Adjuster Name:

Personal Injury Check-List

Adjuster Phone #:

___ Lien to Med Pay
___ Lien to Liable
___ Lien to Attorney

Adjuster Fax #:

Claim # :

The following items are mandatory

___ Accident sheet completed

___ Declaration page

___ Police Report

___ Visible copy of identification

___ Health Insurance card

___ Original Lien

___ Letter of Representation (If they have an attorney)

___ Copies of all letters, hcfas and information patient may have brought in

___ Copy of billing package sent out

CONFIDENTIAL VEHICLE ACCIDENT REPORT

Name: ______________________________ DOB: __________ Age: _______ Gender: _______

Address:______________________________City:__________ State: _______ Zip: _________

Home phone: ____________________ Cell Phone: ____________________ Work Phone: ______________

Driver's license #: _______________________ Marital Status: ______________

Occupation: __________________ Email: ____________________

Nearest Relative – Name & Telephone: ____

Height: ______ Weight: ______ Race: __________ Date of accident: ____________

Time of accident: ________________

Were you: a) driver: _____ b) passenger – front: _____ c) passenger – rear: _____ d) number of passengers: _____

e) pedestrian: _____

Were you wearing a shoulder harness: Y / N Were you wearing a seatbelt: Y / N

Your vehicle: a) auto b) truck c) van d) motorcycle e) motorhome f) bicycle g) other

Year and model of your vehicle: ________________________

Owner of vehicle: _______________________ Approx. damage to the vehicle: $______ Was it drivable: Y / N

Other vehicle: a) car b) truck c) van d) motorcycle e) motorhome f) bicycle g) other

Year and model of other vehicle: ________________________

Owner of vehicle: ______________________

Visibility at time of accident: ____ Poor ____ Fair ____Good

Road conditions at time of accident: ___ Dry ___Wet ___ Rainy ___Snow ___ Ice ___Fog ___ Clear ___Dark

How accident occurred: a) struck by another vehicle b) struck another vehicle c) struck stationary object d) other

Where was your vehicle hit: a) front b) rear c) front right side d) front left side e) rear right side

f) rear left side g) other

Other vehicle contact: a) front b) rear c) front right side d) front left side e) rear right side

f) rear left side g) other

In your own words, please describe the accident:

____

____

____

____

____

____

____

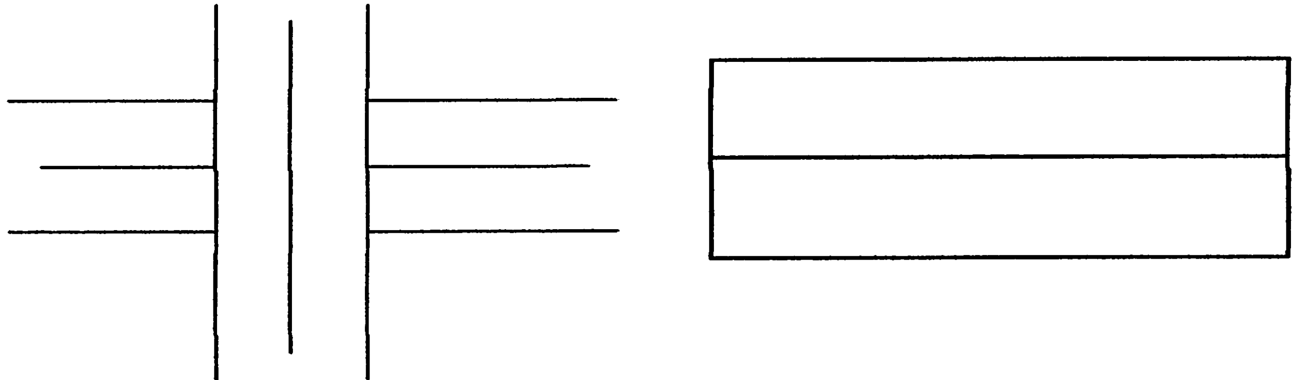
____

____

____

____

INDICATE ON APPROPRIATE DIAAGRAM HOW THE ACCIDENT HAPPENED:



Did you see the accident coming: Y / N   Were you pre-warned that the accident was about to happen: Y / N

Did you brace for impact: Y / N   Does your car have headrests: Y / N

If yes, what was the position of those headrests compared to your head before the accident: a) top of headrest even with bott of head   b) top of headrest even with top of head c) top of headrest even with middle of neck

Was the car you were in breaking: Y / N   Your approx. speed: _______   Other vehicles approx. speed: _______

What was occurring at the moment of impact: (circle as many as apply)

a) tensed body for impact   b) neck whipped forward and back   c) spine torqued and twisted

d) thrown over seat   e) thrown from vehicle   f) pinned vehicle

g) thrown from side-to-side   h) cut and bruised   i) other: ____________________

What was your head position at the time of impact:

Head turned: ___ right   ___ left   ___ looking back   ___pinned in vehicle

Body rotated: ___ right   ___ left

Did you strike your: (circle as many as apply)

a) Head against: Dashboard Windshield Steering Wheel Right Door Left Door Headrest Unknown object

b) Shoulder against: Dashboard Windshield Steering Wheel Right Door Left Door Headrest Unknown object

c) Arm against: Dashboard Windshield Steering Wheel Right Door Left Door Headrest Unknown object

d) Elbow against: Dashboard Windshield Steering Wheel Right Door Left Door Headrest Unknown object

e) Wrist against: Dashboard Windshield Steering Wheel Right Door Left Door Headrest Unknown object

f) Hip against: Dashboard Windshield Steering Wheel Right Door Left Door Headrest Unknown object

g) Knee against: Dashboard Windshield Steering Wheel Right Door Left Door Headrest Unknown object

h) Ankle against: Dashboard Windshield Steering Wheel Right Door Left Door Headrest Unknown object

Were you rendered unconscious: Y / N

Were you able to move all of your body parts: Y / N   If no, explain: ____________________________________

Were you able to get out of the car? Y / N   If no, explain: ____________________________________

Did you bleed or get cuts and bruises: Y / N If yes, bleeding: ________________ Cuts/bruises: ____________

Were there any flying objects in the car: Y / N Where you hit: ________________ Where: ______________

Please describe how you felt:

During the accident: ____

Immediately after the accident: ____

Later that day: ____

The next day: ____

Circle symptoms you have noticed since the accident:

Headache	Dizziness	Light bothers eyes	Cold sweats
Neck pain	Head heavy	Loss of memory	Feet cold
Neck stiffness	Pins/Needles in arm	Ears ring	Hands cold
Sleeping problems	Pins/Needles in leg	Face Flush	Stomach upset
Numbness in fingers	Buzzing in ears	Constipation	Loss of taste
Mid-back pain	Nervousness	Loss of balance	Diarrhea
Low-back pain	Numbness in toes	Tension	Shortness of breath
Fainting	Fever	Loss of smell	Vomit
Irritability	Fatigue	Chest pain	Depression

Symptoms other than above: ____

Pain level: on a scale of 0-10, with 0 being pain free and fully functional, and 10 being constant agony and totally inability to function, where would you rate yourself: 0 – 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10

Indicate ability to perform the following activities:

U – Unable P – Painful D – Difficult L – Limited N – Normal

__ Coughing or sneezing	__ Lying on side	__ Gripping	__ Climbing stairs
__ Getting in/out of car	__ Bending forward	__ Pushing	__ Bending to brush teeth
__ Pulling	__ Turning over in bed	__ Kneeling	__ Reaching
__ Walking short distance	__ Balancing	__ Sexual activity	__ Standing more than 1 hour
__ Dressing self	__ Stooping	__ Lying on back	__ Sleeping
__ Lying on stomach	__ Sitting at table	__ Other: ______________________	

Have you lost any time from work as a result of this accident: Y / N If yes, please complete below:

a) Last day worked: ______________________

b) Type of employment: ______________________

c) Are you being compensated for time from lost work: Y / N

Was a police report filed: Y / N

Did you receive medical attention at the time of the accident: Y / N

If yes, what was done: ____

Were you taken by ambulance to the hospital: Y / N If yes, where: ______________________

What was done: ______________________

What was the diagnosis give: ______________________

Where did you go immediately after the accident: a) resume activities b) home c) this office

d) Medical attention: Y / N If yes, where: __________ Were you examined: Y / N

e) Were you x-rayed: Y / N If yes, where: __________ What treatment was given: ______

f) Date of treatment: ________

Second doctor/clinic seen: ______________________ Date of visit: ________

a) Were you examined: Y / N b) Were you x-rayed: Y / N

c) Were you given treatment: Y / N If yes, explain: ______________

d) What benefits did you receive from treatment: ______________________

e) Date of last treatment: ________

Did you have any physical complaint before the accident: Y / N If yes, please describe: ________

____

____

Have you ever been involved in an accident before: Y / N If yes, please describe and indicate date: ____

____

____

List surgical operation(s) and year(s): ______________________

____

____

____

Medications you take now (circle all that apply):

None Nerve pills Pain killers Muscle Relaxers

Stimulant(s) Tranquilizers Insulin Birth Control

Other: ______________________

Do you smoke: Y / N Packs per day: ______ For how long: ______

Drink alcohol: Y / N Drinks per day: ______

Caffeine: Y / N Cups per day: ______

Exercise regularly: Y / N What exercises: ______________________

During the day (at work or home) do you: a) sit b) computer c) desk d) stand in one position

Lift more/less than 25 lbs. Explain: ______________________

Have you ever suffered from (circle all that apply):

Dizziness Backaches Heart trouble Diabetes Arthritis

Headaches Asthma Digestive Disorders Nervousness Sinus trouble Neck pain

FAMILY MEDICAL HISTORY: Has any family member (parents, brothers, sisters, grandparents) had any of the following disorders. Please list family member next to disorder:

High blood pressure: ____________________ Heart disease: ____________________

Cancer: ____________________ Diabetes: ____________________

Thyroid: ____________________ Kidney: ____________________

Arthritis: ____________________ Tuberculosis: ____________________

Stoke: ____________________ Lund disease: ____________________

Patient Name: ______________________________ Date: ______________

Height: _______ Weight: ____________ Date of birth: ______________

Please list any medication(s) you are presently taking (including vitamins)

Medication	Dose	Reason

When treatment is concluded, Patient agrees to have Capitol Chiropractic paid directly from the insurance company or Attorney. IF patient is paid directly or no payment is received, patient is responsible for any billing incurred. _______

Your Auto Insurance Information

Company: ______________________________

Address: ______________________________

City: ____________ State: ____ Zip:__________

Contact Name: ______________________________

Phone number: ______________________________

Policy Holder: ______________________________

Policy number: ______________________________

Claim number: ______________________________

Other Vehicle Insurance Information

Company: ______________________________

Address: ______________________________

City: ____________ State: ____ Zip:__________

Contact Name: ______________________________

Phone number: ______________________________

Policy holder: ______________________________

Policy number: ______________________________

Claim number: ______________________________

Your Health Insurance Information

Policy Holder: ______________________________

Company Name: ______________________________

Policy number: ______________________________

Relationship to Patient: self / spouse / child / other

Policy holder DOB: ______________________________

Emergency contact: ______________________________

X-Ray Assignment Agreement and Consent Form

I understand that my doctor is submitting my X-Rays for radiological interpretation and report by John R. Henry, DC DACBR, a radiologist certified by the American Chiropractic Board of Radiology.

I give my consent to Brookside Radiology Consultants, Inc. for use and disclosure of my Protected Health Information for the purpose of treatment, payment or healthcare operations of the Practice. I acknowledge that I have received or reviewed and understand the Notice of Privacy Practice of Brookside Radiology Consultants, Inc. which describes the Practice's policies and procedures regarding the use and disclosure of any of my Protected Health Information created, received, or maintained by the Practice. **My signature authorizes the release of medical information.**

______________________________	______________________________
Patient Name	Today's Date
______________________________	______________________________
Patient Signature	Parent/Guardian Signature (if applicable)

TO BE MAINTAINED BY REFERRING DOCTOR

INFORMED CONSENT FORM

PATIENT NAME:_______________________________**DATE:**_________________

To the patient: Please read this entire document prior to signing it. It is Important that you understand the information contained in this document. If anything is unclear, please ask questions before you sign.

The nature of the chiropractic adjustment:

The primary treatment I use as a Doctor of Chiropractic is spinal manipulative therapy. I will use that procedure to treat you. I may use my hands or a mechanical Instrument upon your body in such a way as to move your joints. That may cause an audible "pop" or "click," much as you have experienced when you "crack" your knuckles. You may feel a sense of movement.

Analysis / Examination/ Treatment

As a part of the analysis, examination, and treatment. you are consenting to the following procedures:

- spinal manipulative therapy
- range of motion testing
- muscle strength testing
- pressure wave medical wave
- radiographic studies
- whole body vibration
- palpation
- orthopedic testing
- postural analysis testing
- hot/cold therapy
- mechanical traction
- extremity manipulative therapy
- vital signs
- basic neurological
- myofascial release
- electrical stim
- cold laser therapy
- TENS units

Other:____

The material risks inherent in chiropractic adjustment:

As with any healthcare procedure, there an, certain complications which may arise during chiropractic manipulation and therapy. These complications, though ***extremely rare,*** include but are not limited to fractures, there have been reports of disc injuries although no clinical scientific study has ever demonstrated chiropractic care to be the cause, dislocations, muscle strain, cervical myelopathy, costovertebral strains and separations and bums. Some manipulations of the upper spine have been associated with Injury to the 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. Stroke has been the subject of tremendous disagreement and cause is yet to be determined. Some patients will feel some stiffness and soreness following the first few days of treatment.
I will make every reasonable effort during the examination to screen for contraindications to care; however, if you have a condition that would otherwise not come to my attention, it is your responsibility to inform me.
Overall, compared to other forms of health care, chiropractic is extremely safe, and complications are generally rare.

The risks and dangers attendant to remaining untreated:

Remaining untreated may allow the formation of adhesions and reduce mobility which may set up a pain reaction further reducing mobility. Over time this process may complicate treatment making it more difficult and less effective the longer it is postponed.

DO NOT SIGN UNTIL YOU HAVE READ AND UNDERSTAND THE ABOVE.

I have read the above explanation of the chiropractic adjustment and related treatment. By signing below, I state that Ihave 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 and extend this consent to Include all Doctors of Optimal Health Chiropractic, PLLC.

Dated:_______________ **Printed Name:** ____

Patient Signature (Or Signature of Parent or Guardian): ______________________________

To any insurance company with coverage applicable to my claim(s) and to any attorney representing me:

ASSIGNMENT OF BENEFITS

IN CONSIDERATION of the willingness of (*Optimal Health Chiropractic*) to treat me on a credit without demand for payment at the time of services are rendered, I do hereby agree and stipulate as follows:

I irrevocably assign to (*Optimal Health Chiropractic*) any proceeds or compensation that I am or may become entitled to receive as result of injuries that occurred on ______________________________ to the extent of the chiropractic services rendered. I make this agreement without prejudice to any rights I may have to prosecute the legal claims against any party who may be liable for my injuries, but I hereby authorize and instruct you to pay directly to (*Optimal Health Chiropractic*), from any of my disability benefits, medical payments benefits, liability benefits, health and accident benefits, workers' compensation benefits, judgments, settlements, or proceeds of any kind that would be otherwise payable to me, such sums as are due or may become due to (*Optimal Health Chiropractic*) for its services rendered.

I appoint (*Optimal Health Chiropractic*) as my attorney in fact to affix my name as an endorsement upon the reverse of any check or draft upon which I am named a payee and to deposit said check or draft and apply the proceeds to any unpaid balance that I have with (*Optimal Health Chiropractic*).

I authorize (*Optimal Health Chiropractic*) to release to any insurer with applicable coverage or to my attorney or successor attorney any information regarding my injuries, prior medical history, or treatment as may be necessary to facilitate collection of proceeds under this assignment.

I acknowledge that I remain personally liable for the total amount due to (*Optimal Health Chiropractic*) for services rendered, including any balance remaining after the application of insurance payments and settlement or judgment proceeds. If (*Optimal Health Chiropractic*) is required to take legal action against me to recover any unpaid balance on my account, I agree to reimburse (*Optimal Health Chiropractic*) for its costs of recovery, including reasonable attorney's fees.

____
Patient

____
Date

____
Witness

NOTICE OF LIEN

Pursuant to N.C.G.S. 44-49 and 44-50, (*Optimal Health Chiropractic*) hereby asserts and gives notice of lien upon any sums recovered in damages for personal injury in any civil action and also upon all funds paid to the above-named patient in compensation for or settlement of injuries sustained, whether in litigation or otherwise.

(*Optimal Health Chiropractic*) hereby requests that if its claim is not paid in full from the foregoing proceeds, a full disclosure and accounting of proceeds be provided in conformity with N.C.G.S. 44-50.1. (*Optimal Health Chiropractic*) agrees to be bound by any confidentiality agreements regarding the contents of the accounting.

(*Optimal Health Chiropractic*)

By: ______________________________

Election To Not File Health Insurance Claim

To Whom It May Concern:

Upon my inquiry, the staff of Optimal Health Chiropractic has advised me that the cost of my treatment may be covered in whole or in part by my own health insurance. The staff has informed me that if I file on my own health insurance, I will be responsible for paying deductibles and co-payments, and these payments will be due as treatment is received. The staff has provided me with factual information regarding the various forms of reimbursement available to me and has answered my questions.

After giving due consideration to my options, I have decided that **I do not wish to file any claims on my health insurance.** I hereby instruct the staff to refrain from sending bills and treatment records to my health insurance carrier or health benefit plan. I authorize the staff to send bills and treatment records only to potential sources of payment other than my health insurance.

I understand that the clinic will rely on my decision and render treatment based on the assumption that payment will be received from sources other than my health insurance. I will not be expected to pay deductibles and co-payments. I understand that if third-party payors are billed, they will be billed at the clinic's usual rates rather than at discounted rates that may apply to in-network providers.

I understand that contractual and statutory deadlines may prevent me from filing on my health insurance at a later date. **The decision I am making today not to file on my health insurance is irrevocable.**

I understand that I remain personally liable for the reasonable value of the treatment rendered to me by the clinic.

Today's Date: ____________________________

____
Patient

____
Witness

Optimal Health

Chiropractic & Wellness Care

History of Present and Past Illness

Chief Complaint (Purpose of this appointment):_______________________________________

Date symptoms appeared or accident happened:_____________________________________

Is this due to : Auto ___ Work ____ Other _____

How did this happen?____

Have you ever had the same or a similar condition? YES NO

If yes, when and describe:____

Do you have a history of stroke or hypertension? YES NO If YES, Date of stroke:______________

Date of last physical examination:______________ Are you pregnant? YES NO UNCERTAIN

Have you had any major illnesses, injuries, falls, auto accidents or surgeries?

____

____

Women, please include information about childbirth/dates:

____

____

What medications and/or drugs are you currently taking?_______________________________

Do you have allergies of any kind? YES NO

If yes, describe:____

Do you have a congenital condition? YES NO

If yes, describe:____

Social History

Please indicate beside each activity whether you engage in it:

OFTEN=O SOMETIMES= S NEVER=N

___Exercise

___Alcohol use

___Drug use

___Tobacco use

___Caffeine

___High stress activity

___Family pressures

___Other mental stresses

___Other (specify)

____

Chiropractic Case History/Patient Information

Patient Name:_______________ Date:_______________

Home Address:_______________ City:_______________ State:___ Zip:_____

Email:_______________ Phone number:_______________

Age:____ Date of Birth:_______________ Race:___________ Marital Status: M S W D

Occupation:_______________ Employer:_______________

Employer's Phone:_______________ EXT:_______________

Emergency Contact:_______________ Relationship:_______________ Phone:_______________

Family Medical Doctor:_______________ Phone:_______________ Fax:_______________

Address:_______________ City:_______________ State:___ Zip:_________

When doctors work together, it benefits you. May we have your permission to update your medical doctor regarding your care at this office? YES NO

Family and Personal Health History

Do you or any family member have/had any of the following? Please put an "X" for you, and "F" for family.

_____Depression
_____Heart Attack
_____Diabetes
_____Thyroid Disease
_____Liver/Gallbladder Disease
_____Kidney Disease
_____Stroke
_____Fatigue
_____Brain Fog
_____Dizziness
_____Hypoglycemia
_____Anemia
_____Cancer
_____High Blood Pressure
_____Heart Trouble
_____Intestine Problems
_____Shortness of Breath
_____High Cholesterol
_____Headaches/Migraines
_____Poor Sleep
_____Osteoporosis
_____Arthritis
_____Carpal Tunnel
_____Neuropathy
_____Weight Gain
_____Back Pain
_____Neck Pain
_____Shoulder Pain
_____Knee Pain

☐ **I am interested in the practitioner presenting solutions for ALL checked ailments.**

I certify the information provided is accurate to the best of my knowledge.

Name:_______________ Signature of Patient/Legal Guardian:_______________

Patient Name:_______________ Date of Birth:_______________

The Rivermead Post-Concussion Symptoms Questionnaire*

Patient name______________________________ Date of Injury___________ Today's Date___________

After a head injury or accident some people experience symptoms which can cause worry or nuisance. We would like to know if you now suffer any of the symptoms given below. As many of these symptoms occur normally, we would like you to compare yourself now with before the accident. For each one please circle the number closest to you answer.

0 = Not experienced at all
1 = no more of a problem now than before the accident
2 = a mild problem now
3 = a moderate problem now
4 = a severe problem now

Compared with before the accident, do you now (i.e. over the last 24 hours) suffer from:

Headaches	0	1	2	3	4
Feelings of dizziness	0	1	2	3	4
Nausea and/or vomiting	0	1	2	3	4
Noise sensitivity, or easily upset by loud noise	0	1	2	3	4
Sleep disturbance	0	1	2	3	4
Fatigue trying more easily	0	1	2	3	4
Being irritable, easily angered	0	1	2	3	4
Feeling depressed or tearful	0	1	2	3	4
Feeling frustrated or impatient	0	1	2	3	4
Forgetfulness, poor memory	0	1	2	3	4
Poor Concentration	0	1	2	3	4
Taking longer to think	0	1	2	3	4
Blurred Vision	0	1	2	3	4
Light sensitivity, or easily upset or irritated by bright light	0	1	2	3	4
Double vision	0	1	2	3	4
Restlessness	0	1	2	3	4

Are you experiencing any other difficulties?
Please specify, and rate as above.

1.______________________________	0	1	2	3	4
2.______________________________	0	1	2	3	4

*King, N, Crawford S., Wenden F., Moss, N., and Wade, D. (1995) J. Neurology 242: 587-592

Lumbar Questionnaire

Name: ____________________

Date: ____________________

1. **Over the past week, how would you rate your back pain?**

No Pain — Worst Possible Pain

○ 0 ○ 1 ○ 2 ○ 3 ○ 4 ○ 5 ○ 6 ○ 7 ○ 8 ○ 9 ○ 10

2. **Over the past week, how much has your back pain interfered with your daily activities (housework, washing, dressing, walking, climbing stairs, getting in/out of bed/chair)?**

No Interference — Unable to Carry Out Activity

○ 0 ○ 1 ○ 2 ○ 3 ○ 4 ○ 5 ○ 6 ○ 7 ○ 8 ○ 9 ○ 10

3. **Over the past week, how much has your back pain interfered with your ability to take part in recreational, social, and family activities?**

No Interference — Unable to Carry Out Activity

○ 0 ○ 1 ○ 2 ○ 3 ○ 4 ○ 5 ○ 6 ○ 7 ○ 8 ○ 9 ○ 10

4. **Over the past week, how anxious (tense, uptight, irritable, difficulty in concentrating/relaxing) have you been feeling?**

Not At All Anxious — Extremely Anxious

○ 0 ○ 1 ○ 2 ○ 3 ○ 4 ○ 5 ○ 6 ○ 7 ○ 8 ○ 9 ○ 10

5. **Over the past week, how depressed (down-in-the-dumps, sad, low in spirits, pessimistic, unhappy) have you been feeling?**

Not At All Depressed — Extremely Depressed

○ 0 ○ 1 ○ 2 ○ 3 ○ 4 ○ 5 ○ 6 ○ 7 ○ 8 ○ 9 ○ 10

6. **Over the past week, how have you felt your work (both inside and outside of the home) has affected (or would affect) your back pain?**

Have Made it No Worse — Have Made it Much Worse

○ 0 ○ 1 ○ 2 ○ 3 ○ 4 ○ 5 ○ 6 ○ 7 ○ 8 ○ 9 ○ 10

7. **Over the past week, how much have you been able to control (reduce/help) your back pain on your own?**

Completely Control it — No Control Whatsoever

○ 0 ○ 1 ○ 2 ○ 3 ○ 4 ○ 5 ○ 6 ○ 7 ○ 8 ○ 9 ○ 10

Cervical Questionnaire

Name: ___________________________

Date: ___________________________

1. **Over the past week, how would you rate your neck pain?**

   No Pain — Worst Possible Pain

   O 0 O 1 O 2 O 3 O 4 O 5 O 6 O 7 O 8 O 9 O 10

2. **Over the past week, how much has your neck pain interfered with your daily activities (housework, washing, dressing, walking, climbing stairs, getting in/out of bed/chair)?**

   No Interference — Unable to Carry Out Activity

   O 0 O 1 O 2 O 3 O 4 O 5 O 6 O 7 O 8 O 9 O 10

3. **Over the past week, how much has your neck pain interfered with your ability to take part in recreational, social, and family activities?**

   No Interference — Unable to Carry Out Activity

   O 0 O 1 O 2 O 3 O 4 O 5 O 6 O 7 O 8 O 9 O 10

4. **Over the past week, how anxious (tense, uptight, irritable, difficulty in concentrating/relaxing) have you been feeling?**

   Not At All Anxious — Extremely Anxious

   O 0 O 1 O 2 O 3 O 4 O 5 O 6 O 7 O 8 O 9 O 10

5. **Over the past week, how depressed (down-in-the-dumps, sad, low in spirits, pessimistic, unhappy) have you been feeling?**

   Not At All Depressed — Extremely Depressed

   O 0 O 1 O 2 O 3 O 4 O 5 O 6 O 7 O 8 O 9 O 10

6. **Over the past week, how have you felt your work (both inside and outside of the home) has affected (or would affect) your neck pain?**

   Have Made It No Worse — Have Made It Much Worse

   O 0 O 1 O 2 O 3 O 4 O 5 O 6 O 7 O 8 O 9 O 10

7. **Over the past week, how much have you been able to control (reduce/help) your neck pain on your own?**

   Completely Control It — No Control Whatsoever

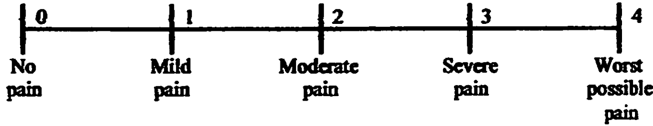
   O 0 O 1 O 2 O 3 O 4 O 5 O 6 O 7 O 8 O 9 O 10

Functional Rating Index

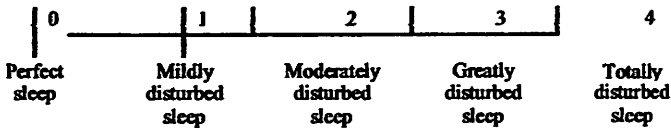
For use with **Neck and/or Back Problems** only.

In order to properly assess your condition, we must understand how much your **neck and/or back problems** has affected your ability to manage everyday activities. For each item below, **please circle the number which most closely describes your condition right now.**

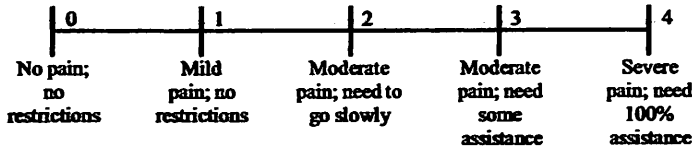
1. Pain Intensity



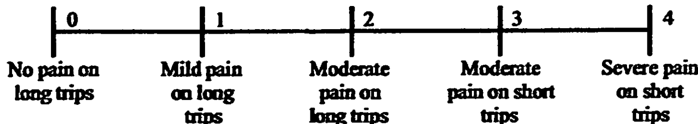
2. Sleeping



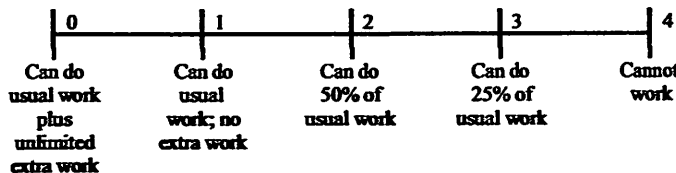
3. Personal Care (washing, dressing, etc.)



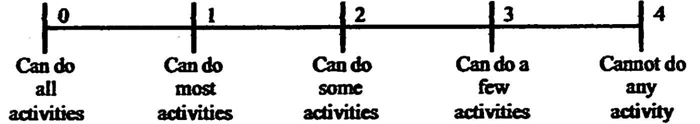
4. Travelling (driving, etc.)



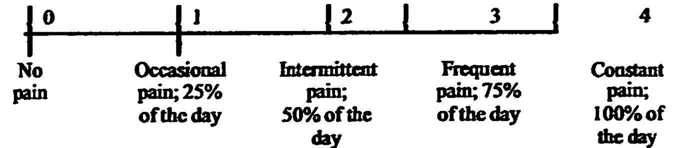
5. Work



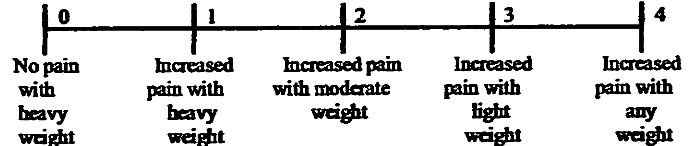
6. Recreation



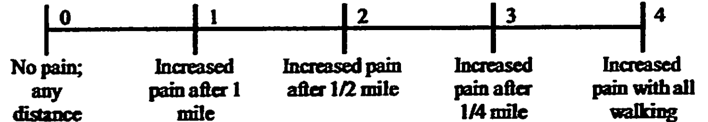
7. Frequency of Pain



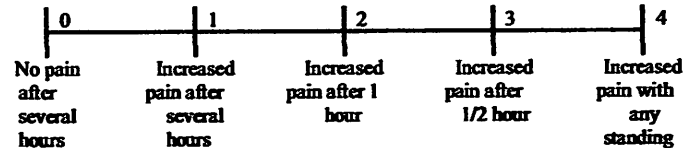
8. Lifting



9. Walking



10. Standing



______________________________ **Patient's Signature**

______________________________ **Date**

For Office Use Only:

Clinical Diagnosis Codes:

Practitioner ID#: ______________________________

Patient ID#: ______________________________

Total Score ______________ **/40**

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