MARSTELLER FAMILY CHIROPRACTIC

100 Kings Way East, Suite D5, Sewell, NJ 08080
Phone: (856) 589-0076

Welcome To Our Office!

New Patient

Name (First, Last, MI) ____________________

Address ____________________

City, State, Zip ____________________

Home Phone ____________ Work ____________ Cell ____________

E-mail address ____________ Website ____________

SS# ____________ Date of Birth ____________ Age ________

Marital Status ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Physician Care

Are you receiving care from other health professionals? ☐ No ☐ Yes

If yes, please name them and their specialty ____________________

Primary Care Physician ____________________

Accident Information

Insured ____________ Insurance Company/Policy #____________

Please provide your insurance card so that a copy may be kept on file.

Insured Address ____________________
(Street address) (City, State, Zip)

Insured Phone Number ____________ Relation to Insured ____________

Date of Accident ____________ State Accident Occurred In ____________

Lawyer's Name (if applicable) ____________________

Social History

Lifestyle: Exercise: ☐ Regular ☐ Rarely ☐ Sometimes ☐ Never Diet: ☐ Great ☐ Poor ☐ Good

Do you use: ☐ Coffee _______cups/day ☐ Alcohol _______drinks/day ☐ Recreational drugs ☐ Cigarettes _______packs/day ☐ Artificial sweeteners ☐ Tea ☐ Sugar

Current Health

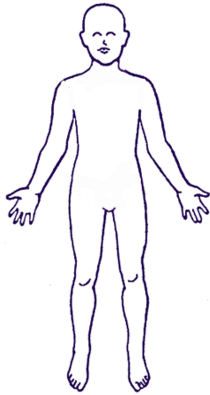
Describe your current health ☐ Great ☐ Good ☐ Fair ☐ Poor

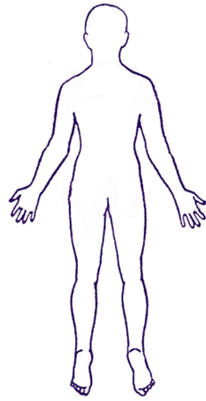
Chief Complaint: ____________________

How and when did the complaint begin? ____________________

Is it: ☐ Constant ☐ Getting worse ☐ Improving ☐ Intermittent ☐ Can't say

Where is the problem? Use the illustrations and lines below to explain.





Front ____
____
____
____

Back ____
____
____
____

Health History

If you have ever been diagnosed with another disease or condition, please describe ______________________________
____
____

Do you have any allergies? If so, please explain ____
____

Past injuries that can affect present health (please check all that apply)

- ☐ Broken bones
- ☐ Extensive dental work
- ☐ Head injuries
- ☐ Sports injuries
- ☐ Dental appliances
- ☐ Falls/accidents
- ☐ Knocked unconscious
- ☐ Traction
- ☐ Dislocations
- ☐ Fights
- ☐ Spinal tap
- ☐ Use(d) a cane or walker

Other injuries:____

Please list any surgeries you have had:
____
____

Please list any medications you are currently taking:

Medication	Reason for taking
______________________	______________________
______________________	______________________
______________________	______________________
______________________	______________________

Females – Pregnancies History:

Are you pregnant? ☐ Yes ☐ No If yes, what month? ______________________

INFORMED CONSENT TO CHIROPRACTIC TREATMENT

The nature of chiropractic treatment: The doctor will use his hands in order to move your joints. You may feel a “click” or “pop”, such as the noise when a knuckle is “cracked”, and you may feel movement of the joint. Various ancillary procedures, such as hot or cold packs, electric muscle stimulation, therapeutic ultrasound or dry hydrotherapy may also be used.

Possible risks: As with any healthcare procedure, complications are possible following a chiropractic adjustment. Complications could include fractures of bone, muscular strain, ligamentous sprain, dislocations of joints, or injury to intervertebral discs, nerves or spinal cord. Cerebrovascular injury or stroke could occur upon severe injury to arteries of the neck. Few patients may notice stiffness or soreness after the first few days of treatment. Some ancillary procedures could produce skin irritation, burns, or minor complications.

Probability of risks occurring: The risks of complications due to chiropractic treatment are rare. The risk of cerebrovascular injury or stroke has been estimated at one in one million to one in twenty million, and can be even further reduced by screening procedures. The probability of adverse reaction due to ancillary procedures is also rare.

Risks of remaining untreated: Delay of treatment allows formation of adhesions, scar tissue and other degenerative changes. These changes can further reduce skeletal mobility and induce chronic pain cycles. It is quite probable that delay of treatment will complicate the condition and make future rehabilitation more difficult.

Non-covered charges: I understand that my insurance company may not cover all of the services performed in this office. I understand that any services not covered are my full responsibility and agree to pay such charges at the time they are performed.

I have had the preceding risks explained to me. I have read the explanation above of chiropractic treatment. I have had the opportunity to have any questions answered to my satisfaction. I have fully evaluated the risks and benefits of undergoing treatment. I have freely decided to undergo the recommended treatment, and hereby give my full consent to treatment. I certify the above information to be true and correct to the best of my knowledge, and hereby authorize Marsteller Family Chiropractic to provide me with chiropractic care in accordance with this state's statutes.

Signature (Parent or Guardian Signature) ____________________________________ Date _____________________

MARSTELLER FAMILY CHIROPRACTIC 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.

Our practice is dedicated, and we are required by applicable federal and state laws, to maintain the privacy of your health information. These laws also require us to provide you with this Notice of our privacy practices, and to inform you of your rights, and our obligations, concerning your health information. We are required to follow the privacy practices described below while this Notice is in effect. This Notice is effective as of June 11, 2007, and will remain in effect until replaced by this office.

CHANGES TO NOTICE:

We reserve the right to change this Notice and the privacy practices described below at any time in accordance with applicable law. Prior to making significant changes to our privacy practices, we will alter this Notice to reflect the changes, and make the revised Notice available to you on request. Any changes we make to our privacy practices and / or this Notice may be applicable to health information created or received by us prior to the date of the changes.
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.

PERMITTED USES AND DISCLOSURES OF HEALTH INFORMATION:

A. TREATMENT, PAYMENT, HEALTHCARE OPERATIONS: You should be aware that during the course of our relationship with you we will likely use and disclose health information about you for treatment, payment, and healthcare operations. Examples of these activities are as follows:

> Treatment: We may use or disclose your health information to other healthcare providers providing treatment to you.
> Payment: We may use and disclose your health information to obtain payment for services we provide for 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 the healthcare professional, evaluating practitioner performance, and other business operations.

B. AUTHORIZATIONS: You may specifically authorize us to use your health information for any purpose or to disclose your health information to anyone, by submitting such an authorization in writing. Upon receiving an authorization from you in writing we may use or disclose your health information in accordance with that authorization. You may revoke an authorization at any time by notifying us in writing. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those permitted by this Notice.

C. DISCLOSURES TO FAMILY AND PERSONAL REPRESENTATIVES: We must disclose your health information to you, as described in the Patient Rights section of this Notice. Such disclosures will be made to any of your personal representatives appropriately authorized to have access and control of your health information. 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 of your healthcare only if authorized to do so. In the event of your incapacity or in 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.

D. MARKETING: We will not use your health information for marketing communications without your written authorization.

E. USES OR DISCLOSURES REQUIRED BY LAW: We may use or disclose your health information when we are required to do so by law, including for public health reasons (e.g., disease reporting). In some instances, and in accordance with applicable law, we may be required to disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes.

F. PATIENT AND THIRD PARTY PROTECTION: Only as permitted by law, 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.

G. LAW ENFORCEMENT/NATIONAL SECURITY: Under certain circumstances we may disclose health information relating to members of the Armed Forces to military authorities. Under certain circumstances we may also disclose health information relating to inmates or patients to correctional institutions or law enforcement personnel having lawful custody of those individuals. We may disclose health information in response to judicial proceedings and law enforcement inquiries as permitted by law and to authorized federal official's health information required for lawful intelligence, counterintelligence, and other national security activities.

PATIENT RIGHTS:

A. ACCESS TO RECORDS: Upon submission of a written request to us, you have the right to review or receive copies of your health information, with limited exceptions. You may obtain a form to request access by using the contact information listed at the end of this Notice. You may request that we provide copies in a format other than photocopies and we will use the format you request if it is readily available. If you request copies, we will charge you our standard copying fee for each page, and postage if you want the copies mailed to you. If you request an alternative format, we will charge a reasonable 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 if you are interested in receiving a summary of your information instead of copies.
B. ACCOUNTING OF CERTAIN DISCLOSURES: Upon written request, 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 other activities authorized by you. If you request this accounting of more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests.
C. RESTRICTIONS AND ALTERNATIVE COMMUNICATIONS: You have the right to request that we place additional restrictions on our use or disclosure of your health information for treatment, payment and healthcare operations purposes. Depending on the circumstances of your request we may, or may not agree to those restrictions. If we do agree to your requested restrictions we must abide by those restrictions, except in emergency treatment scenarios. You have the right to request that we communicate with you about your health information by alternative means or to alternative locations (e.g., at your place of business rather than at your home). Such requests must be made in writing, must specify the alternative means or locations, and must provide satisfactory explanation how payments will be handled under the alternative means or location you request.
D. AMENDMENTS TO RECORDS: You have the right to request that we amend your health information. Such requests must be made in writing, and must explain why the information should be amended. We may deny your request under certain circumstances.
E. ELECTRONIC NOTICES: 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 or any decisions we may make regarding the use, disclosure, or access to your health information you may complain to us using the contact information listed below. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file such a complaint upon request.
We support your right to 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.
Please direct any of your questions or complaints to:

Contact:	Jill Marsteller, CT, Office Manager	Email:	mfamilychiro@verizon.net
Telephone:	856.589.0076	Fax:	856.589.3822
Address:	100 Kings Way East, Suite D5 Sewell, NJ 08080		

Marsteller Family Chiropractic

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I, ______________________________________, acknowledge that I have received, reviewed, understand and agree to the Notice of Privacy Practices of Marsteller Family Chiropractic, which describes the Office's policies and procedures regarding the use and disclosure of any of my Protected Health Information created, received or maintained by the Office. I authorize and request that my insurance company pay directly to Marsteller Family Chiropractic, the amount due me under the terms of my insurance policy as a result of the care rendered by Dr. Marsteller and all medical staff associated with his office.

Signature ______________________________________ Date ____________________________

DISCLOSURE OF HEALTH INFORMATION

Please list the name(s) of those whom you authorize us to disclose your health information to as it relates to your care in this office.

Name	Relationship	Phone Number
__________________________	__________________________	__________________________
__________________________	__________________________	__________________________
__________________________	__________________________	__________________________

I authorize representatives of Marsteller Family Chiropractic to disclose my health information to the above mention person(s). I understand that I may alter this list at any time and that this authorization will remain in effect until I provide written notice of its termination.

Signature _________________________________ Date _______________________

MARSTELLER FAMILY CHIROPRACTIC

X-RAY CONSENT FORM

Patient: ______________________________________ Date: ___________________________

During your examination, the doctor may feel that x-rays will be needed in order to provide your treatment. In order to perform x-rays on any patient our office requires that patients consent for such tests to be performed. I understand that my x-rays may be used for educational purposes and that my identity will be concealed at all times. By signing this form, you understand that some fees occurred regarding x-rays may not be covered under your insurance plan and that you are responsible to pay any such fees.

Please choose one:

______ I understand that the doctor may need x-rays in order to administer my treatment and I give my permission to perform such tests.

______ I understand that it may be necessary for the doctor to take x-rays to administer my care. I choose not to have any x-rays at this time and release the doctor of all liabilities.

Signature: ____________________________________ Date: ___________________________

FEMALES ONLY:

I understand that if I am pregnant and have x-rays taken it is possible to injure the fetus.

I have been advised that the ten (10) days following the onset of a menstrual period are generally considered to be safe for x-ray exams.

With those factors in mind, I am advising the doctor that:

I am pregnant	______ yes	______ no	______ don't know
I could be pregnant	______ yes	______no	______ don't know
My menstrual period is late	______ yes	______ no	
I have an IUD	______ yes	______ no	
I have had a tubal ligation	______ yes	______ no	
I have had a hysterectomy	______ yes	______ no	
I have irregular menstrual periods	______ yes	______ no	
My last menstrual period began	____________________		
I have begun menopause	______ yes	______ no	

With full understanding of the above, and believing that I am not currently at risk, I wish to have an x-ray examination performed today if requested by the doctor.

Signature: ___________________________________ Date: ___________________________

MARSTELLER FAMILY CHIROPRACTIC

ASSIGNMENT OF BENEFITS

I, ________________________________, the insured and/or beneficiary of the policy of policies of ___________________ Insurance Company providing medical benefits to me, do hereby authorize you to pay directly to Dr. Marsteller, medical provider, benefits due me out of the indemnity under the terms of the applicable policy/policies issued by your company.

Payment is authorized upon receipt of the itemized statement for services rendered. This policy was in full force and effect at the time services were rendered. I also authorize the above medical provider to obtain counsel and enter legal or other action on my behalf and/or in my name to collect such sums due it, should sums not be paid within the legally prescribed, or within a reasonable period of time. I do hereby promise full and complete cooperation with any legal counsel obtained by the medical provider, including attending any type of Disposition, arbitration, or Court preceding. I understand that if I fail to cooperate with legal Counsel, I may be held personally responsible to the medical provider for my expenses not covered by this assignment. Payment, in whole or in part shall be considered the same as if paid by your company directly to me. A photocopy of this assignment shall be valid as the original.

I hereby agree and acknowledge that I may receive benefit checks directly from the insurance carrier for services rendered by the provider. I hereby agree to immediately forward said checks to the provider upon receipt of the same. It is understood and agreed that should I not forward any benefits to the provider, the provider does maintain the right to request checks from me and initiate any and all collection efforts. If such action is taken by the provider, I agree to be responsible for any and all benefit checks received, plus any and all collection costs incurred including attorney fees and Court costs.

I irrevocably assign to above company or provider all rights and benefits under any insurance contracts for payment of services rendered to provider. I irrevocably authorize all information regarding my benefits under any insurance policy relating to any claims by provider to be released to provider. I irrevocably authorize provider to file insurance claims on my behalf for services rendered to me. I irrevocably authorize provider to act on my behalf and report any suspected violation of proper claims practices to the proper regulatory authorities.

This assignment of benefits has been explained to my full satisfaction, and I understand its nature and effect.

INSURED: ____
(Policyholder)

CLAIM NUMBER: ____

CLAIMANT:____
(Patient)

ADDRESS: ____

LEGAL SIGNATURE: ____
(If a minor, parent or guardian must sign)

PATIENT SIGNATURE: ____

DATE: ____

Clinical Symptoms Intake: Please check **ANY** of the following symptoms that you may have.

Symptoms	Both Sides	Left Side	Right Side
Back Pain			
Pain in your lower back	☐	☐	☐
Pain in your buttocks	☐	☐	☐
Leg Pain			
Pain or burning in your legs	☐	☐	☐
Numbness or tingling in your legs	☐	☐	☐
Weakness in your legs	☐	☐	☐
Loss of strength in your legs	☐	☐	☐
Foot Pain			
Pain or burning in your feet	☐	☐	☐
Numbness or tingling in your feet	☐	☐	☐
Pins and needles in your feet	☐	☐	☐
Increased sensitivity to touch in your feet	☐	☐	☐
Trouble feeling hot or cold in your feet	☐	☐	☐
Trouble feeling your feet when you walk	☐	☐	☐
Discomfort or pain at night in your feet	☐	☐	☐
Wrist, Hand or Finger Pain			
Burning in your fingers	☐	☐	☐
Numbness or tingling in your fingers	☐	☐	☐
Difficulty gripping things with your hands	☐	☐	☐
Difficulty forming a fist with your hand	☐	☐	☐
Discomfort in hands wakes you up at night	☐	☐	☐
Neck Pain			
Burning in your neck	☐	☐	☐
Numbness or tingling in your neck	☐	☐	☐
Pain in your neck	☐	☐	☐
Discomfort in your neck wakes you up at night	☐	☐	☐
Coldness in your neck	☐	☐	☐

☐ *I have **NONE** of the symptoms listed above*

Name: ____________________ Date: ____________

New Jersey Department of Banking and Insurance

CONSENT TO REPRESENTATION IN APPEALS OF UTILIZATION MANAGEMENT DETERMINATIONS AND AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS IN UM APPEALS AND INDEPENDENT ARBITRATION OF CLAIMS

APPEALS OF UTILIZATION MANAGEMENT DETERMINATIONS

You have the right to ask your insurer, HMO or other company providing your health benefits (carrier) to change its utilization management (UM) decision if the carrier determines that a service or treatment covered under your health benefits plan is or was not medically necessary.* This is called a UM appeal. You also have the right to allow a doctor, hospital or other health care provider to make a UM appeal for you.

There are three appeal stages if you are covered under a health benefits plan issued in New Jersey. Stage 1: the carrier reviews your case using a different health care professional from the one who first reviewed your case. Stage 2: the carrier reviews your case using a panel that includes medical professionals trained in cases like yours. Stage 3: your case will be reviewed through the Independent Health Care Appeals Program of the New Jersey Department of Banking and Insurance (DOBI) using an Independent Utilization Review Organization (IURO) that contracts with medical professionals whose practices include cases like yours. The health care provider is required to attempt to send you a letter telling you it intends to file an appeal before filing at each stage.

At Stage 3, the health care provider will share your personal and medical information with DOBI, the IURO, and the IURO's contracted medical professionals. Everyone is required by law to keep your information confidential. DOBI must report data about IURO decisions, but no personal information is ever included in these reports.

You have the right to cancel (revoke) your consent at any time. Your financial obligation, IF ANY, does not change because you choose to give consent to representation, or later revoke your consent. Your consent to representation and release of information for appeal of a UM determination will end 24 months after the date you sign the consent.

INDEPENDENT ARBITRATION OF CLAIMS

Your health care provider has the right to take certain claims to an independent claims arbitration process through the DOBI. To arbitrate the claim(s), the health care provider may share some of your personal and medical information with the DOBI, the arbitration organization, and the arbitration professional(s). Everyone is required to keep your information confidential. The DOBI reports data about the arbitration outcomes, but no personal information will be in the reports. Your consent to the release of information for the arbitration process will end 24 months after the date you sign the consent.

CONSENT TO REPRESENTATION IN UM APPEALS AND AUTHORIZATION TO RELEASE OF INFORMATION IN UM APPEALS AND ARBITRATION OF CLAIMS

I, [PRINT NAME], by marking [√] (or [x]) and signing below, agree to:

☐ representation by Marsteller Family Chiropractic in an appeal of an adverse UM determination as allowed by N.J.S.A. 26:2S-11, and release of personal health information to DOBI, its contractors for the Independent Health Care Appeals Program, and independent contractors reviewing the appeal. My consent to representation and authorization of release of information expires in 24 months, but I may revoke both sooner.

☐ release of personal health information to DOBI, its contractors for the Independent Claims Arbitration Program, and any independent contractors that may be required to perform the arbitration process. My authorization of release of information for purposes of claims arbitration will expire in 24 months.

Signature: ______________________________ Ins. ID#:______________ Date: ____________

Relationship to Patient: ☐ I am the Patient ☐ I am the Personal Representative (provide contact information on back)

New Jersey Department of Banking and Insurance

NOTICE OF REVOCATION OF CONSENT TO REPRESENTATION IN APPEALS OF UTILIZATION MANAGEMENT DETERMINATIONS AND OF AUTHORIZATION TO RELEASE OF MEDICAL RECORDS

You may, at any time, revoke the consent you gave allowing a health care provider to represent you in an appeal of a UM determination and allowing the release of your medical records to the DOBI, the IURO and medical professionals that contract with the IURO. You may use this form to revoke your consent, or you may submit some other written evidence of your intent to revoke consent, if you prefer. Either way, if you have not yet received a Stage 2 UM determination from the carrier, send the written and signed revocation to the carrier at the address indicated

* If the patient is a minor, or unable to read and complete this form due to mental or physical incapacity, a personal representative of the patient may complete the form.

Oswestry Disability Questionnaire

Name :　　　　　　　　　　　　　　　　　　　Date :

Section 1: Pain Intensity

0. I have no pain at the moment
1. The pain is very mild at the moment
2. The pain is moderate at the moment
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

Section 2: Personal Care (washing, dressing, etc)

0. I can look after my self 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 manage most of my personal care.
4. I need help every day in most aspects of self care.
5. I do not get dressed, wash with difficulty and stay in bed.

Section 3: Lifting

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

Section 4: Walking

0. Pain does not prevent me walking any distance.
1. Pain prevents me from walking more than 1 mile.
2. Pain prevents me from walking more than ½ mile.
3. Pain prevents me from walking more than ¼ mile.
4. Can only walk using a stick or crutches.
5. I'm in bed most of the time.

Section 5: 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 sitting more than one hour.
3. Pain prevents me from sitting more then 30 minutes.
4. Pain prevents me from sitting more then 10 minutes.
5. Pain prevents me from sitting at all.

Section 6: Standing

0. I can stand as long as I want without extra pain
1. I can stand as long as I want but it gives me extra pain.
2. Pain prevents me from standing for more than 1 hour.
3. Pain prevents me from standing from more than 30 minutes.
4. Pain prevents me from standing fro more than 10 minutes.
5. Pain prevents me from standing at all.

Section 7: Sleeping

0. My sleep is never disturbed by pain.
1. My sleep is occasionally disturbed by pain.
2. Because of pain I have less than 6 hours sleep.
3. Because of pain I have less than 4 hours sleep.
4. Because of pain I have less than 2 hours sleep.
5. Pain prevents me form sleeping at all.

Section 8: 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 effect on my social life apart from limiting my more energetic interests e.g. sport.
3. Pain has restricted my social life and I do not go out as often.
4. Pain has restricted my social life to my house.
5. I have no social life because of pain.

Section 9: Traveling

0. I can travel anywhere without pain.
1. I can travel anywhere but it gives me extra pain.
2. Pain is bad but I manage journeys over two hours.
3. Pain restricts me to journeys of less that one hour.
4. Pain restricts me to short necessary journeys under 30,
5. Pain prevents me from traveling except to receive treatment.

Section 10: Employment/Homemaking

0. my normal homemaking / job activities do not cause pain
1. My normal homemaking/ job activities increase my pain but I can still perform all that is required of me.
2. I can perform most of my homemaking/job activities, but pain prevents me from performing more physically stressful activities(e.g. lifting, vacuuming)
3. Pain prevents me from doing anything but light duties.
4. Pain prevents me from doing even light duties.
5. Pain prevents me from performing any job or homemaking chores.