

# CHIROPRACTIC REGISTRATION AND HISTORY

## ① PATIENT INFORMATION

Date \_\_\_\_\_

SS/HIC/Patient ID# \_\_\_\_\_

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

Last name

\_\_\_\_\_

First name

Middle Initial

Address \_\_\_\_\_

City \_\_\_\_\_

State \_\_\_\_\_ Zip \_\_\_\_\_

Sex  Male  Female Age \_\_\_\_\_

Birth date \_\_\_\_\_

Married  Single  Divorced  Minor

Widowed  Separated  Partnered

Patient Employer/School \_\_\_\_\_

Occupation \_\_\_\_\_

Employer/School Address \_\_\_\_\_

\_\_\_\_\_

Spouses Name \_\_\_\_\_

Spouses Employer \_\_\_\_\_

How did you come to find us?  Search Engine/Google

Phone Book  Doctor Referral  other \_\_\_\_\_

Would you like important updates emailed to you?

EMAIL ADDRESS: \_\_\_\_\_

## ③ PHONE NUMBERS

Home Phone ( ) \_\_\_\_\_ Cell # ( ) \_\_\_\_\_

Best time to reach you \_\_\_\_\_

## IN CASE OF EMERGENCY, CONTACT

Name \_\_\_\_\_ Relationship \_\_\_\_\_

Home Phone ( ) \_\_\_\_\_ Work Phone ( ) \_\_\_\_\_

## ⑤ PATIENT CONDITION

Reason for visit \_\_\_\_\_

When did your symptoms appear? \_\_\_\_\_

## ② INSURANCE INFORMATION

Insurance Company \_\_\_\_\_

Policy # \_\_\_\_\_

Group # \_\_\_\_\_

Is patient covered by additional insurance?  Yes  No

Insurance Company \_\_\_\_\_

Policy # \_\_\_\_\_

Group # \_\_\_\_\_

## ASSIGNMENT AND RELEASE

I certify that I, and/or my dependent(s), have insurance coverage with the above named company(ies) and assign directly to Dr. Marotta all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named doctor may use my health information and may disclose such information to the above named insurance company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

Signature of Patient, Parent, Guardian or Personal Representative

Please print name

Date

Relationship to Patient

## ④ ACCIDENT INFORMATION

Is this condition due to an accident?  Yes  No

Date of accident \_\_\_\_\_

Type of accident  Auto  Work  Home  Other

To whom have you made a report of your accident?

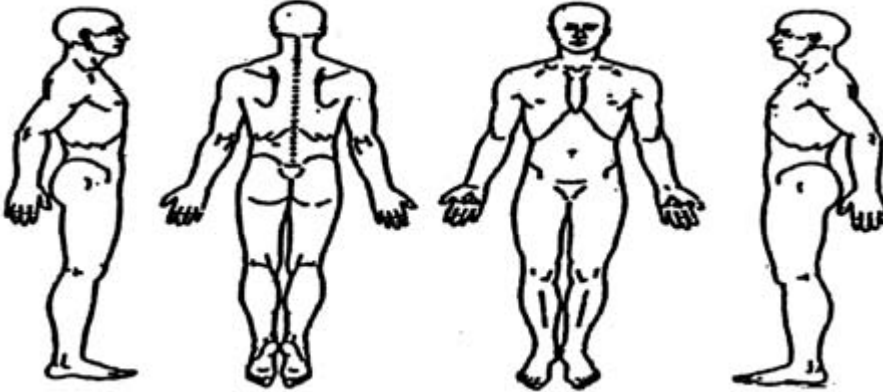
Auto Ins.  Employer  Work Comp  Other

# PATIENT INTAKE FORM

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_

1. Is today's problem caused by:  Auto Accident  Workman's Compensation

2. Indicate on the drawings below where you have pain/symptoms



3. How often do you experience your symptoms?

- Constantly (76-100% of the time)  Occasionally (26-50% of the time)  
 Frequently (51-75% of the time)  Intermittently (1-25% of the time)

4. How would you describe the type of pain?

- Sharp  Numb  
 Dull  Tingly  
 Diffuse  Sharp with motion  
 Achy  Shooting with motion  
 Burning  Stabbing with motion  
 Shooting  Electric like with motion  
 Stiff  Other: \_\_\_\_\_

5. How are your symptoms changing with time?

- Getting Worse  Staying the Same  Getting Better

6. Using a scale from 0-10 (10 being the worst), how would you rate your problem?

0 1 2 3 4 5 6 7 8 9 10 (Please circle)

7. How much has the problem interfered with your work?

- Not at all  A little bit  Moderately  Quite a bit  Extremely

8. How much has the problem interfered with your social activities?

- Not at all  A little bit  Moderately  Quite a bit  Extremely

9. Who else have you seen for your problem?

- Chiropractor  Massage Therapist  Primary Care Physician  
 Orthopedist  ER physician  Other: \_\_\_\_\_  
 Neurologist  Physical Therapist  No one

10. How long have you had this problem? \_\_\_\_\_

11. How do you think your problem began?  
\_\_\_\_\_

12. Do you consider this problem to be severe?

- Yes  Yes, at times  No

13. What aggravates your problem?  
\_\_\_\_\_

13a. What alleviates your problem? \_\_\_\_\_

14. What concerns you the most about your problem; what does it prevent you from doing?  
\_\_\_\_\_

15. What is your: Height \_\_\_\_\_ Weight \_\_\_\_\_ Age \_\_\_\_\_

Occupation \_\_\_\_\_

**16. How would you rate your overall Health?**

- Excellent     Very Good     Good     Fair     Poor

**17. What type of exercise do you do?**

- Strenuous     Moderate     Light     None

**18. Indicate if you have any immediate family members with any of the following:**

- Rheumatoid Arthritis     Diabetes     Lupus  
 Heart Problems     Cancer     ALS

**19. 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.**

**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  
  Tumor  
  Asthma  
  Chronic Sinusitis  
  Other: \_\_\_\_\_

**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  
  Loss of Appetite  
  Abdominal Pain  
  Ulcer  
  Hepatitis  
  Liver/Gall Bladder Disorder  
  General Fatigue  
  Muscular Incoordination  
  Visual Disturbances  
  Dizziness

**Past Present**

- Diabetes  
  Excessive Thirst  
  Frequent Urination  
  Smoking/Tobacco Use  
  Drug/Alcohol Dependence  
  Allergies  
  Depression  
  Systemic Lupus  
  Epilepsy  
  Dermatitis/Eczema/Rash  
  HIV/AIDS

**For Females Only**

- Birth Control Pills  
  Hormonal Replacement  
  Pregnancy

**20. List all prescription medications you are currently taking:**

\_\_\_\_\_

**21. List all of the over-the-counter medications you are currently taking:**

\_\_\_\_\_

**22. List all surgical procedures you have had:**

\_\_\_\_\_

**23. What activities do you do at work?**

- Sit:**                       Most of the day                       Half the day                       A little of the day  
 **Stand:**                       Most of the day                       Half the day                       A little of the day  
 **Computer work:**                       Most of the day                       Half the day                       A little of the day  
 **On the phone:**                       Most of the day                       Half of the day                       A little of the day

**24. What activities do you do outside of work?**

\_\_\_\_\_

**25. Have you ever been hospitalized?**  No                       Yes

if yes, why \_\_\_\_\_

**26. Have you had significant past trauma?**  No  Yes

**Have you ever been to a chiropractor before?**  No  Yes how long ago? \_\_\_\_\_

**27. Anything else pertinent to your visit today?** \_\_\_\_\_

**Patient Signature** \_\_\_\_\_ **Date:** \_\_\_\_\_

**WORKING WITH A HEALTHCARE PROVIDER IS A  
PARTNERSHIP OF SHARED RESPONSIBILITY**

OUR RESPONSIBILITY:

1. We will provide a friendly, helpful, and courteous staff.
2. We strive to keep waiting time to a minimum. Most patients are seen within minutes of signing in.
3. We will provide a clear explanation of any health problems and the strategies to solve them.
4. We will help to verify your insurance to see what is and what is not covered.
5. We will submit your insurance claims using the appropriate codes and notes the same day of your visit, given that you have provided us with your most up-to-date insurance information.
6. After 30 days, if your insurance has not responded, we will resubmit the entire claim.
7. If your insurance has still not responded or not paid the entire bill after 60 days, we will then bill you. We will expect this bill to be paid within 30 days.

YOUR RESPONSIBILITY:

1. We realize that life is hectic and unpredictable. **If you cannot make a scheduled appointment, we expect a phone call at least one hour before the time.** We give everyone one (1) warning but we will charge you the cost of an office visit for any missed appointments from then on. Insurance does not pay this fee.
2. **We expect that you arrive for your appointment on time.** Late arrivals affect other patients and may cause increased waiting time for yourself and others.
3. The Doctor will recommend specific exercises, stretches, nutrients, and/or activities to use/limit/avoid. If you should choose not to follow the recommendations, you may find that your results are less than optimal.
4. If your insurance does not pay for your visit for any reason, you will be sent a bill which must be paid within 30 days. **Your insurance may send you an explanation of benefit letter stating that you owe us some money. IN MOST CASES YOU WILL NOT, but if you have any questions please ask us.**
5. Please notify us with any changes in your insurance, billing, address, or contact information so we can keep your file current and continue to provide you with quality care.

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**PATIENT CARE AGREEMENT**

**AS A PATIENT OF MAROTTA HEALTH AND WELLNESS I AGREE TO THE FOLLOWING:**

- If for any reason my insurance company does not make a complete payment to Marotta Health and Wellness (MHAW) within 60 days of my office visit, I understand that I will be sent a bill explaining my amount due. If I do not send a payment to MHAW within the following 30 days, I understand the bill may go to collections.
- In the event that my insurance company denies payment or applies the visit charges to my deductible, I understand that I am responsible for the amount billed by MHAW. If I do not respond to the bill and make a payment within 30 days of the bill being sent, I understand the bill may go to collections.
- In the event that my insurance company sends payment directly to me, I understand that I must remit the full amount of payment to MHAWC.
- If a check that I have written to MHAW is returned, I understand that I am responsible for the associated fees incurred by MHAW.
- If for any reason I am unable to make my appointment and I do not notify MHAW at least one hour before the appointment time, I understand that I may be charged for the cost of an office visit. Here at Marotta Health and Wellness we strive to make your visits worthwhile, and by providing these guidelines, we can continue to offer you the best possible care. If you have any questions or need to make special payment arrangements, please feel free to call us and discuss it. We appreciate your cooperation.

I, \_\_\_\_\_ (patient name), am insured  
by \_\_\_\_\_ (insurance company name) and am seeking care in this office.

I understand that if my insurance company does not cover certain aspects of my care (copay, co-insurance, deductible, out-of-network benefits, fees related to missing referrals, or any other allowable fees), I will be financially responsible. I also understand that if I do not make payments to Marotta Health and Wellness in a timely manner, my account will be forwarded to a Collections Agency.

Thank you for your understanding.

\_\_\_\_\_ (patient signature)      DATE: \_\_\_\_\_

**Our Privacy Pledge**

We are very concerned with protecting your privacy. While the law requires us to give you this disclosure, please understand that we have, and always will, respect the privacy of your health information.

There are several circumstances in which we may have to disclose your health information:

- We may have to disclose your health information to another health care provider or a hospital if it is necessary to refer you to them for diagnosis, assessment, or treatment of your health condition;
- We may have to disclose your health information and billing records to another party if they are potentially responsible for the payment of your services;
- We may need to use your health information within our practice for quality control or other operational purposes.

**Your Right to Limit Uses or Disclosures**

You have the right to request that we do not disclose your health information to specific individuals, companies, or organizations. If you would like to place any restrictions on the use or disclosure of your health information, please let us know in writing. We are not required to agree to your restrictions. However, if we agree with your restrictions, the restriction is binding on us.

**Your Right to Revoke Your Authorization**

**You may revoke your consent to us at any time; however, your revocation must be in writing. We will not be able to honor your revocation request if we have already released your health information before we receive your request to revoke your authorization. If you were required to give your authorization as a condition of obtaining insurance, the insurance company may have a right to your health information if they decide to contest any of your claims.**

I have read your consent policy and agree to its terms. I am also acknowledging that I have received a copy of this notice.

\_\_\_\_\_  
Print Name

\_\_\_\_\_  
Authorized Provider Representative

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Date

**AUTHORIZATION FOR RELEASE OF HEALTH SERVICE  
OR TREATMENT INFORMATION**

This authorization or photocopy hereof, will authorize Marotta Health and Wellness (Antonio Marotta, DC) to furnish and/or receive all information regarding my health care while under their observation or treatment, including the history obtained, X-ray, results of testing performed and physical findings, diagnosis and prognosis.

\_\_\_\_\_  
(PRINT NAME)

\_\_\_\_\_  
(SIGNATURE)

(If the applicant is a minor, parent or guardian shall sign and indicate capacity of relationship)

PRIMARY CARE DOCTOR: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

PHONE: \_\_\_\_\_

FAX: \_\_\_\_\_

Name and contact information of others which you would like your information disclosed to:


# INFORMED CONSENT

## CHIROPRACTIC

It is important to acknowledge the difference between the healthcare specialties of chiropractic, osteopathy, and medicine. Chiropractic seeks to restore health through natural means without the use of drugs or surgery. This gives the body maximum opportunity to utilize its innate recuperative powers. The success of the chiropractic doctor's procedures often depends on environment, underlying causes, physical and spinal conditions. It is important to understand what to expect from chiropractic healthcare services.

## ANALYSIS

A doctor of chiropractic conducts a clinical analysis for the express purpose of determining whether there is evidence of Vertebral Subluxation Syndrome (VSS) or Vertebral Subluxation Complex (VSC). When such VSS and/or VSC are found, chiropractic adjustments and ancillary procedures may be given in an attempt to restore spinal integrity. It is the chiropractic premise that spinal alignment allows nerve transmission throughout the body and gives the body an opportunity to use its innate recuperative powers. Due to the complexities of nature, no doctor can promise you specific results. This depends on the inherent recuperative powers of the body.

## DIAGNOSIS

Although doctors of chiropractic are experts in chiropractic diagnosis, the VSS and VSC, they are not internal medical specialists. Every chiropractic patient should be mindful of his/her own symptoms and should secure other opinions if he/she has any concern as to the nature of his/her condition. Your doctor of chiropractic may express an opinion as to whether or not you take this step, but you are responsible for the final decision.

## INFORMED CONSENT FOR CHIROPRACTIC CARE

A patient, in coming to the doctor of chiropractic, gives the doctor permission and authority to care for the patient in accordance with the chiropractic tests, diagnosis, and analysis. The chiropractic adjustment or other clinical procedures are usually beneficial and seldom cause any problem. In rare cases, underlying physical defects, deformities, or pathologies may render the patient susceptible to injury. The doctor, of course, will not give a chiropractic adjustment or health care, if he/she is aware that such care may be contraindicated. Again, it is the responsibility of the patient to make it known or to learn through health care procedures whatever he/she is suffering from: latent pathological defects, illnesses, or deformities, which would otherwise not come to the attention of the doctor of chiropractic. The patient should look to the correct specialist for the proper diagnostic and clinical procedures. The doctor of chiropractic provides a specialized, non-duplicating health service. The doctor of chiropractic is licensed in a special practice and is available to work with other types of providers in your healthcare regime.

## RISK

I have discussed with the doctor any risk that may be associated with chiropractic spinal manipulative therapy. These risks include mild soreness, fracture and the extremely rare and poorly correlated vertebral basilar artery infarction or vertebral artery stroke.

## RESULTS

The purpose of chiropractic services is to promote natural health through the reduction of the VSS or VSC. Since there are so many variables, it is difficult to predict the time schedule or efficiency of the chiropractic procedures. Sometimes the response is phenomenal. In most cases, there is a more gradual, but quite satisfactory response. Occasionally, the results are less than expected. Two or more similar conditions may respond differently to the same chiropractic care. Many medical failures find quick relief through chiropractic. In turn, we must admit that conditions which do not respond to chiropractic care, may come under the control or be helped through medical science. The fact is that the science of chiropractic and medicine may never be so exact as to provide definite answers to all problems. Both have made great strides in alleviating pain and controlling disease.

## TO THE PATIENT

Please discuss any questions or problems with the doctor **before** signing this statement of policy.

I have read, and understand the foregoing.

## OFFICE POLICIES:

If I am accepted as a patient at Marotta Health and Wellness, I agree to pay for all services, including services not covered by my insurance company. If I suspend (or terminate) my treatment without the doctor's permission, it will be understood that I have reached maximum healing for my condition. I then agree to be fully responsible for my condition and future care. I understand that no medical records or x-rays will be released from this office if I owe any money on my account.

## CONSENT TO TREAT:

I also understand that no cures are promised (or implied) and any risks regarding this care at this office will be explained to me upon my request. I now authorize Dr. Antonio Marotta to proceed with any necessary treatment. I have read Dr. Marotta's office policies and consent to treat information, and I agree with them by signing below:

PATIENT SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_

# Low Back

## OSWESTRY DISABILITY INDEX 2.0

NAME: \_\_\_\_\_ DATE: \_\_\_\_\_ SCORE: \_\_\_\_\_

**PLEASE READ:** Could you please complete this questionnaire. It is designed to give us information as to how your back (or leg) trouble has affected your ability to manage in everyday life.

Please answer **every section**. Mark **one box only** in each section that most closely describes you **today**.

<p><b>SECTION 1 - Pain Intensity</b></p> <p>A <input type="checkbox"/> I have no pain at the moment.            B <input type="checkbox"/> The pain is very mild at the moment.            C <input type="checkbox"/> The pain is moderate at the moment.            D <input type="checkbox"/> The pain is fairly severe at the moment.            E <input type="checkbox"/> The pain is very severe at the moment.            F <input type="checkbox"/> The pain is the worst imaginable at the moment.</p>	<p><b>SECTION 6 - Standing</b></p> <p>A <input type="checkbox"/> I can stand as long as I want without extra pain.            B <input type="checkbox"/> I can stand as long as I want but it gives me extra pain.            C <input type="checkbox"/> Pain prevents me from standing for more than 1 hour.            D <input type="checkbox"/> Pain prevents me from standing for more than 1/2 hour.            E <input type="checkbox"/> Pain prevents me from standing for more than 10 minutes.            F <input type="checkbox"/> Pain prevents me from standing at all.</p>
<p><b>SECTION 2 - Personal Care (washing, dressing, etc.)</b></p> <p>A <input type="checkbox"/> I can look after myself normally without causing extra pain.            B <input type="checkbox"/> I can look after myself normally but it is very painful.            C <input type="checkbox"/> It is painful to look after myself and I am slow and careful.            D <input type="checkbox"/> I need some help but manage most of my personal care.            E <input type="checkbox"/> I need help every day in most aspects of self care.            F <input type="checkbox"/> I do not get dressed, wash with difficulty and stay in bed.</p>	<p><b>SECTION 7 - Sleeping</b></p> <p>A <input type="checkbox"/> My sleep is never disturbed by pain.            B <input type="checkbox"/> My sleep is occasionally disturbed by pain.            C <input type="checkbox"/> Because of pain I have less than 6 hours' sleep.            D <input type="checkbox"/> Because of pain I have less than 4 hours' sleep.            E <input type="checkbox"/> Because of pain I have less than 2 hours' sleep.            F <input type="checkbox"/> Pain prevents me from sleeping at all.</p>
<p><b>SECTION 3 - Lifting</b></p> <p>A <input type="checkbox"/> I can lift heavy weights without extra pain.            B <input type="checkbox"/> I can lift heavy weights, but it causes extra pain.            C <input type="checkbox"/> Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned, e.g. on a table.            D <input type="checkbox"/> Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.            E <input type="checkbox"/> I can only lift very light weights, at the most.            F <input type="checkbox"/> I cannot lift or carry anything at all.</p>	<p><b>SECTION 8 - Sex Life (if applicable)</b></p> <p>A <input type="checkbox"/> My sex life is normal and causes me no extra pain.            B <input type="checkbox"/> My sex life is normal, but causes some extra pain.            C <input type="checkbox"/> My sex life is nearly normal but is very painful.            D <input type="checkbox"/> My sex life is severely restricted by pain.            E <input type="checkbox"/> My sex life is nearly absent because of pain.            F <input type="checkbox"/> Pain prevents any sex life at all.</p>
<p><b>SECTION 4 - Walking</b></p> <p>A <input type="checkbox"/> Pain does not prevent me from walking any distance.            B <input type="checkbox"/> Pain prevents me from walking more than one mile.            C <input type="checkbox"/> Pain prevents me from walking more than 1/4 mile.            D <input type="checkbox"/> Pain prevents me from walking more than 100 yards.            E <input type="checkbox"/> I can only walk while using a stick or crutches.            F <input type="checkbox"/> I am in bed most of the time and have to crawl to the toilet.</p>	<p><b>SECTION 9 - Social Life</b></p> <p>A <input type="checkbox"/> My social life is normal and causes me no extra pain.            B <input type="checkbox"/> My social life is normal, but increases the degree of pain.            C <input type="checkbox"/> Pain has no significant effect on my social life apart from limiting my more energetic interests, e.g., sport, etc.            D <input type="checkbox"/> Pain has restricted my social life and I do not go out as often.            E <input type="checkbox"/> Pain has restricted my social life to my home.            F <input type="checkbox"/> I have no social life because of the pain.</p>
<p><b>SECTION 5 - Sitting</b></p> <p>A <input type="checkbox"/> I can sit in any chair as long as I like.            B <input type="checkbox"/> I can only sit in my favorite chair as long as I like.            C <input type="checkbox"/> Pain prevents me from sitting more than 1 hour.            D <input type="checkbox"/> Pain prevents me from sitting more than 1/2 hour.            E <input type="checkbox"/> Pain prevents me from sitting more than ten minutes.            F <input type="checkbox"/> Pain prevents me from sitting at all.</p>	<p><b>SECTION 10 - Traveling</b></p> <p>A <input type="checkbox"/> I can travel anywhere without pain.            B <input type="checkbox"/> I can travel anywhere but I gives extra pain.            C <input type="checkbox"/> Pain is bad but I manage journeys over 2 hours.            D <input type="checkbox"/> Pain restricts me to journeys of less than 1 hour.            E <input type="checkbox"/> Pain restricts me to short necessary journeys under 30 minutes.            F <input type="checkbox"/> Pain prevents me from traveling except to receive treatment.</p>

**COMMENTS:** \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

# NECK DISABILITY INDEX QUESTIONNAIRE

NAME: \_\_\_\_\_ AGE: \_\_\_\_\_ DATE: \_\_\_\_\_ SCORE: \_\_\_\_\_

**PLEASE READ:** This questionnaire is designed to enable us to understand how much your neck pain has affected your ability to manage your everyday activities. Please answer each section by circling the ONE CHOICE that most applies to you. We realize that you may feel that more than one statement may relate to you, but **PLEASE JUST CIRCLE THE ONE CHOICE THAT MOST CLOSELY DESCRIBES YOUR PROBLEM RIGHT NOW.**

<p><i>SECTION 1 - Pain Intensity</i></p> <p>A. I have no pain at the moment.            B. The pain is very mild at the moment.            C. The pain is moderate at the moment.            D. The pain is fairly severe at the moment.            E. The pain is very severe at the moment.            F. The pain is the worst imaginable at the moment.</p>	<p><i>SECTION 6 - Concentration/</i></p> <p>A. I can concentrate fully when I want to with no difficulty.            B. I can concentrate fully when I want to with slight difficulty.            C. I have a fair degree of difficulty in concentrating when I want to.            D. I have a lot of difficulty in concentrating when I want to.            E. I have a great deal of difficulty in concentrating when I want to.            F. I cannot concentrate at all.</p>
<p><i>SECTION 2 -Personal Care (Washing, Dressing, etc.)</i></p> <p>A. I can look after myself normally without causing extra pain.            B. I can look after myself normally, but it causes extra pain.            C. It is painful to look after myself and I am slow and careful.            D. I need some help, but manage most of my personal care.            E. I need help every day in most aspects of self care.            F. I do not get dressed, I wash with difficulty and stay in bed.</p>	<p><i>SECTION 7 - Work</i></p> <p>A. I can do as much work as I want to.            B. I can only do my usual work, but no more.            C. I can do most of my usual work, but no more.            D. I cannot do my usual work.            E. I can hardly do any work at all.            F. I cannot do any work at all.</p>
<p><i>SECTION 3 - Lifting</i></p> <p>A. I can lift heavy weights without extra pain.            B. I can lift heavy weights, but it gives extra pain.            C. Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned, for example, on a table.            D. Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.            E. I can lift very light weights.            F. I cannot lift or carry anything at all.</p>	<p><i>SECTION 8 - Driving</i></p> <p>A. I can drive my car without any neck pain.            B. I can drive my car as long as I want with slight pain in my neck.            C. I can drive my car as long as I want with moderate pain in my neck.            D. I cannot drive my car as long as I want because of moderate pain in my neck.            E. I can hardly drive at all because of severe pain in my neck.            F. I cannot drive my car at all.</p>
<p><i>SECTION 4 - Reading</i></p> <p>A. I can read as much as I want to with no pain in my neck.            B. I can read as much as I want to with slight pain in my neck.            C. I can read as much as I want to with moderate pain in my neck.            D. I cannot read as much as I want because of moderate pain in my neck.            E. I cannot read as much as I want because of severe pain in my neck.            F. I cannot read at all.</p>	<p><i>SECTION 9 - Sleeping</i></p> <p>A. I have no trouble sleeping.            B. My sleep is slightly disturbed (less than 1 hour sleepless).            C. My sleep is mildly disturbed (1-2 hours sleepless).            D. My sleep is moderately disturbed (2-3 hours sleepless).            E. My sleep is greatly disturbed (3-5 hours sleepless).            F. My sleep is completely disturbed (5-7 hours)</p>
<p><i>SECTION 5 - Headaches</i></p> <p>A. I have no headaches at all.            B. I have slight headaches which come infrequently.            C. I have moderate headaches which come infrequently.            D. I have moderate headaches which come frequently.            E. I have severe headaches which come frequently.            F. I have headaches almost all the time.</p>	<p><i>SECTION 10 - Recreation</i></p> <p>A. I am able to engage in all of my recreational activities with no neck pain at all.            B. I am able to engage in all of my recreational activities with some pain in my neck.            C. I am able to engage in most, but not all of my recreational activities because of pain in my neck.            D. I am able to engage in a few of my recreational activities because of pain in my neck.            E. I can hardly do any recreational activities because of pain in my neck.            F. I cannot do any recreational activities at all.</p>

COMMENTS: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_