Email**: Lisa@sehc.net

Inability to Condition Treatment: I understand that Southeastern Healthcare may not condition my treatment on my refusal to sign this authorization.

If you would like for us to leave medical information regarding your care (i.e. lab results) or appointments on an answering machine, please complete the section below.

Southeastern Healthcare may leave a message regarding my medical information on the answering machine at this number: (_____) _____ - _____.

I acknowledge that I have been made aware of Southeastern Healthcare's Notice of Privacy Practices. I have had full opportunity to read and consider the contents of the Southeastern Healthcare Notice of Privacy Practices.

SIGNATURE - YOU MAY REFUSE TO SIGN THIS AUTHORIZATION

Signature: _____ **Date:** _____

If this authorization is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's Name: _____ Relationship to Patient: _____

NECK INDEX

128M-0219

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 ☐

Patient's Comments _____

_____ _____
Patient's Signature

_____ _____
Date

Doctor's Comments _____

_____ _____
Doctor's Signature

_____ _____
Date

BACK INDEX

129M-0219

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

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

Sleeping

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

Sitting

⓪I can sit in any chair as long as I like.
①I can only sit in my favorite chair as long as I like.
②Pain prevents me from sitting more than 1 hour.
③Pain prevents me from sitting more than ½ hour.
④Pain prevents me from sitting more than 10 minutes.
⑤I avoid sitting because it increases pain immediately.

Standing

⓪I can stand as long as I want without pain.
①I have some pain while standing but it does not increase with time.
②I cannot stand for longer than 1 hour without increasing pain.
③I cannot stand for longer than ½ hour without increasing pain.
④I cannot stand for longer than 10 minutes without increasing pain.
⑤I avoid standing because it increases pain immediately.

Walking

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

Personal Care

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

Lifting

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

Traveling

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

Social Life

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

Changing degree of pain

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

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

Back Index Score ☐

Patient's Comments _____ _____
Patient's Signature

_____ _____
Date

Doctor's Comments _____ _____
Doctor's Signature

_____ _____
Date