# PLEASE READ!!

IF YOU HAVE QUESTIONS ABOUT HOW THIS WORKS, LET US KNOW AND WE CAN HELP ANSWER ANY QUESTIONS YOU MAY HAVE.

## IF YOU ARE THE DRIVER NOT AT FAULT, THEN....

## YOU WILL USE YOUR MEDPAY OPTIONS THROUGH YOUR AUTO INSURANCE COMPANY

****BY LAW, YOUR AUTO INSURANCE PREMIUMS CANNOT INCREASE IF YOU USE YOUR MEDICAL PAYMENTS (MEDPAY) PORTION OF YOUR AUTO INSURANCE. YOUR MEDPAY IS THE FIRST TO BE BILLED.****

REF: 3_CRR_702-5:5-2-12

## IF AND WHEN YOUR MEDPAY IS EXHAUSTED, THERE ARE 3 OPTIONS....

### General Health Insurance

-Your personal health insurance will be billed, all copays and deductibles apply

### Lien

-For cases involving at fault insured driver, uninsured driver, or underinsured driver

-Must have attorney representation for this option

-If you are at fault and not using MedPay, you will be billed and responsible for the remainder of your balance

### Personal Pay

-You would be responsible for payment in full at time of service

FOR ADDITIONAL QUESTIONS, PLEASE CONTACT RHONDA AT 720-452-1563

# AUTO INSURANCE AUTHORIZATION

TODAY'S DATE: ______________

PATIENT'S NAME: ____________________________________________ DOB: _____________

PHONE ______________________________ ☐ HOME ☐ CELL ☐ OTHER

DATE OF ACCIDENT: ______________ *CITY/STATE OF ACCIDENT: ______________

YOU WERE THE (check one): ☐ DRIVER ☐ PASSENGER

AT FAULT: ☐ DRIVER ☐ OTHER DRIVER

***DRIVER'S INSURANCE INFORMATION:***

**INSURANCE COMPANY:** ________________________

**MEDICAL PAY MAXIMUM: $** ______________ **(this is on the patient's own auto insurance policy)**

**CLAIM #:** ________________________

**INSURANCE ADJUSTER:** ________________________

**INSURANCE PHONE #:** ________________________

***OTHER DRIVER'S INSURANCE INFORMATION:***

**INSURANCE COMPANY:** ________________________

**MEDICAL PAY MAXIMUM: $** ________________________

**CLAIM #:** ________________________

**INSURANCE ADJUSTER:** ________________________

**INSURANCE PHONE #:** ________________________

COPY OF: (BRING WITH YOU TO OFFICE)

☐ PROOF OF AUTO INSURANCE

☐ POLICE REPORT

☐ GENERAL HEALTH INSURANCE

8155 W. 94th Avenue • Westminster, CO 80021 •Phone 303/423-4610•Fax 303/431-8658

## *AUTO ACCIDENT-PERSONAL INJURY-WORK COMP. INFORMATION FORM*

Your Name: ______________________________ Today's Date: ______________

Birth Date: ___/___/___ Age: _______ Marital Status: Single Married Divorced Widowed Other

Address: ______________________________ City: ______________________ Zip: ____________

Phone Number: ____________________ ☐ CELL ☐ HOME ☐ WORK S.S. #: _____/_____/______

Emergency Contact: __________________ Relationship: _______________ Phone: ______________

E- Mail Address: ______________________________

Referred to this office by: ______________________________

Your Employer: ______________________________ City: ______________________________

Your Occupation: ______________________________

Type of Job: ☐ Office Orientated • ☐ Manual • ☐ Travel • ☐ Homemaker

Job Requirements: ☐ Lifting • ☐ Bending • ☐ Stooping • ☐ Telephone Cradling • ☐ Typewriting/Data Entry ☐ Prolonged Sitting • ☐ Prolonged Standing • ☐ Lifting Children, Ages: __________

Your Primary Care Physician: ______________________________ Phone #: ________________

Date of Accident: ______________ Time: __________ AM ☐ PM ☐ •Location: ________________

Have your injuries been reported? Yes ☐ No ☐ If yes, to whom: ______________________________

**For AUTO ACCIDENTS ONLY:**

Your Vehicle Year: ______ Make: ______________ Model: ______________ Damage: $____________

Other Vehicle Year: ______ Make: ______________ Model: ______________ Damage: $____________

Road Conditions: ☐ Dry ☐ Wet ☐ Icy Other: ______________ Traveling or Stopped Facing: N S E W

Accident Was: ☐ Auto to Auto • ☐ Auto to Object • ☐ Pedestrian/Cyclist to Auto • ☐ Industrial-on Job

Were you the ☐ Driver ☐ Passenger

History of accident: ☐ Stopped and Rear-ended ☐ Hit Head On ☐ Car Ran A Stop Sign Or Red Light ☐ Broad-sided ☐ Side Swiped ☐ Lost Control Of Car ☐ Other: ______________________

Was Your Car...? ☐ Slowing Down • ☐ Speeding Up • ☐ Steady Speed • ☐ Stopped

What Direction Were You looking at the time of the accident? (i.e. forward, backward, etc.)______________

Was Your Foot on the Brake? Yes ☐ No ☐ • What approximate speed was the other vehicle moving? ______

Were you wearing a seat belt? Yes ☐ No ☐ • lap belt ☐ shoulder + lap belt ☐

Did your vehicle have a headrest? Yes ☐ No ☐ • Was it Up ☐ or Down ☐

Did your vehicle have an airbag? Yes ☐ No ☐ • Did it deploy? Yes ☐ No ☐

Were you aware of the approaching collision? Yes ☐ No ☐

Did you strike any objects in the car? Yes ☐ No ☐

☐ Steering column ☐ Rearview mirror ☐ Dash board ☐ Windshield
☐ Headrest ☐ Seat broke ☐ Cannot remember ☐ Other: ______________

What portion of your body did you strike?

☐ Head ☐ Chest ☐ Face ☐ Knees ☐ Arms ☐ Other If so, where? ______________

Were you rendered unconscious? Yes ☐ No ☐ If so, how long? ______________________________

Accident Scene: Did the police come? Yes ☐ No ☐

**ALL Accidents complete the following:**

Were you taken to the hospital? Yes ☐ No ☐ Were you seen in the emergency room? Yes ☐ No ☐

If yes, how?
☐ By ambulance
☐ By friend
☐ Drove yourself
☐ Went home and later was taken or drove
☐ Name of hospital:________________________ City: ________________________

What was done?
☐ Examination ☐ Stitches ☐ X-rays
☐ Physiotherapy ☐ Cervical collar ☐ Complete bed rest
☐ Prescription ☐ Other:________________________

After your release, what did you do? ☐ Return home to bed ☐ Return to work
☐ Other:________________________

Have you seen other doctors and been treated as a result of this accident? Yes ☐ No ☐

If yes, please list names and specialties:

________________________________________________

________________________________________________

________________________________________________

What did the other doctor(s) do?
☐ Examination ☐ Injections ☐ X-rays
☐ Prescriptions ☐ Traction
☐ Physiotherapy: how long:________________________
☐ Other:________________________

How long have you been under the care of a physician?

________________________________________________

We would ask your assistance in obtaining copies of your records.

Are you still under their care? Yes ☐ No ☐

## ***Tell Us What Is Bothering You***

In order to give the doctor a clear understanding of your case, we would like you to answer a few simple questions. Please be as specific as possible on both the body diagrams and the questions. If you are unsure about any part of this form, please feel free to ask the staff, or especially the doctor.

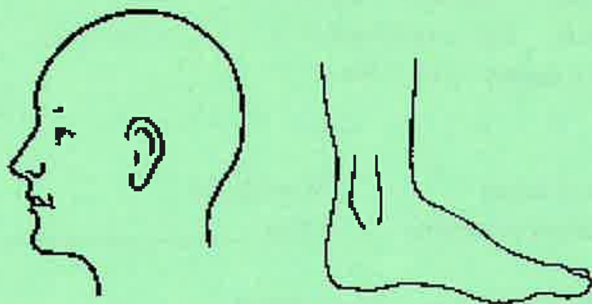
What is your main area of chief complaint? (i.e. neck pain, headaches, low back pain, arm/leg pain)

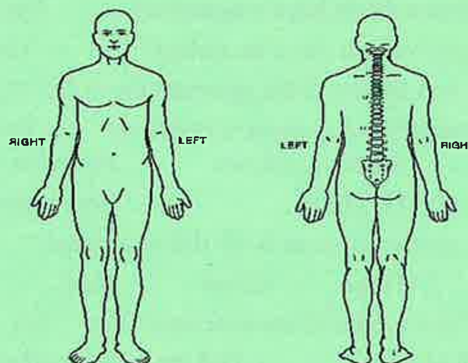
________________________________________________

________________________________________________

________________________________________________

Please ***mark*** the appropriate area of your chief complaint on the following diagrams. If you are experiencing radiating pain, please mark the areas that the pain is going to.





**Please check the following symptoms which apply to your condition *following* the accident:**

| | | | |
|---|---|---|---|
| ☐ Headache | ☐ Depression | ☐ Neck pain | ☐ Neck stiffness |
| ☐ Insomnia | ☐ Irritability | ☐ Tension | ☐ Loss of taste |
| ☐ Diarrhea | ☐ Anxiety | ☐ Fainting | ☐ Loss of smell |
| ☐ Chest pain | ☐ Constipation | ☐ Dizziness | ☐ Loss of memory |
| ☐ Eye strain | ☐ Double vision | ☐ Pain behind eyes | ☐ Ringing in ears |
| ☐ Face flushed | ☐ Pallor | ☐ Shortness of breath | ☐ Pain upon rising |
| ☐ Tremors | ☐ Palpitations | ☐ Nausea or vomiting | ☐ Muscle jerking |
| ☐ Sore muscles | ☐ Pain in joints | ☐ Leg problems | ☐ Extreme fatigue |
| ☐ Loss of feeling | ☐ Feet cold | ☐ Hands cold | ☐ Swelling |
| ☐ Mental dullness | ☐ Sinus trouble | ☐ Extreme nervousness | |

☐ Excessive sweat ☐ Digestive disorders ☐ Difficulty in prolonged sitting

☐ Back pain or stiffness: ☐ Upper ☐ Mid ☐ Lower

☐ Pain radiating into: ☐ Arms ☐ Buttock ☐ Legs ☐ Feet

☐ Head seems too heavy ☐ Head and shoulders feel tired

☐ Restriction of motion: ☐ Neck ☐ Upper back ☐ Low back

Numbness in: ☐ Neck R/L ☐ Shoulders R/L ☐ Arms R/L
☐ Fingers R/L ☐ Hips R/L ☐ Legs R/L ☐ Feet R/L

Pins and needles in: ☐ Neck R/L ☐ Shoulders R/L ☐ Arms R/L
☐ Fingers R/L ☐ Hips R/L ☐ Legs R/L ☐ Feet R/L

Any other condition not specified:

______________________________________________________________________

What factors aggravate your complaint?(Make you worse)

☐ Sitting for long periods of time ☐ Standing for long periods of time

☐ Walking ☐Getting up and down out of chair/car ☐ Driving

☐Lifting: ____ Light ____ Moderate ____ Heavy ____ Repeated

☐Twisting: ____ Light ____ Moderate ____ Heavy ____ Repeated

☐Standing: ____ Light ____ Moderate ____ Heavy ____ Repeated

☐Other activities (please list):________________________________________

Check any of the following that have helped you get relief from your complaint.

☐ Ice ☐ Heat ☐ Stretches/exercise ☐Rest ☐ Massage

☐ Other (please list):________________________________________

☐Medication(Please List): ________________________________________

Does your pain seem to be worse at any of the following times of day?

☐ Worse when I wake up ☐ Worse in the afternoon ☐ Worse in the evening

☐Wakes me up at night ☐ Worse only with activity ☐ Constant, no relief

☐Other (please list): ________________________________________

Are there any activities you cannot do because of your condition?

☐ Work ☐ Clean house ☐ Drive

☐ Lift things ☐ Play sport/activity

☐ Other (please list): ________________________________________

Does your pain seem to be getting: ☐ Same ☐ Better ☐ Worse

Were any of the above symptoms present immediately prior to the accident? ☐ Yes ☐ No
If yes, which ones?: ____________________

## HISTORY:

**Auto Accident:** ____________________
**Serious Fall:** ____________________
**Hospitalizations:** ____________________
**Surgeries:** ____________________
**Emotional Upsets:** ____________________
**Recent Dr. Visits:** ____________________

**Date of Last:** Physical Exam, Chest X-Ray, Urine Test, Spinal X-Ray, Blood Test, Spinal Exam, Dental X-Ray

**Do you take:** ☐ Nerve pills ☐ Muscle relaxers ☐ Pain killers ☐ "Pep" pills ☐ Tranquilizers ☐ Insulin ☐ Birth control ☐ Other: ________

**Do you now take vitamins and/or minerals?:** ☐ Yes ☐ No If yes, list: ____________

**Habits (please give amount):**

☐ Tobacco _____ (packs/day) o Alcohol ______ (drinks/day)
☐ Caffeine (coffee/tea/cola) ______ (drinks/day) o Non-job exercise _____ (hrs/wk)
☐ Sleep _____ (hrs/night) ☐ Do you sleep on your: ☐ Back ☐ Side ☐ Stomach
☐ Do you use a bed board? ☐ Yes ☐ No Is your bed comfortable? ☐ Yes ☐ No

**Do you wear:** ☐ Heel lifts ☐ Sole lifts ☐ Inner soles ☐ Arch supports ☐ Back brace ☐ Prescribed orthotics

**Mark the following diseases you have had:**

☐ AIDS/HIV
☐ Hepatitis ☐ A ☐ B ☐ C
☐ Small pox
☐ Diabetes
☐ Mumps
☐ Polio
☐ Heart Disease
☐ Rheumatic fever
☐ Chicken Pox
☐ Multiple Sclerosis
☐ Whooping Cough
☐ Epilepsy
☐ Rheumatoid Arthritis
☐ Cancer/Tumors
☐ Measles
☐ Typhoid Fever
☐ Eczema
☐ Other: ________
☐ Anemia
☐ Malaria
☐ Tuberculosis
☐ Diphtheria
☐ Pneumonia

**Are you aware of any diseases that run in your family?** ☐ **Yes** ☐ **No** **If yes, describe:** ____________________

**Do any family members have similar health problems?** ☐ **Yes** ☐ **No (If yes, please describe):** ____________________

## FOR WOMEN ONLY:

**Date of your last normal period:** ________ ***Interval between periods: _____ days***

**First period at age:** ________ **Date of last visit to gynecologist:** ________

***Is there any chance you may be pregnant?*** ☐ Yes ☐ No

**Check all that apply:**

- ☐ Irregular cycles
- ☐ Premenstrual tension
- ☐ Pain or bleeding during
- ☐ Cramps or backache
- ☐ Excessive flow
- ☐ Other menstrual symptoms
- ☐ Vaginal discharge
- ☐ Menopausal symptoms
- ☐ Congested breasts, lumps in breasts

**The best doctor/patient relationship is when there is complete understanding of treatment and financial responsibilities between the doctor and the patient.**

**If you do not have insurance, you are responsible for payment at the time services are rendered. If you believe that another person's insurance should cover your bill, we strongly recommend you seek legal advice, as the other person's insurance is not automatically responsible for your health care bills.**

It is possible the other insurance company will accept responsibility for your bill rather than go to court over the matter. In order for our office to accept insurance assignment in such a case we must obtain a signed authorization from the insurance company to that effect. If proper authorization is supplied to us, we will bill the insurance company for payment for services you receive.

**I acknowledge that I have read and understand the above policy.**

____________________ ____________________________________

Date Signature of Patient **OR** Guardian

____________________ ____________________________________

Date Witness

## AUTHORIZATION TO RELEASE INFORMATION & AUTHORIZATION TO PAY PHYSICIAN/LIEN

I hereby authorize Lifetime Health & Wellness, Inc. to release any information you deem appropriate concerning my physical condition to any insurance company, attorney, or adjuster in order to process any claim for reimbursement of charges incurred by me as a result of professional services rendered by Lifetime Health & Wellness, Inc.; and I hereby release you of any consequences thereof. I also authorize my attorney and/or insurance company to pay by check made out and mailed directly to CEO Westminster, Inc. any moneys due, and otherwise payable to me, the same to be deducted from any settlement made on my behalf, for professional services rendered. Further I agree to pay CEO Westminster, Inc. the difference, if any, between the total amount of their charges and the amount paid by the attorney and/or insurance carrier. I understand and agree that all services rendered are charged directly to me, and that I am personally responsible for payment upon delivery of services unless prior arrangements are made. All patient "co-pays" or non-covered percentage fees are to be paid by the patient following each day's services. I understand that should my account fall delinquent, it may be turned over for collection, I agree to pay the costs of collection, I agree to pay the costs of collection, including reasonable attorney fees. I understand that the collection agency takes 50% of all monies collected. This charge would be passed on to me and added to my outstanding balance. I hereby state and agree that a photocopy of this document will be deemed as valid and binding on all parties involved as the original form.

__________________________________________________________

Signature of Patient **OR** Legal Guardian Date

Lifetime Health & Wellness
WWW.LTHAW.COM

8155 W. 94th Avenue • Westminster, CO 80021 • Phone: 303-423-4610 • Fax: 303-431-8658

## ACKNOWLEDGMENT OF RECEIPT OF HIPPA PRIVACY NOTICE

I, ______________________________, have been offered/provided a copy of the Notice of Privacy Practices from this office. I understand that I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

1. Conduct, plan, and direct my treatment and follow-up among the health care providers who may be directly and indirectly involved in the provision of my treatment.
2. Obtain payment from third-party payers.
3. Conduct normal healthcare operations such as quality assessments and accreditation.

I understand that I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment, or healthcare operations. The practice of C.E.O. Westminster is not required to agree to the restrictions that I may request.

I understand that my "protected health information" means health information including my demographic information collected from me, created or received by my doctor, another health care provider, a health plan, my employer, or a health care compensation center. This protected health information relates to my past, present, or future health or physical or mental condition and identifies me, or there is a reasonable basis to believe that you can identify me.

The Notice of Privacy Practices for C.E.O. Westminster is also posted in the waiting room at 8155 W. 94th Ave., Broomfield, CO 80021. The Notice of Privacy Practices is subject to change and a revised version may be requested and mailed to me or provided for me at the time of my next appointment.

Patient Name (printed): ______________________________ Date: ______________

Patient Signature: ______________________________

☐ **Please check here to authorize our office to release records to you Primary Care Physician.**

**For Official Use Only**

We attempted to obtain written Acknowledgement of Receipt of our Notice of Privacy Practices, but acknowledgment could not be obtained because:

☐ Individual refused to sign
☐ Communication barriers prohibited obtaining the acknowledgement
☐ An emergency situation prevented our office from obtaining acknowledgment
☐ Other (please specify): ______________________________
______________________________.

Staff Signature: ______________________________ Date: ______________

## OFFICE POLICIES

***Please read our policies and acknowledge by initialing next to each statement and sign the bottom***

________ All payments are **DUE AT TIME OF SERVICE** including co-pays, co-insurance, deductible amounts, and/or non-covered procedures. If payment is not made at time of service, a **$10 billing fee** will be applied to your balance.

________ Insurance cards presented are current and accurate. We will contact your insurance to verify benefits, however, this is not a guarantee of coverage or payment. Ultimately, it is the patient's responsibility to know insurance coverage. We know your claim is processed once we receive payment and an explanation of benefits (EOB).

________ Insurance companies have 45 days to approve or deny a claim. In some cases, this may take longer if extra information is requested.

________ For any balance remaining after insurance has paid, you will be mailed a statement. Please contact your insurance company if you feel insurance has paid incorrectly.

________ If bill is not paid within 30 days of receiving statement or billing department is not contacted, a **$15 billing fee** will be applied each billing thereafter.

________ We understand there are times where you are unable to keep an appointment. We request 24-hour notice for cancelling an appointment. A **$20 fee** may be assessed if we are not contacted in time. You may leave a voicemail if the office is closed.

________ In accordance with the State of Colorado statutes, no doctor shall engage in a personal relationship with any patient outside the parameters of normal conduct of doctor-patient interaction.

## *AUTHORIZATION TO RELEASE INFORMATION*

I hereby authorize CEO Westminster Inc. to release any appropriate information concerning my physical condition to any insurance company, attorney, or adjuster in order to process any claim for reimbursement of charges incurred by me as a result of professional services rendered and hereby release CEO Westminster Inc. of any consequences thereof. I authorize my insurance and/or attorney to pay by check made out and directly mailed to CEO Westminster Inc. Further, I agree to pay CEO Westminster Inc. the difference, if any, between the total amount of charges and the amount paid by the insurance carrier and/or attorney. A photocopy of this document will be deemed as valid and binding on all parties involved.

I have read and have full understanding of all policies and HIPPA agreement of Lifetime Health & Wellness.

Patient Name: ____________________________________________

Patient Signature: ________________________________________ Date: ____________________

**OR**

Legal Guardian Signature: ___________________________________ Date: ____________________

Relationship to Patient: _____________________________________ Witness Initials: ___________

**To the patient: Please read this document in its entirety prior to signing it. It is important that you understand the information explained below. If you have any questions please ask before you sign.**

**Nature of Chiropractic Treatment**

Prior to beginning treatment, you will be given a physical examination that can include taking vital signs, range of motion testing, muscle strength testing, palpation, orthopedic testing, and neurological testing. Once your condition has been diagnosed, the primary method of treatment will be spinal manipulation, also known as spinal adjustment. An adjustment is a quick, precise movement of the spine over a short distance. Adjustments are usually performed by hand but may be performed by hand-guided mechanical instruments. In addition to spinal manipulation, treatment can also involve other forms of therapy including electrical stimulation, traction, cold packs, hydrotherapy, infrared heat, exercise, acupuncture, dry needling, massage, A.R.T., cranial therapy, rapid release, and nutritional supplements.

**Risks of Chiropractic Treatment**

All health care procedures carry some degree of risk. The most common side effect of spinal manipulation is short-term muscle soreness. More serious side effects can include bone fractures, muscle strain, ligament sprain, joint dislocation and injury to the discs, nerves or spinal cord. Some manipulations of the upper spine have been associated with injury to arteries in the neck, which could cause or contribute to stroke. However, documented cases are exceedingly rare, and it has been estimated by researchers that the probability of a spinal adjustment causing a stroke is one in several million. Compared to other forms of health care, chiropractic is extremely safe, and complications are generally rare.

**Treatment Options Other Than Chiropractic**

Other treatment options for your condition may include:

- Self-administered, over-the-counter analgesics;
- Medical care and prescription drugs such as muscle relaxers, pain killers and drugs to reduce inflammation;
- Surgery;
- Remaining untreated.
- Physical therapy

If you decide to pursue other treatment options, you should discuss the risks and benefits with your medical physician. Remaining untreated carries its own risks and may allow the formation of adhesions, scar tissue and other degenerative changes. These changes can further reduce mobility and induce chronic pain cycles.

*I have read above the explanation and risks of Chiropractic treatment and possible therapies. By signing below, I state that I have weighed the risks involved in undergoing treatment and have decided that it is in my best interest to undergo the treatment recommended. Having been informed of the risks, I hereby give my consent to that treatment.*

________________________________ ____________________

Patient/Guardian Signature Date

________________________________ ____________________

Witness Date

# Authorization To Release Information

I hereby authorize Lifetime Health & Wellness to release any information deemed appropriate concerning my physical condition to any insurance company, attorney, or adjustor in order to process any claim for reimbursement of charges incurred by me as a result of professional services rendered by Lifetime Health & Wellness; and I hereby release you of any consequences thereof.

Printed Name: ______________________________

Signature: ________________________________ Date: ____________________

# Authorization To Pay Physician/Lien

I hereby authorize my attorney and/or insurance company to pay by check made out and mailed directly to CEO Westminster any monies due, and otherwise payable to me, the same to be deducted from any settlement made on my behalf for professional services rendered. Further, I agree to pay CEO Westminster the difference, if any, between the total amount of charges and the amount paid by the attorney and/or insurance carrier. I hereby state and agree that a photocopy of this document will be deemed as valid and binding on all parties involved as the original copy.

Printed Name: ______________________________

Signature: ________________________________ Date: ____________________

# Visual Pain Rating Scale & Pain Diagram

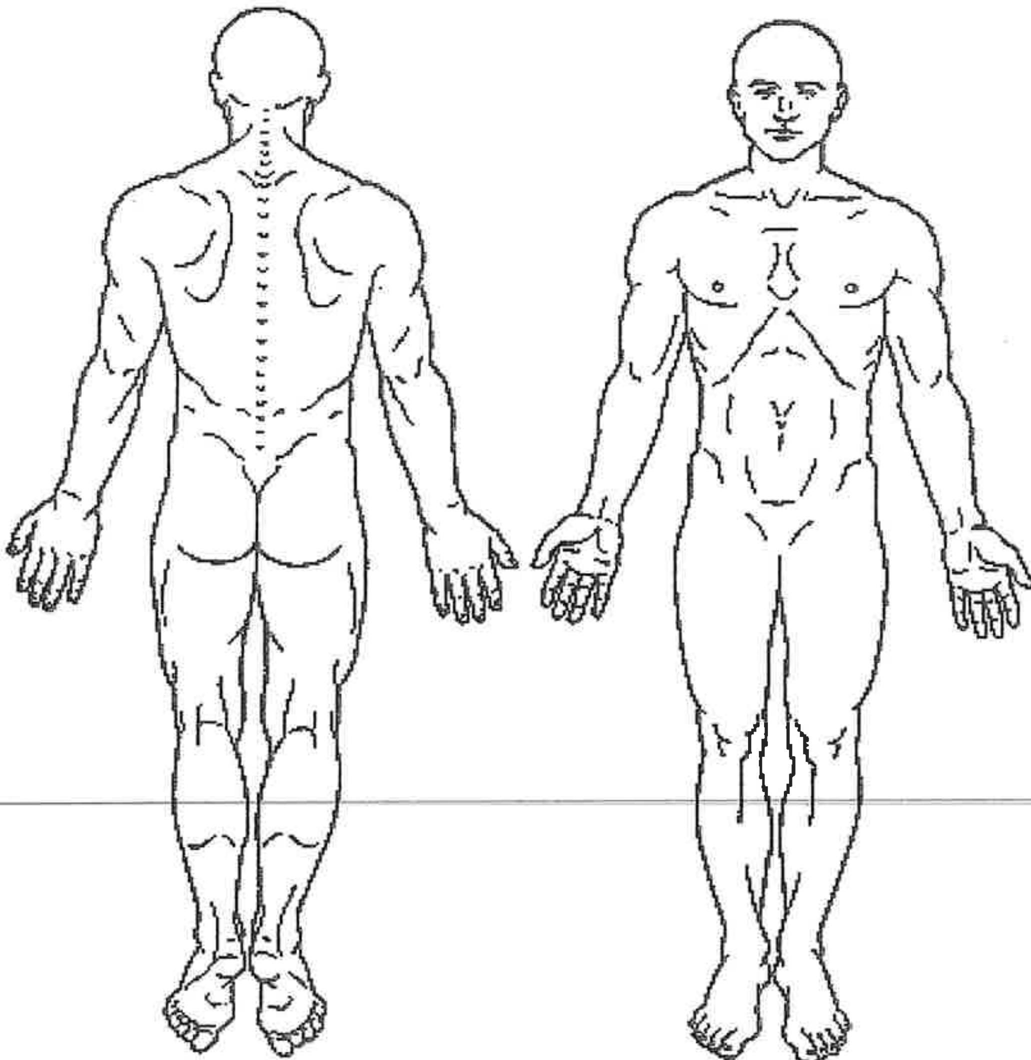
**Name:** ______________________ **Date:** ______________

Make a mark ( x ) along the line which you think represents your current level of pain in your major area of injury, somewhere between "NO PAIN AT ALL" and "EXCRUCIATING PAIN"

**NO PAIN AT ALL** **EXCRUCIATING PAIN**

On the following diagrams, indicate all areas of:

**PINS & NEEDLE** : oooo
**BURNING** : xxxx
**STABBING** : ///////
**ACHE** : ═══
**OTHER (Describe)**: pppp ______________



# Oswestry Low Back Pain Disability Questionnaire

Date: ____________

Please read:
This questionnaire has been designed to give the doctor/clinician information as to how your back pain has affected your ability to manage in everyday life. Please answer every section, and mark in each section only the ONE sentence which applies to you. We realize you may consider that two of the statements in any one section relate to you, but please just mark the sentence which most closely describes your problem.

Name: ____________

**Section 1 - Pain Intensity**

- ☐ I can tolerate the pain I have without having to use pain killers.
- ☐ The pain is bad but I manage without taking pain killers.
- ☐ Pain killers give complete relief from pain.
- ☐ Pain killers give moderate relief from pain.
- ☐ Pain killers give very little relief from pain.
- ☐ Pain killers have no effect on the pain and I do not use them.

**:tion 2 - Personal Care (Washing, Dressing, etc)**

- ☐ I can look after myself normally without causing extra pain
- ☐ I can look after myself normally but it causes extra pain
- ☐ It is painful to look after myself and I am slow and careful
- ☐ I need some help but manage most of my personal care
- ☐ I need help every day in most aspects of self care
- ☐ I do not get dressed, wash with difficulty and stay in bed

**Section 3 - Lifting**

- ☐ I can lift heavy weights without extra pain
- ☐ I can lift heavy weights but it gives me extra pain
- ☐ Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned, eg. on a table
- ☐ Pain prevents me from lifting heavy weights but I can manage light to medium weights if they are conveniently positioned
- ☐ I can lift only very light weights
- ☐ I cannot lift or carry anything at all

**Section 4 - Walking**

- ☐ Pain does not prevent me walking any distance
- ☐ Pain prevents me walking more than 1 mile
- ☐ Pain prevents me walking more than 1/2 mile
- ☐ Pain prevents me walking more than 1/4 mile
- ☐ I can only walk using a stick or crutches
- ☐ I am in bed most of the time and have to crawl to the toilet

**Section 5 - Sitting**

- ☐ I can sit in any chair as long as I like
- ☐ I can only sit in my favourite chair as long as I like
- ☐ Pain prevents me from sitting more than 1 hour
- ☐ Pain prevents me from sitting more than 1/2 hour
- ☐ Pain prevents me from sitting more than 10 mins
- ☐ Pain prevents me from sitting at all

**Section 6 - Standing**

- ☐ I can stand as long as I want without extra pain
- ☐ I can stand as long as I want but it gives me extra pain
- ☐ Pain prevents me from standing for more than 1 hour
- ☐ Pain prevents me from standing more than 30 mins
- ☐ Pain prevents me from standing more than 10 mins
- ☐ Pain prevents me from standing at all

**Section 7 - Sleeping**

- ☐ Pain does not prevent me from sleeping well.
- ☐ I can sleep well only by using tablets.
- ☐ Even when I take tablets I have less than six hours sleep.
- ☐ Even when I take tablets I have less than four hours sleep.
- ☐ Even when I take tablets I have less than two hours sleep.
- ☐ Pain prevents me from sleeping at all

**Section 8 - Sex Life**

- ☐ My sex life is normal and causes no extra pain
- ☐ My sex life is normal but causes some extra pain
- ☐ My sex life is nearly normal but is very painful
- ☐ My sex life is severely restricted by pain
- ☐ My sex life is nearly absent because of pain
- ☐ Pain prevents any sex life at all

**Section 9 - Social Life**

- ☐ My social life is normal and gives me no extra pain
- ☐ My social life is normal but increases the degree of pain
- ☐ Pain has no significant affect on my social life apart from limiting my more energetic interests, eg. dancing, etc.
- ☐ Pain has restricted my social life and I do not go out as often
- ☐ Pain has restricted my social life to my home
- ☐ I have no social life because of pain

**Section 10 - Travelling**

- ☐ I can travel anywhere without extra pain
- ☐ I can travel anywhere but it gives me extra pain
- ☐ Pain is bad but I manage journeys over two hours
- ☐ Pain restricts me to journeys of less than one hour
- ☐ Pain restricts me to short necessary journeys under 30 minutes.
- ☐ Pain prevents me from travelling except to the doctor or hospital

# Neck Disability Index

Date: ______________

This questionnaire has been designed to provide information as to how your neck pain has affected your ability to manage in everyday life. Please answer every section, and mark in each section only the ONE sentence which applies to you. We realize you may consider that two of the statements in any one section relate to you, but please just mark the sentence which most closely describes your problem.

Name: ______________________________

**Section 1 - Pain Intensity**

- ☐ I have no pain at the moment.
- ☐ The pain is very mild at the moment.
- ☐ The pain is moderate at the moment.
- ☐ The pain is fairly severe at the moment.
- ☐ The pain is very severe at the moment.
- ☐ The pain is the worst imaginable at the moment.

**Section 2 - Personal Care (Washing, Dressing, etc)**

- ☐ I can look after myself normally without extra pain.
- ☐ I can look after myself normally but it causes extra pain.
- ☐ It is painful to look after myself and I am slow and careful.
- ☐ I need some help but manage most of my personal care.
- ☐ I need help every day in most aspects of self care.
- ☐ I do not get dressed, I wash with difficulty and stay in bed.

**Section 3 - Lifting**

- ☐ I can lift heavy weights without extra pain.
- ☐ I can lift heavy weights but it gives extra pain.
- ☐ Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned, for example on a table.
- ☐ Pain prevents me from lifting heavy weights but I can manage light to medium weights if they are conveniently positioned.
- ☐ I can lift only very light weights.
- ☐ I cannot lift or carry anything at all.

**Section 4 - Reading**

- ☐ I can read as much as I want to with no pain in my neck.
- ☐ I can read as much as I want to with slight pain in my neck.
- ☐ I can read as much as I want to with moderate pain in my neck.
- ☐ I can't read as much as I want because of moderate pain in my neck.
- ☐ I can hardly read at all because of severe pain in my neck.
- ☐ I cannot read at all.

**Section 5 - Headaches**

- ☐ I have no headaches at all.
- ☐ I have slight headaches which come infrequently.
- ☐ I have moderate headaches which come infrequently.
- ☐ I have moderate headaches which come frequently.
- ☐ I have severe headaches which come frequently.
- ☐ I have headaches almost all the time.

**Section 6 - Concentration**

- ☐ I can concentrate fully when I want to with no difficulty.
- ☐ I can concentrate fully when I want to with slight difficulty.
- ☐ I have a fair degree of difficulty in concentrating when I want to.
- ☐ I have a lot of difficulty in concentrating when I want to.
- ☐ I have a great deal of difficulty concentrating when I want to.
- ☐ I cannot concentrate at all.

**Section 7 - Work**

- ☐ I can do as much work as I want to.
- ☐ I can only do my usual work, but no more.
- ☐ I can do most of my usual work, but no more.
- ☐ I cannot do my usual work.
- ☐ I can hardly do any work at all.
- ☐ I can't do any work at all.

**Section 8 - Driving**

- ☐ I can drive my car without any neck pain.
- ☐ I can drive my car as long as I want with slight pain in my neck.
- ☐ I can drive my car as long as I want with moderate pain in my neck.
- ☐ I can't drive my car as long as I want because of moderate pain in my neck.
- ☐ I can hardly drive at all because of severe pain in my neck.
- ☐ I can't drive my car at all.

**Section 9 - Sleeping**

- ☐ I have no trouble sleeping.
- ☐ My sleep is slightly disturbed (less than 1 hr. sleepless
- ☐ My sleep is mildly disturbed (1-2 hrs. sleepless).
- ☐ My sleep is moderately disturbed (2-3 hrs. sleepless).
- ☐ My sleep is greatly disturbed (3-5 hrs. sleepless).
- ☐ My sleep is completely disturbed (5-7 hrs. sleepless).

**Section 10 - Recreation**

- ☐ I am able to engage in all my recreational activities with no neck pain at all.
- ☐ I am able to engage in all my recreational activities with some pain in my neck.
- ☐ I am able to engage in most, but not all of my usual recreational activities because of pain in my neck.
- ☐ I am able to engage in a few of my usual recreational activities because of pain in my neck.
- ☐ I can hardly do any recreational activities because of pain in my neck.
- ☐ I can't do any recreational activities at all.

## HEADACHE DISABILITY INDEX

Patient Name ______________________________ Date ______________

**INSTRUCTIONS:** Please CIRCLE the correct response:

1. I have headache: (1) 1 per month (2) more than 1 but less than 4 per month (3) more than one per week
2. My headache is: (1) mild (2) moderate (3) severe

**Please read carefully:** The purpose of the scale is to identify difficulties that you may be experiencing because of your headache. Please check off "YES", "SOMETIMES", or "NO" to each item. Answer each question as it pertains to your headache only.

| YES | SOMETIMES | NO | | |
|---|---|---|---|---|
| ____ | ____ | ____ | E1. | Because of my headaches I feel handicapped. |
| ____ | ____ | ____ | F2. | Because of my headaches I feel restricted in performing my routine daily activities. |
| ____ | ____ | ____ | E3. | No one understands the effect my headaches have on my life. |
| ____ | ____ | ____ | F4. | I restrict my recreational activities (eg, sports, hobbies) because of my headaches. |
| ____ | ____ | ____ | E5. | My headaches make me angry. |
| ____ | ____ | ____ | E6. | Sometimes I feel that I am going to lose control because of my headaches. |
| ____ | ____ | ____ | F7. | Because of my headaches I am less likely to socialize. |
| ____ | ____ | ____ | E8. | My spouse (significant other), or family and friends have no idea what I am going through because of my headaches. |
| ____ | ____ | ____ | E9. | My headaches are so bad that I feel that I am going to go insane. |
| ____ | ____ | ____ | E10. | My outlook on the world is affected by my headaches. |
| ____ | ____ | ____ | E11. | I am afraid to go outside when I feel that a headaches is starting. |
| ____ | ____ | ____ | E12. | I feel desperate because of my headaches. |
| ____ | ____ | ____ | F13. | I am concerned that I am paying penalties at work or at home because of my headaches. |
| ____ | ____ | ____ | E14. | My headaches place stress on my relationships with family or friends. |
| ____ | ____ | ____ | F15. | I avoid being around people when I have a headache. |
| ____ | ____ | ____ | F16. | I believe my headaches are making it difficult for me to achieve my goals in life. |
| ____ | ____ | ____ | F17. | I am unable to think clearly because of my headaches. |
| ____ | ____ | ____ | F18. | I get tense (eg, muscle tension) because of my headaches. |
| ____ | ____ | ____ | F19. | I do not enjoy social gatherings because of my headaches. |
| ____ | ____ | ____ | E20. | I feel irritable because of my headaches. |
| ____ | ____ | ____ | F21. | I avoid traveling because of my headaches. |
| ____ | ____ | ____ | E22. | My headaches make me feel confused. |
| ____ | ____ | ____ | E23. | My headaches make me feel frustrated. |
| ____ | ____ | ____ | F24. | I find it difficult to read because of my headaches. |
| ____ | ____ | ____ | F25. | I find it difficult to focus my attention away from my headaches and on other things. |

**OTHER COMMENTS:**______________________________

______________________
Examiner

With permission from: Jacobson GP, Ramadan NM, et al. *The Henry Ford Hospital headache disability inventory (HDI)*. Neurology 1994;44:837-842.