Langford & Karls
CHIROPRACTIC
YOUR FOUNDATION FOR HEALTH

Anne Langford, DC, DICCP • Heather Karls, DC, CCSP • Jessica Eliason, DC • Victoria Nelson, DC • Brittany Schmidt, MHS, DC

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY.
THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

OUR LEGAL DUTY

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect **04/14/2003**, and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request.

You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

Uses and Disclosures of Health Information

We use and disclose health information about you for treatment, payment, and healthcare operations. For example:

Treatment: We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.

Payment: We may use and disclose your health information to obtain payment for services we provide to you.

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credential activities.

Your Authorization: In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

To your Family and Friends: We must disclose your health information to you, as described in the Patient Rights section of this Notice. We may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.

Persons Involved In Care: We may use or disclose health information to notify, assist in the notification of (including identifying or location) a family member, you personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosers. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare, We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up medical supplies, x-rays, or other similar forms of health information.

Marketing Health-Related Services: We will not use your health information for marketing communications without your written authorization.

Required by Law: We may use or disclose your health information when we are required to do so by law.

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

National Security: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorize federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institution or law enforcement official having custody of protected health information of inmate or patient under certain circumstances.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, or letters).

Patient Rights
Access: You have the right to look at or get copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. (You must make a request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information listed at the end of this Notice. We will charge you a reasonable cost-based fee for expenses such as copies and staff time. You may also request access by sending us a letter to the address at the end of this Notice. If you request copies, we will charge you $.10 for each page. $0 per hour for staff time to locate and copy your health information, and postage if you want the copies mailed to you. If you request an alternative format, we will charge a cost-based fee for providing your health information in that format. If you prefer, we will prepare a summary or an explanation of your health information for a fee. Contact us using the information listed at the end of this Notice for a full explanation of our fee structure.)

Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes, other than treatment, payment, healthcare operations and certain other activities, for the last 6 years, but not before April 14, 2003. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests.

Restrictions: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency).

Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. (You must make your request in writing.) Your request must specify the alternatives means or location, and provide satisfactory explanations of how payments will be handles under the alternative means or location you request.

Amendment: You have the right to request that we amend your health information. (Your request must be in writing, and it must explain why the information should be amended.) We may deny your request under certain circumstances.

Electronic Notice: If you receive this Notice on our Web site or by electronic mail (e-mail), you are entitled to receive this Notice in written form.

Questions and Complaints
If you want more information about our privacy practices or have questions or concerns, please contact us.

If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use of disclosure of your health information or to have us communicate with you by alternative means or alternative locations, you may complain to us using the contact information listed at the end of this Notice. You also may submit a written complaint t the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request.

We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S Department of Health and Human Services.

Contact Officer: Anne Langford, DC

Telephone: 651-699-8610

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I HAVE READ AND RECEIVED THE NOTICE OF PRIVACY PRACTICES INFORMATION

_____
Patient Name

_____ _____
Patient Signature Date

_____ _____
Parent or Guardian Signature Date

Relationship to Patient if unable to sign: _____

Please Turn Over

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INFORMED CONSENT FOR CHIROPRACTIC TREATMENT

Please read this entire document prior to signing it. It is important that you understand the information contained in this document and that you notify your chiropractor of any questions or concerns.

By any standard, a chiropractic adjustment is a conservative and very safe procedure. However, we would like to notify you that there is a very remote possibility for injury from a chiropractic adjustment. These complications can include, but are not limited to, fracture, disc injury, dislocation, muscle strain, cervical myelopathy, costovertebral strains or separations and burns. These complications usually occur more often in individuals with pre-existing conditions, which may predispose them to injury.

Something all patients should be aware of when initiating chiropractic care is the risk of stroke following treatment. In 2010, a study was performed by Cassidy et al. which examined this proposed risk. It was concluded that the incidence of stroke following chiropractic care is very minimal.

As part of the chiropractic analysis, examination, and treatment process you are consenting to the following, as recommended by your Doctor of Chiropractic. **By signing this document I am providing my consent for all of the following treatments and/or procedures and will consult my doctor with any questions or concerns that I may have:**

Spinal Manipulative Therapy	Palpation	Vital Signs
Range of Motion Testing	Orthopedic Testing	Basic Neuro Testing
Muscle Strength Testing	Postural Analysis	Hot/Cold Therapy
Ultrasound	Electrical Muscle Stimulation	

I understand that there are risks to any treatment that I have. I also understand that my doctor has given me a treatment plan that best suits my condition and that I have that information to make my own decision on whether or not to have the recommended treatment. I understand the remote possibility of an injury from a chiropractic treatment and elect to receive the recommended treatment.

_____ _____

Patient Signature Date

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PAYMENT POLICY

If your insurance policy provides for chiropractic services, this is our payment plan.

LIMITED ASSIGNEMENT: We will submit a bill for services to your insurance company and wait for payment directly from them. This can take anywhere from 30 to 90 days. If you have a deductible, **you will be responsible** for any amount that you have not met to date. We will send you a statement at the beginning of the month that will include the portion you owe. Any unpaid balances are due on the 15th of the month. **Copays are due at time of service.**

If you require services that are not covered by your insurance company, you will be expected to pay for those services. (Prices are available before the service is performed.) Payment is expected at the time of service.

Please note that your insurance coverage is a contract between you and your insurance company and that you are ultimately responsible for your bills at Langford & Karls Chiropractic. It is therefore important that **you** contact your insurance company to know your specific chiropractic benefits.

Any charges not paid, whether in full or partial, are considered delinquent. Payment plans are available. Delinquent charges will be assessed an interest rate of (10%) ten percent monthly. In the event that an account becomes delinquent in excess of three months, collective action will take place. A fee of $20.00 will be charged for any returned checks.

NO SHOW POLICY

We expect a phone call if you are unable to keep your appointment. If we do not hear from you by the time of your appointment, you will be charged a fee of $20.00 for the missed appointment.

Thank you for your consideration and understanding. We hope that this explanation will answer your questions and clarify our policy. Feel free to ask us any questions regarding the above payment policy.

I have read the above payment policy and understand the terms of payment for this office.

_____ _____

Patient or Guardian Signature Date

Please Turn Over

Acknowledgement of Financial Responsibility

Non-Covered Services Disclosure Form

As your Doctors of Chiropractic, we want to provide you with the best possible care. There are services that we feel are in your best interest for the treatment of your condition and maintenance of good health that may not be covered by your health insurance policy. You will be expected to pay for those services in full at the time of service. We want to assure you that we will only provide care that we feel is medically necessary.

Covered services traditionally include:

- Treatment that has the potential to significantly improve a clinical condition.
- Limited treatment of symptom flare-ups or exacerbations where a permanent condition exists.

Services not covered include:

- Some Diagnostic Services
- Some Therapeutic services
- Some Durable Medical Products (braces, ice packs, etc.)
- Maintenance Care also known as Elective Care

Future dates of service:
It is our policy that if a patient has not received care in **six months or longer** we are required to do a re-examination prior to treatment. This updated information gives us a better understanding of a patient's current condition so we can properly administer an updated treatment plan.

I acknowledge that I am signing this statement voluntarily and that it is not being signed after the services have already been provided. I understand that by signing this form, I will be fully responsible for the billed charge(s) related to the non-covered services.

Non-covered services **may** include but are not limited to:

- Acupuncture: $45.00
- Electrical Stimulation: $25.00
- Cold Laser Treatment: $25.00
- Ultrasound Therapy: $25.00
- 1st Day examination: $100.00
- Re-examination: $60.00
- Kinesiotape: $35.00

Maintenance/Elective Care is never covered and may also be determined by your health insurance and not Langford & Karls Chiropractic Clinic.

Patient Signature: _____ Date: _____

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PATIENT INFORMATION

Last Name: _____ First Name: _____ MI: _____

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

Cell Phone: _____ Home Phone: _____ Work/Other: _____

E-mail Address: _____ Height: _____ Weight: _____

Social Security Number: _____ Birthdate: _____ Age: _____ Gender: ☐ M ☐ F

Marital Status : ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed Spouse's Name: _____

Occupation: _____ Employer: _____

How were you referred to Langford Chiropractic Clinic? ☐ Family Member ☐ Friend ☐ Doctor ☐ Other: _____

Please give us the name of the family member, friend or doctor that referred you: _____

Emergency Contact: _____ Phone Number: _____ Relationship to Patient: _____

INSURANCE INFORMATION

Policy Holder's Name: _____ Policy Holder's Birthdate: _____

Policy Holder's Relationship to the Patient: ☐ Self ☐ Spouse ☐ Parent/Guardian ☐ Other: _____

What are your current complaints? _____

When and how did your problem begin? _____

Is your current injury/condition related to an auto/work accident? Y N If yes, what is the date of the accident? _____

Please describe your current pain.

☐ Sharp ☐ Dull Ache ☐ Numb ☐ Shooting ☐ Burning ☐ Tingling

Since your problem began, is the pain…

☐ Increasing ☐ Decreasing ☐ Not Changing

How frequent is your pain?

☐ Constantly ☐ Frequently ☐ Occasionally ☐ Intermittently

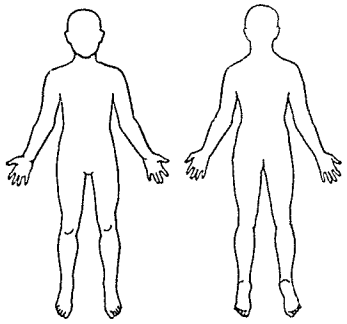
What makes your problem better? _____

What makes your problem worse? _____

Please list any other health care providers consulted for this condition: _____

Date of last physical examination: _____

Please mark the location where you have the pain or other symptoms.



Rate the severity of your pain

None 1 2 3 4 5 6 7 8 9 10 Unbearable

Women: Are you or is there a possibility that you may be pregnant? Yes ____ No ____ If yes, what is the due date? _____

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PATIENT HISTORY

Please mark the conditions which apply to you.

General

Past	Current	
____	____	Chronic Fatigue
____	____	Tobacco Use
____	____	Alcohol Use
____	____	Cancer
____	____	Dizziness
____	____	Anxiety
____	____	Depression

Respiratory

Past	Current	
____	____	Shortness of Breath
____	____	Asthma
____	____	Pneumonia
____	____	Emphysema

Eyes, Ears, Nose, Throat

Past	Current	
____	____	Allergies
____	____	Throat Problems
____	____	Ear Problems
____	____	Nose Problems
____	____	Eye Problems

Neurological

Past	Current	
____	____	Ringing in Ears
____	____	Headaches
____	____	Migraines
____	____	Arthritis
____	____	Leg/Foot Numbness
____	____	Seizures

Gastro-Intestinal

Past	Current	
____	____	Diarrhea
____	____	Crohn's Disease
____	____	Digestive Problems
____	____	Acid Reflux
____	____	Constipation
____	____	Gallbladder Problems
____	____	Liver Problems

Genito-Urinary

Past	Current	
____	____	Urinary Problems
____	____	Kidney Problems
____	____	Kidney Stones
____	____	Bed Wetting
____	____	Prostate Problems

Musculoskeletal

Past	Current	
____	____	Muscle Aches
____	____	Difficulty Walking
____	____	Joint Stiffness
____	____	Muscle Weakness
____	____	Osteoporosis
____	____	Joint Replacement

Endocrine

Past	Current	
____	____	Hot Flashes
____	____	Hair Loss
____	____	Type I Diabetes
____	____	Type II Diabetes
____	____	Menstrual Problems
____	____	Hypothyroidism
____	____	Hyperthyroidism

Cardiovascular

Past	Current	
____	____	Easy Bruising
____	____	Poor Circulation
____	____	High/Low BP
____	____	Heart Disease
____	____	Heart Attack
____	____	High Cholesterol
____	____	Stroke
____	____	Pacemaker
____	____	Blood Clots

Please list all medications (prescription and non-prescription) and all nutritional/herbal supplements you are taking *as well as the associated dosage and frequency:* _____

_____

_____

Drug Use: No ____ Yes ____ Alcohol Use: ____ drinks/week ____ drinks/day

Caffeine Intake: ____ cups of coffee/day ____ cans of pop/day Exercise: ____ hours/week

Allergies (medication or environmental): _____

Past surgeries, hospitalizations and/or injuries, *including associated dates*: _____

_____

Please list all known relatives with the following conditions, *including whether they are on your **paternal** or **maternal** side:*

Cancer (include type): _____

Diabetes (include type): _____

Heart Disease: _____

Arthritis: _____

Stroke: _____

Other: _____

Are you interested in receiving nutrition coaching? Yes _____ No _____

Patient Signature: _____ Date: _____

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Automobile Accident History

Name: _____ Date of Birth: _____

Insurance Company: _____ Agent: _____ Agent Phone #: _____

Address of Insurance Company: _____ Claim #: _____

Have you retained an attorney? ☐ Yes ☐ No Name, Address, & Phone # of Attorney: _____

_____

General Symptoms:

Did you hit any part of your body during the collision, such as head on dashboard, chest on steering wheel, etc.? ☐ Yes ☐ No

If yes, which body part and how? _____

Where were you taken after the accident? _____

Were you hospitalized? ☐ Yes ☐ No If yes, for how long? _____ Were x-rays taken? ☐ Yes ☐ No

Did you receive care from any other doctor or health care specialist? ☐ Yes ☐ No If yes, what is the name of the doctor and/or specialist and their phone number? _____

What type of care were you given and for how long? _____

Where did you feel the pain? _____

What are your current symptoms? _____

Please rate your current pain level: 1 2 3 4 5 6 7 8 9 10

Has your pain increased, decreased, or remained at a constant level since the accident? _____

Have you ever been injured in a similar manner? ☐ Yes ☐ No If yes, when and how? _____

Accident History:

Date of Accident: _____ Time of Accident: _____ Weather Conditions: _____

State how the accident happened in your own words: _____

_____

_____

What type of vehicle were you in? Make: _____ Year: _____

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Were you driving or were you a passenger? ☐ Driving ☐ Passenger If passenger, which seat? _____

Were you rotated in the seat? ☐ Yes ☐ No Were you reclined? ☐ Yes ☐ No

Were others in the car? ☐ Yes ☐ No If any others were injured, please explain: _____

Were seat belts on? ☐ Yes ☐ No Shoulder Harness? ☐ Yes ☐ No What was the headrest position? Did you hit your head? _____

Were you tired? ☐ Yes ☐ No Were you awake? ☐ Yes ☐ No

Where were you prior to the accident? _____ What were the traffic conditions? _____

What was the posted speed limit? _____ How fast were you going? _____

Were you at a: ☐ Stop Sign ☐ Traffic Light ☐ Intersection ☐ Highway ☐ Other: _____

Which side was your car hit on? ☐ Front ☐ Back ☐ Right ☐ Left Was your car damaged? ☐ Yes ☐ No

Describe damage to interior: _____ Exterior: _____

In what condition was your vehicle prior to the accident? _____

Did your vehicle strike: ☐ Another Car ☐ Sign ☐ Tree ☐ Hedge ☐ Bridge ☐ Other: _____

Were you completely conscious after the impact? ☐ Yes ☐ No Do you remember the impact? ☐ Yes ☐ No

Did your vehicle go off the road? ☐ Yes ☐ No If yes, did it go into a: ☐ Ditch ☐ Embankment ☐ Other: _____

Was the other vehicle involved in the accident a: ☐ Car ☐ Truck ☐ Motorcycle ☐ Other: _____

What was the size and make of the other car? _____

Was an accident report made? ☐ Yes ☐ No If yes, with which police department? _____

Does it bother you to ride in a car now? ☐ Yes ☐ No If yes, as a: ☐ Driver ☐ Passenger ☐ Both

State any strange events that happened during or immediately after the accident: _____

Have you had any time loss from work resulting from the accident? ☐ Yes ☐ No If yes, from _____ to _____

Have you had to have any outside help? ☐ Yes ☐ No If yes, what type? _____

Have you been in any other accidents? ☐ Yes ☐ No If yes, please explain _____

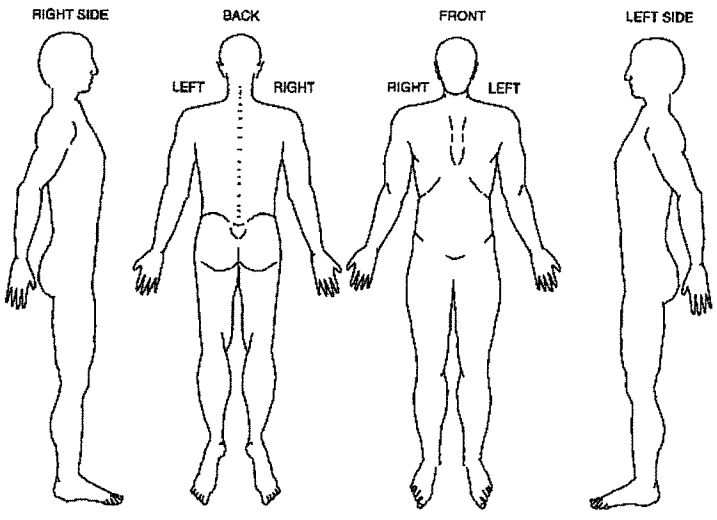
Please mark your area(s) of pain using the following:

Constant: *

Burning: +

Stabbing: -

Sharp: 0



Signature: _____

Date: _____

Back Index

ACN Group, Inc. Form BI-100

Langford & Karls
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Patient Name _____ Date _____

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.

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.

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.

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.

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.

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.

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.

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.

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.

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.

Back Index Score ☐

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Neck Index

ACN Group, Inc. Form NI-100

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Patient Name _____ Date _____

Pain Intensity

⓪ I have no pain at the moment.
① The pain is very mild at the moment.
② The pain comes and goes and is moderate.
③ The pain is fairly severe at the moment.
④ The pain is very severe at the moment.
⑤ The pain is the worst imaginable at the moment.

Sleeping

⓪ I have no trouble sleeping.
① My sleep is slightly disturbed (less than 1 hour sleepless).
② My sleep is mildly disturbed (1-2 hours sleepless).
③ My sleep is moderately disturbed (2-3 hours sleepless).
④ My sleep is greatly disturbed (3-5 hours sleepless).
⑤ My sleep is completely disturbed (5-7 hours sleepless).

Reading

⓪ I can read as much as I want with no neck pain.
① I can read as much as I want with slight neck pain.
② I can read as much as I want with moderate neck pain.
③ I cannot read as much as I want because of moderate neck pain.
④ I can hardly read at all because of severe neck pain.
⑤ I cannot read at all because of neck pain.

Concentration

⓪ I can concentrate fully when I want with no difficulty.
① I can concentrate fully when I want with slight difficulty.
② I have a fair degree of difficulty concentrating when I want.
③ I have a lot of difficulty concentrating when I want.
④ I have a great deal of difficulty concentrating when I want.
⑤ I cannot concentrate at all.

Work

⓪ I can do as much work as I want.
① I can only do my usual work but no more.
② I can only do most of my usual work but no more.
③ I cannot do my usual work.
④ I can hardly do any work at all.
⑤ I cannot do any work at all.

Personal Care

⓪ I can look after myself normally without causing extra pain.
① I can look after myself normally but it causes extra pain.
② It is painful to look after myself and I am slow and careful.
③ I need some help but I manage most of my personal care.
④ I need help every day in most aspects of self care.
⑤ I do not get dressed, I wash with difficulty and stay in bed.

Lifting

⓪ I can lift heavy weights without extra pain.
① I can lift heavy weights but it causes extra pain.
② Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned (e.g., on a table).
③ Pain prevents me from lifting heavy weights off the floor, but I can manage light to medium weights if they are conveniently positioned.
④ I can only lift very light weights.
⑤ I cannot lift or carry anything at all.

Driving

⓪ I can drive my car without any neck pain.
① I can drive my car as long as I want with slight neck pain.
② I can drive my car as long as I want with moderate neck pain.
③ I cannot drive my car as long as I want because of moderate neck pain.
④ I can hardly drive at all because of severe neck pain.
⑤ I cannot drive my car at all because of neck pain.

Recreation

⓪ I am able to engage in all my recreation activities without neck pain.
① I am able to engage in all my usual recreation activities with some neck pain.
② I am able to engage in most but not all my usual recreation activities because of neck pain.
③ I am only able to engage in a few of my usual recreation activities because of neck pain.
④ I can hardly do any recreation activities because of neck pain.
⑤ I cannot do any recreation activities at all.

Headaches

⓪ I have no headaches at all.
① I have slight headaches which come infrequently.
② I have moderate headaches which come infrequently.
③ I have moderate headaches which come frequently.
④ I have severe headaches which come frequently.
⑤ I have headaches almost all the time.

Neck Index Score ☐

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