EASTMAN-KINGREY CLINIC
WESTLAKE, LA

MVA CONFIDENTIAL HEALTH HISTOR'
Date:_____ File:_____

PERSONAL

Name: _____ Sex: M/F Age:_____Date of Birth:_____
Phone (home):_____(cell):_____ (work): _____
What do you prefer to be called?: _____ SS#: _____Height:_____ Weight: _____
Marital Status: Single__Married__ Divorced__ Widowed__ Number of children:_____
Address: _____ City:_____ State:_____ Zip: _____
Employer: _____ How long?: _____ Employer Address:_____
Occupation: _____ How long?: _____
Spouse: _____ Spouse's employer: _____
Referred by: _____ In case of emergency notify: _____
Preferred Language: _____

INSURANCE

Your Insurance Co. _____ Other Insurance _____
Your Attorney _____ Adjustor _____
Have you notified your insurance company yet? Yes _No____ Claim # _____

ACCIDENT

Accident date _____Time _____am/pm City/Street_____
You were? __ Driver __Passenger (__mid front __right front __left rear __mid rear __right rear)
Your Vehicle _____
PLEASE ANSWER:

Y/N Belted? If yes, __shoulder and lap __shoulder __lap
Y/N Aware that the accident was going to happen? If yes, did you brace? __ yes __no
Y/N Was your head facing to the side? If yes, which side? __left __right __back __rear view mirror
Y/N Did you lose consciousness? If yes, how long? _____
Y/N Was there an airbag inflation?
Y/N Police report made? Which Department? _____
Y/NDid you go to the hospital the day of the accidents? If yes, how? __ Ambulance __Drove Self __Driven by someone else
Y/N Have you been to the hospital or any other
doctor since the day of the accident?

CURRENT CONDITION

Please describe the principal health problems for which you came to this office: _____
_____
How and when did symptoms first occur?: _____
List any other doctors seen for these problems: _____
List any diagnosis(es) and type of treatment: _____

Are you taking any medications for the current condition?: Yes__ No__ Have they helped?: A lot__ Some__ Not at all __
Type of medications?: Pain killers__ Muscle relaxers__ Anti-inflammatory__ Other_____
Have you lost any days of work?: Yes__ No__ Dates:_____
Have you had similar symptoms before?: Yes__ No__ When?:_____

AUTHORIZATION AND ASSIGNMENT

In consideration of your undertaking to care for me, I agree to the following:

1. I authorize the direct payment to you of any sum I now or hereafter owe you by my attorney out of the proceeds of any settlement of my case, and by any insurance company obligated to make to me or you based in whole or in part upon the charges made for your services.
2. In the event any insurance company obligated to contractual agreement to make payment to me or to you for the charges made for your services refuses to make such payment upon demand by you, I hereby assign and transfer to you the cause of action that exists in my favor against any such company (the name(s) of which is believed to be correctly set forth under pertinent data) and authorize you to prosecute said action either in my name as you see fit and further authorize you to compromise, settle or otherwise resolve said claims as you see fit, I understand that whatever amounts you do not collect from insurance companies proceeds, whether it be all or part of what is due, I personally owe you.

Date_____ Signature _____

HEALTH HISTORY

Check the following conditions/procedures you have/had:

__Anemia
__Cancer
__ Diabetes
__ Epilepsy
__ Fibromyalgia
__Gout
__Hepatitis
__HIV/AIDS
__Lupus
__ Multiple Sclerosis
__Osteoporosis
__ Rheumatoid Arthritis
__ Thyroid Condition
__ Urinary Tract Infections
__Venereal Disease
__Asthma
__Emphysema
__Tuberculosis
__Artificial Joints
__ Bone Fracture
__ Bone Fusion
__ Disc Herniation
__Dislocations
__Hernia
__Sciatica
__Scoliosis
__Tendon/Ligament Rupture
__ TMI Condition
__ Whiplash
__Arteriosclerosis
__ Cardiovascular Disease
__ Heart Attack/Stroke
__ Heart Defect
__Heart Murmur
__High Blood Pressure
__Low Blood Pressure
__Pacemaker
__Colitis
__ Gallbladder Condition
__ Gastric Reflux
__ Hemorrhoids
__Kidney Condition
__ Liver Condition
__Rectal Polyps
__ Ulcers
__Endometriosis
__ Hormone Replacement
__ Ovarian/Uterine Cyst
__Prostate Condition
__Testicle Condition

Please Circle the appropriate letter for any of the following symptoms:

O-OCCASIONAL
F- FREQUENT
C-CONSTANT

O F C- Severe/frequent Headaches
O F C- Jaw Pain
O F C- Eye Problems
O F C- Sinus Problems
O F C- Ear Problems
O F C- Nose Bleeding
O F C- Nose Discharge
O F C- Sore Throat
O F C- Dental Problems
O F C- Swollen Lymph Nodes

GENITOURINARY
O F C- Bladder Trouble
O F C- Excessive Urine
O F C- Painful Urination
O F C- Discolored Urine
O F C- Urinary Infection

RESPIRATORY
O F C- Difficulty Breathing
O F C- Coughing Blood
O F C- Coughing Phlegm
O F C- Chest Pain

CARDIOVASCULAR
O F C- Pain over Heart
O F C- Rapid Heartbeat

GASTROINTESTINAL
O F C- Weight Trouble
O F C- Excessive Thirst
O F C- Excessive Hunger
O F C- Poor Appetite
O F C- Heartburn
O F C- Abdominal Pain
O F C- Nausea/Vomiting
O F C- Diarrhea
O F C- Constipation
O F C- Black Stool
O F C- Bloody Stool

MUSCULOSKELETAL
O F C- Back Pain
O F C- Neck Pain
O F C- Pain Between Shoulders

PAIN OR NUMBNESS IN :
O F C- Shoulders
O F C- Arms
O F C- Elbows
O F C- Hands
O F C- Hips
O F C- Legs
O F C- Knees
O F C- Feet
O F C- Swollen/Stiff Joints
O F C- Loss of Strength
O F C- Walking Problems

NERVOUS
O F C- Seizures
O F C- Fainting
O F C- Dizziness
O F C- Paralysis
O F C- Loss of Feeling

FEMALES ONLY:
O F C- Vaginal Discharge
O F C- Irregular Vaginal Bleeding
O F C- Vaginal Pain
O F C- Breast Pain
O F C- Breast Lumps
O F C- Hot Flashes

Please Answer

List any health conditions within the last year:

_____
_____
_____

List any medications not listed previously that you currently take:

_____
_____
_____

List approximate date of any other operations, diseases, serious illnesses or accidents you have had:

_____
_____
_____
_____
_____
_____
_____
_____

DO YOU:

Wear heel lifts, arch supports, sole lifts, or inner soles? Y/N
Smoke? Y/N
Exercise? Y/N
Take Vitamins? Y/N

Allergies: _____
Usual sleeping position? Back__ Stomach__ Right Side__ Left Side __
Mattress: Age: ___ Type: _____ Is it comfortable: Yes__ No __
How would you rate your overall health?: Excellent_ Good_ Fair_ Poor_
Received chiropractic care before?: Yes __ No __

FEMALES ONLY

Are you currently pregnant?: Yes __ No __
If yes, due date?: _____
Are you currently menstruating?: Yes __ No __

Doctor's Notes:

PATIENT SIGNATURE: _____ **DATE:** _____

NAME: _____ DATE: _____ FILE #: _____

Functional Rating Index

Please circle the number which most closely descries your condition right now.

1. Pain Intensity

0	1	2	3	4
No Pain	Mild Pain	Moderate Pain	Severe Pain	Worst Possible Pain

2. Sleeping

0	1	2	3	4
Perfect Sleep	Mildly Disturbed Sleep	Moderately Disturbed Sleep	Greatly Disturbed Sleep	Totally Disturbed Sleep

3. Personal Care (washing, dressing, etc.)

0	1	2	3	4
No Pain; No Restrictions	Mild Pain; No Restrictions	Moderate Pain; Need To Go Slowly	Moderate Pain; Need Some Assistance	Severe Pain; Need 100% Asssistance

4. Travel (driving, etc.)

0	1	2	3	4
No Pain On Long Trips	Mild Pain On Long Trips	Moderate Pain On Long Trips	Moderate Pain On Short Trips	Severe Pain On Short Trips

5. Work

0	1	2	3	4
Can Do Usual Work Plus Unlimited Extra Work	Can Do Usual Work; No Extra Work	Can Do 50% Of Usual Work	Can Do 25% Of Usual Work	Cannot Work

6. Recreation

0	1	2	3	4
Can Do All Activities	Can Do Most Activities	Can Do Some Activities	Can Do A Few Activities	Cannot Do Any Activities

Please Turn Over

7. Frequency of Pain

0	1	2	3	4
No Pain	Occasional Pain; 25% Of The Day	Intermittent Pain; 50% Of The Day	Frequent Pain; 75% Of The Day	Constant Pain; 100% Of The Day

8. Lifting

0	1	2	3	4
No Pain With Heavy Weight	Increased Pain With Heavy Weight	Increased Pain With Moderate Weight	Increased Pain With Light Weight	Increased Pain With Any Weight

9. Walking

0	1	2	3	4
No Pain; Any Distance	Increased Pain After 1 Mile	Increased Pain After ½ Mile	Increased Pain After ¼ Mile	Increased Pain With All Walking

10. Standing

0	1	2	3	4
No Pain After Several Hours	Increased Pain After Several Hours	Increased Pain After 1 Hour	Increased Pain After ½ Hour	Increased Pain With Any Standing

Patient Signature **Date**

EASTMAN-KINGREY CLINIC
CONSENT/RELEASE

PATIENT_____ DATE _____ FILE #_____

PATIENT INFORMED CONSENT

I hereby request and/or consent to the performance of chiropractic examinations and/or procedures on (or on the patient names above for who I am legally responsible) by Charles T. Kingrey, Jr. D.C. and/or Jana Kingrey D.C.

I understand and am informed that, as in the practice of chiropractic there are some risks to chiropractic care, including but not limited to strokes, sprains and strains, fractures, dislocations and general aggravations of inflammatory conditions. I understand that I will have an opportunity to discuss with the doctor and/or other office personnel the nature and purpose of the chiropractic procedures I will receive. I understand that the doctor will perform an examination in order to minimize any risk of care; however, I do not expect the doctor to be able to anticipate and explain all risks and complications. I therefore wish to rely on the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts as then known, and is in my best interest.

I have read, or have had read to me, the above consent. I have also had the opportunity to ask questions about its content, and by signing below, I agree to the procedures. I intend this consent form to cover the entire course of care for my present condition(s) and for any future condition(s) for which I seek care.

_____ _____

Patient/Guardian Signature **Doctor's Signature**

AUTHORIZATION TO RELEASE INFORMATION

I authorize release of any medical information necessary to process any claims. I authorize payment of any medical benefits to be paid directly to Eastman-Kingrey Clinic for any medical services rendered to me. This authorization shall remain in effect until cancelled by me.

_____

Patient Signature

INSURANCE/PATIENT RESPONSIBILITY

I have been informed and am aware that my health insurance coverage may have some limitations pertaining to chiropractic care. I am also aware that this could cause benefits to be denies or paid at a lower percentage rate due to such policy limitations as yearly maximum payment amounts, yearly number of visit limits, referral needed from primary care physicians, etc.

I am aware that my visits may not be covered by my insurance and that I will be fully responsible for payment of services rendered at such time that a denial is received from my insurance carrier.

_____

Patient Signature

NO CALL-NO SHOW/CANCELATION POLICY

I have been informed of the cancelation policy by the staff/doctors at Eastman Kingrey Clinic. I understand that I am required to cancel and/or reschedule my appointments 24 hours prior to scheduled appointments. Failure to do so will result in a charge of $25.00 to my account. I also understand that a $25.00 charge will be added to my account for failure to appear for any scheduled appointment without communication to our office (no call-no show). For an existing patient with a new condition or new patient appointment requiring an exam and x-rays, a no call-no show charge of $50.00 will added to accounts if failure to appear without communication with our office. By signing this form, I understand the terms of the Cancelation Policy and the charges that would be applies to my account without compliance.

_____

Patient Signature

VERIFICATION OF NON-PREGNANCY

By my signature on this form, I hereby state that, to the best of my knowledge, I am NOT pregnant, nor is pregnancy suspected or confirmed at this particular time.

_____

Patient Signature

CONSENT TO TREAT MINOR CHILD

I hereby authorize Dr. Charles T. Kingrey, Jr. and/or Dr. Jana Kingrey and whoever he or she may designate as assistants to administer chiropractic care as deemed necessary to my _____ (indicate relationship to child).
Name of child: _____

_____

Parent/Guardian Signature

EXPLANATION OF CHIROPRACTIC MEDICARE BENEFITS

***MEDICARE COVERS CHIROPRACTIC CARE, BUT WITH LIMITATIONS**

The only service covered by Medicare is manual manipulation of the spine. These manipulations under some circumstances and with certain carriers are limited to 12 (twelve) per calendar year.
Your condition may require, in our judgement, more treatments than allowed by Medicare. We can apply for additional treatments by submitting a "medical necessity statement" on your behalf. Your case will be sent for review. We cannot guarantee or predict what the review will decide in your case.

ANY VISITS OVER 12 (TWELVE) IN THIS CALLENDER YEAR, NOT APPROVED BY MEDICARE, WILL BE YOUR FINANCIAL RESPONSIBILTY.

Medicare does not cover the cost of x-rays, examinations, therapy, supports, supplements or any other services offered in this office.

Any services other than spinal manipulation will be your financial responsibility.

I have read and understand the above statement.

_____ _____

Patient Signature **Date**

APPOINTMENT REMINDERS AND HEALTH CARE INFORMATION AUTHORIZATION

Your chiropractor and members of the practice staff may need to use your name, address, phone number, and your clinical records to contact you with appointment reminders, information about treatment alternatives, or other health related information that may be of interest to you. If this contact is made by phone and you are not home, a message will be left on your answering machine or with a family member. If we are unable to reach you at home, we will leave a message at your worksite on an answering machine or with a co-worker.

You may restrict the individuals or organizations to which your health care information is released or you may revoke your authorization to us at any time; however, your revocation must be in writing and mailed to us at your office address. 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. In addition, if you were to give 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.

Information that we use or disclose based on the authorization you are giving us may be subject to re-disclosure by anyone who has access to the reminder or other information and may no longer be protected by the federal privacy rules.

You may inspect or copy the information that we use to contact you to provide appointment reminders, information about treatment alternatives, or other health related information at any time.

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

I authorize you to use or disclose my health information in the manner described above. I am also acknowledging that I have received a copy of this authorization.

_____ _____

Patient Name Printed **Date**

_____ _____

Patient Signature **Authorized Provider Representative**

_____ _____

Personal Representative (Print) **Personal Representative Signature**

_____

Description of Personal Representative's authority to act for the patient

EASTMAN KINGREY CLINIC
902 Sampson Street
Westlake, La 70669
337.436.3145

Consent to use PHI

Acknowledgement for Consent to Use and Disclosure of Protected Health Information

Use and Disclosure of your Protected Health Information

Your Protected Health Information will be used by Chaumont Chiropractic or may be disclosed to others for the purposes of treatment, obtaining payment, or supporting the day-to-day health care operations of this office.

Notice of Privacy Practices

You should review the Notice of Privacy Practices for a more complete description of how your Protected Health Information may be used or disclosed. It describes your rights as they concern the limited use of health information, including your demographic information, collected from you and created or received by this office. I have received a copy of the Notice of Patient Privacy Policy. _____Patient Initials

Requesting a Restriction on the Use or Disclosure of Your Information

- You may request a restriction on the use or disclosure of your Protected Health Information.
- This office may or may not agree to restrict the use or disclosure of your Protected Health Information.
- If we agree to your request, the restriction will be binding with this office. Use or disclosure of protected information in violation of an agreed upon restriction will be a violation of the federal privacy standards.

Notice of Treatment in Open or Common Areas

Describe and Notify private areas available upon request

Revocation of Consent

You may revoke this consent to the use and disclosure of your Protected Health Information. You must revoke this consent in writing. Any use or disclosure that has already occurred prior to the date on which your revocation of consent is received will not be affected.

By my signature below I give my permission to use and disclose my health information.

_____ _____
Patient or Legally Authorized Individual Signature Date

_____ _____
Print Patient's Full Name Time

_____ _____
Witness Signature Date

Eastman-Kingrey Clinic

Personal Injury Financial Agreement

We would like to take a moment to welcome you to our office and assure you that you will receive the very best care available for your injury. In order to familiarize you with the financial policy of our office, I would like to explain how your medical bills will be handled.

PARTY RESPONSIBLE:
If you were involved in an auto accident in your own vehicle, we will bill medical payments portion or Person Injury Protection portion of your insurance policy to cover the treatment charges incurred in our office.

MEDPAY:
If you were a passenger in another vehicle, the insurance company which insures the automobile may be billed for your medical services incurred.

PIP (Personal Injury Protection):
If you were a passenger in another vehicle, and you own a car which has PIP coverage, the insurance company which carries your policy will be responsible to pay your medical bills.

3rd Party:
If another vehicle has caused the accident, we will first bill the responsible party automobile MedPay or PIP. In special circumstances we can bill your own health insurance policy for your medical services, providing your policy does not state otherwise. Any amount received above and beyond your total bill in this office will be refunded to you.

ATTORNEY LIENS:
If you hire an attorney to represent you in a law suit, it is our policy to send your attorney a signed doctor's lien. This will guarantee direct payment to our office for any undid balance upon the settlement of your law suit. We retain the right to first submit all charges to your private and/or auto insurance policy for payment. Further, this office does not discount or reduce the amount of your balance based upon the outcome of your settlement.

RESPONSIBILITY FOR PAYMENT:
As a courtesy to you, we will gladly submit your charges to the responsible party, your insurance company(ies) and/or your attorney; however, all services rendered by this office are charged directly to you, and ultimately, you are personally responsible for payment of these charges, regardless of any insurance reimbursement or settlement you may or may not receive.

Once again, we welcome you to our office. We hope that this has answered any questions that you might have about our financial arrangements. If, at any time, you have further questions about your care, please do not hesitate to ask.

I have read and agree to the above.

_____ _____

Patient Printed Name **Date**

_____

Patient or Guardian Signature

Back Index

ACN Group, Inc. Form BI-100

ACN Group, Inc. Use Only 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

ACN Group, Inc. Form NI-100

ACN Group, Inc. Use Only 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 _____