

**New Client Registration Form (please complete entire form)**

Today's Date: \_\_\_\_\_ Primary Care Provider: \_\_\_\_\_ Phone #: \_\_\_\_\_

**Client Information:**

Legal Last Name: \_\_\_\_\_ Legal First Name: \_\_\_\_\_ Middle Initial: \_\_\_\_\_

Nickname: \_\_\_\_\_ Former Name: \_\_\_\_\_

Birth date: \_\_\_\_\_ Age: \_\_\_\_\_ Relationship status: single / married / divorced / separated / widowed

Occupation: \_\_\_\_\_

Gender: Male / Female / Preferred Pronoun \_\_\_\_\_ Prefer not to answer \_\_\_\_\_

Home phone #: \_\_\_\_\_ Cell phone #: \_\_\_\_\_ Work phone #: \_\_\_\_\_

I would like text message reminders for my appointments sent to my cell phone # provided above: Yes / No

Emergency Contact: \_\_\_\_\_ Phone #: \_\_\_\_\_

Billing address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Email Address: \_\_\_\_\_ Email reminders? Yes / No

How did you hear about the office? \_\_\_\_\_

Are you covered by medical insurance? Yes / No

Does your insurance require a referral from your PCP? Yes / No (Please ask front desk for more info if needed)

Primary Insurance: \_\_\_\_\_

Subscribers Name: \_\_\_\_\_ Subscribers date of birth: \_\_\_\_\_

Clients relationship to insurance subscriber: self / spouse / child / domestic partner / other: \_\_\_\_\_

Who is the financially responsible party for the bill?  Self  Other: (Please fill out below)

Name: \_\_\_\_\_ Date of birth: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone Number: \_\_\_\_\_ Employer: \_\_\_\_\_

1. I understand that I am responsible for charges not covered or reimbursed by my health plan or similar payer. I agree to pay you directly if my insurer, health plan, employer program or similar benefits program does not pay.
2. I authorize my insurer, health plan, employer program or similar benefits program to release information to you regarding my coverage
3. My right to payment for care, treatment, supplies and other services are hereby assigned to you. This assignment covers any and all benefits under Medicare, other government sponsored programs, insurance, employer programs and any other health plans. I acknowledge this document as a legally binding assignment to collect my benefits as payment of claims for services. If my insurer, health plan, employer program or similar benefit program does not accept assignment of benefits, or if payments are made directly to me or my representative I will endorse such payment to you.
4. I understand and authorize release of all health information about me to my insurer, health plan, employer program or similar benefits program identified above to obtain payment for care, treatment, supplies and other services. The above information is true to the best of my knowledge.

Client / Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Confidential Patient Information**

Name: \_\_\_\_\_ Date: \_\_\_\_\_ Date of birth: \_\_\_\_\_

**About You**

What is the primary reason/complaint that you are seeking Chiropractic and/or Massage care?

When did it begin? \_\_\_\_\_

What do you think caused this? (car accident or work injury please inform front desk)

Is it getting worse? Yes/No

Specifically, what makes it better? \_\_\_\_\_

Specifically, what makes it worse? \_\_\_\_\_

Is the complaint:  Constant  Frequent  Intermittent  Occasional

Is the complaint worse in the:  Morning  Afternoon  Evening  While sleeping

Is the complaint getting:  Better  Worse  Staying the same

Rate the severity of the complaint (0=no pain / 10=severe pain) 0 1 2 3 4 5 6 7 8 9 10

Do you experience any radiating pain?  Yes  No

If yes, where? \_\_\_\_\_

Do you have increase pain with coughing and sneezing?  Yes  No

If yes, where? \_\_\_\_\_

Are you experiencing any weakness or loss of function?  Yes  No

If yes, where? \_\_\_\_\_

Describe the pain (please check all that apply):

Sharp  Dull  Throbbing  Aching  Numb  Shooting

Burning  Tingling  Cramping  Stiffness  Swelling  Pressure

Are there any other (secondary) complaints? Please list: \_\_\_\_\_

**How does your complaint affect the following aspects of your life:**

Length and quality of your sleep: \_\_\_\_\_

Exercise: \_\_\_\_\_

Work: \_\_\_\_\_

Family: \_\_\_\_\_

Social interaction: \_\_\_\_\_

**Specifically list activities that you are avoiding due to your complaint and your goal for that activity:**

Activity: \_\_\_\_\_ Goal: \_\_\_\_\_

Activity: \_\_\_\_\_ Goal: \_\_\_\_\_

Activity: \_\_\_\_\_ Goal: \_\_\_\_\_

**Past/current care information**

Have you ever seen a Chiropractor before?  Yes  No    A Massage Therapist?  Yes  No

If yes, who: \_\_\_\_\_

Have you seen any other health care provider for this complaint?  Yes  No

List provider name: \_\_\_\_\_ Phone: \_\_\_\_\_

List provider name: \_\_\_\_\_ Phone: \_\_\_\_\_

List all medication: \_\_\_\_\_

List all supplements: \_\_\_\_\_

List any allergies: \_\_\_\_\_

Do you smoke? Yes / No; Consume alcohol? Yes / No use recreational drugs? Yes / No

**If female:**

Date of menarche (first menstrual cycle): \_\_\_\_\_

Do you experience symptoms during your cycle: \_\_\_\_\_

Are you currently pregnant?  Yes  No  I don't know    If yes due date: \_\_\_\_\_

If pregnant, who is your OB or midwife?: \_\_\_\_\_

Are you currently breastfeeding?  Yes  No

Number of Pregnancies: \_\_\_\_\_

If you have been pregnant in the past, how did you deliver?  Vaginally  C-Section  Vbac

Describe any complications during delivery: \_\_\_\_\_

**Have you or anyone in your immediate family experienced:**

Cancer:  Self  mother  father  other \_\_\_\_\_

Heart Disease:  Self  mother  father  other \_\_\_\_\_

Arthritis:  Self  mother  father  other \_\_\_\_\_

Scoliosis:  Self  mother  father  other \_\_\_\_\_

Diabetes:  Self  mother  father  other \_\_\_\_\_

Parkinsons:  Self  mother  father  other \_\_\_\_\_

Alzheimers:  Self  mother  father  other \_\_\_\_\_

**Have you experienced any:**

Car accidents:  Yes  No \_\_\_\_\_

Work related injuries:  Yes  No \_\_\_\_\_

Hospitalizations:  Yes  No \_\_\_\_\_

Surgeries:  Yes  No \_\_\_\_\_



Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Today's Date: \_\_\_\_\_

**Please check any boxes that apply to your health, past or current.**

|  |  |  |
|--|--|--|
| <p><b>General-</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Weight loss or gain</li> <li><input type="checkbox"/> Fatigue</li> <li><input type="checkbox"/> Fever or chills</li> <li><input type="checkbox"/> Weakness</li> <li><input type="checkbox"/> Trouble sleeping</li> </ul> <p><b>Skin-</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Rashes</li> <li><input type="checkbox"/> Lumps</li> <li><input type="checkbox"/> Itching</li> <li><input type="checkbox"/> Dryness</li> <li><input type="checkbox"/> Color changes</li> <li><input type="checkbox"/> Hair and nail changes</li> </ul> <p><b>Head-</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Headache</li> <li><input type="checkbox"/> Head injury</li> <li><input type="checkbox"/> Neck Pain</li> </ul> <p><b>Ears-</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Decreased hearing</li> <li><input type="checkbox"/> Ringing in ears</li> <li><input type="checkbox"/> Earache</li> <li><input type="checkbox"/> Drainage</li> </ul> <p><b>Eyes-</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Vision Loss/Changes</li> <li><input type="checkbox"/> Glasses or contacts</li> <li><input type="checkbox"/> Pain</li> <li><input type="checkbox"/> Redness</li> <li><input type="checkbox"/> Blurry or double vision</li> <li><input type="checkbox"/> Flashing lights</li> <li><input type="checkbox"/> Specks</li> <li><input type="checkbox"/> Glaucoma</li> <li><input type="checkbox"/> Cataracts</li> <li><input type="checkbox"/> Last eye exam: _____</li> </ul> <p><b>Nose-</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Stuffiness</li> <li><input type="checkbox"/> Discharge</li> <li><input type="checkbox"/> Itching</li> <li><input type="checkbox"/> Hay fever</li> <li><input type="checkbox"/> Nosebleeds</li> <li><input type="checkbox"/> Sinus pain</li> </ul> | <p><b>Throat-</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Bleeding</li> <li><input type="checkbox"/> Dentures</li> <li><input type="checkbox"/> Sore tongue</li> <li><input type="checkbox"/> Dry mouth</li> <li><input type="checkbox"/> Sore throat</li> <li><input type="checkbox"/> Hoarseness</li> <li><input type="checkbox"/> Thrush</li> <li><input type="checkbox"/> Non-healing sores</li> </ul> <p><b>Neck-</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Lumps</li> <li><input type="checkbox"/> Swollen glands</li> <li><input type="checkbox"/> Pain</li> <li><input type="checkbox"/> Stiffness</li> </ul> <p><b>Respiratory-</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Cough</li> <li><input type="checkbox"/> Sputum</li> <li><input type="checkbox"/> Coughing up blood</li> <li><input type="checkbox"/> Shortness of breath</li> <li><input type="checkbox"/> Wheezing</li> <li><input type="checkbox"/> Painful breathing</li> </ul> <p><b>Cardiovascular-</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Chest pain or discomfort</li> <li><input type="checkbox"/> Tightness</li> <li><input type="checkbox"/> Palpitations</li> <li><input type="checkbox"/> Shortness of breath with activity</li> <li><input type="checkbox"/> Difficulty breathing lying down</li> <li><input type="checkbox"/> Swelling</li> <li><input type="checkbox"/> Sudden awakening from sleep with shortness of breath</li> </ul> <p><b>Gastrointestinal-</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Swallowing difficulties</li> <li><input type="checkbox"/> Heartburn</li> <li><input type="checkbox"/> Change in appetite</li> <li><input type="checkbox"/> Nausea</li> <li><input type="checkbox"/> Change in bowel habits</li> <li><input type="checkbox"/> Rectal bleeding</li> <li><input type="checkbox"/> Constipation</li> <li><input type="checkbox"/> Diarrhea</li> <li><input type="checkbox"/> Yellow eyes or skin</li> </ul> | <p><b>Urinary-</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Change in frequency</li> <li><input type="checkbox"/> Change in urgency</li> <li><input type="checkbox"/> Burning or pain</li> <li><input type="checkbox"/> Blood in urine</li> <li><input type="checkbox"/> Incontinence</li> <li><input type="checkbox"/> Change in urinary strength</li> </ul> <p><b>Vascular-</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Calf pain with walking</li> <li><input type="checkbox"/> Leg cramping</li> </ul> <p><b>Musculoskeletal-</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Muscle or joint pain</li> <li><input type="checkbox"/> Stiffness</li> <li><input type="checkbox"/> Back pain</li> <li><input type="checkbox"/> Redness of joints</li> <li><input type="checkbox"/> Swelling of joints</li> <li><input type="checkbox"/> Trauma</li> </ul> <p><b>Neurologic-</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Dizziness</li> <li><input type="checkbox"/> Fainting</li> <li><input type="checkbox"/> Seizures</li> <li><input type="checkbox"/> Weakness</li> <li><input type="checkbox"/> Numbness</li> <li><input type="checkbox"/> Tingling</li> <li><input type="checkbox"/> Tremor</li> </ul> <p><b>Hematologic-</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Ease of bruising</li> <li><input type="checkbox"/> Ease of bleeding</li> </ul> <p><b>Endocrine-</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Head or cold intolerance</li> <li><input type="checkbox"/> Sweating</li> <li><input type="checkbox"/> Frequent urination</li> <li><input type="checkbox"/> Thirst</li> <li><input type="checkbox"/> Change in appetite</li> </ul> <p><b>Psychiatric-</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Nervousness</li> <li><input type="checkbox"/> Stress</li> <li><input type="checkbox"/> Depression</li> <li><input type="checkbox"/> Memory loss</li> </ul> |
|--|--|--|

**Additional information**

Is there anything else in your health history that you would like the doctor / LMP to know?

---

---

---

**Authorization and Informed Consent to Evaluate and Care for Individual:**

I, \_\_\_\_\_ do hereby authorize, request, and direct the staff and doctors of Northwest Family Chiropractic & Massage to perform in judgment any examination and chiropractic diagnosis or treatment which is deemed necessary. Chiropractic treatment is one of the safest methods of treating back pain. Still, unexpected problems can occur, such as soreness and stiffness, especially at the start of care. More significant problems, such as fracture of weakened bone or sprain/disc injuries are rare. A stroke following neck manipulation is an extremely rare complication, occurring in less than 1 per million treatments. We screen our clients to insure their safety and refer out to supporting providers when necessary.

Patient's signature: \_\_\_\_\_ Date: \_\_\_\_\_

*Our Mission is to provide a profound health care experience in a professional and genuine environment. We empower our clients through individualized Chiropractic programs and lifestyle coaching and inspire our clients to uncover the natural healing power from within.*

*Welcome to NW Family Chiropractic & Massage*

**Claims Escalation to the Washington State Office of the Insurance Commissioner**

In the event of an unreasonable claim denial, unresolvable claims issue, or claim decision that could be a violation of state law; it is possible to escalate claims issues to the Washington State Office of the Insurance Commissioner. In order to solve the issue, the Insurance Commissioner's office does require the patient's name, ID and/or group number, DOB, explanation of benefits, and possible discussion of any claims related communication between the patient, our office, and the insurance carrier.

**Please choose from the following options:**

- Option 1:**  
I give NW Family Chiropractic permission to release my information, as specified above, to the Office of the Insurance Commissioner; in order to resolve claims issues as they deem appropriate.
- Option 2:**  
I may release my information to the Office of the Insurance Commissioner but only on a case by case basis. Please seek my written approval for any applicable claims issue.
- Option 3:**  
Under no circumstances do I wish for NW Family Chiropractic to release my information to the Office of the Washington State Insurance Commissioner.

*The insurance commissioner does not regulate out of state or self-funded health plans.*

**RELEASE OF PERSONAL INFORMATION**

**Please initial:** \_\_\_\_\_

**I authorize the release of my information to the following individual (s)**

- Self only
- Other (please write in below)

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone #: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone #: \_\_\_\_\_

**MISSED APPOINTMENT FEES**

We allocate a specific time for your appointment to better fit your needs. We understand that there may be times when you must cancel or reschedule an appointment but we do request advance notice for the following services:

**24 hours** advance notice is required to cancel or change a **massage** or incur a **\$70.00** missed appointment fee.

Notice **ahead of the scheduled time** to cancel or change a **chiropractic** appointment or incur a **\$20.00** missed appointment fee.

*Missed appointment fees may not be billed to insurance.*

**Please initial:** \_\_\_\_\_

**NOTICE OF PRIVACY PRACTICES**

I have read the privacy notice & understand my rights. I authorize NW Family Chiropractic to use and disclose my protected health information for the purpose of treatment, payment, and healthcare operations as described in the privacy notice. If you have questions about any part of this notice or want more information about your privacy rights, please contact Marisa De Lisle DC, at 206-363-4478 within 2 working days. If you are not satisfied with the manner that this office handles your complaint, you may submit a formal complaint to: DHHS, Office of Civil Rights.

### Insurance Verification Form

Patient Name: \_\_\_\_\_ Month Benefits Refresh: \_\_\_\_\_

Policy Holder: \_\_\_\_\_ Policy Holder Date of Birth: \_\_\_\_\_

Insurance Company Name: \_\_\_\_\_ Effective date: \_\_\_\_\_

Do you have a Secondary Insurance Company? \_\_\_\_\_

**Dear Practice member: this form is provided for you to document your Insurance Benefits. Over the years there have been many changes in the insurance world; because of that, we ask that you verify your benefit information so that you understand how your benefits work.**

**Please verify this information regarding your Chiropractic Benefit:**

**Spinal Manipulation: # per (Calendar / Plan) year** \_\_\_\_\_

**Plan Deductible: \$** \_\_\_\_\_ (Does the deductible apply to the spinal manipulation visits? YES / NO)

**Co-Pay per visit: \$** \_\_\_\_\_

**Co-Insurance %:** \_\_\_\_\_

**Massage Therapy Benefit: Combined with PT? \_\_Yes / No\_\_ Covered if performed by LMP?:\_\_Yes / No\_\_**

**Massage visit max \_\_\_\_\_ Co-pay? \$ \_\_\_\_\_ Co-ins? % \_\_\_\_\_**

**Regence plans: do you need pre-certification for spinal manipulations? YES / NO**

**Premera plans: do you need pre-certification for PT/MT benefits? YES / NO**

Some policies will process services from different benefits within the plan. If you would like to have more in depth information regarding your plan we advise that you verify the following:

X-ray Benefit: \_\_\_\_\_

Examination Benefit: \_\_\_\_\_

Do any of these benefits apply to deductible? Yes / No \_\_\_\_\_

**\*\*If you would like more information about codes we use in office, please ask front desk.\*\***

**After verifying this information please provide this to the front desk staff**

Name: \_\_\_\_\_ Date: \_\_\_\_\_

### Oswestry Low Back Pain Disability Questionnaire

This questionnaire has been designed to give us information as to how your back or leg pain is affecting your ability to manage in everyday life. Please answer by checking one box in each section for the statement which best applies to you. We realize you may consider that two or more statements in any one section apply but please just shade out the spot that indicates the statement which most clearly describes your problem.

|   |   |  |
|---|---|--|
| <p><b>Section 1: Pain Intensity</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> I have no pain at the moment</li> <li><input type="checkbox"/> The pain is very mild at the moment</li> <li><input type="checkbox"/> The pain is moderate at the moment</li> <li><input type="checkbox"/> The pain is fairly severe at the moment</li> <li><input type="checkbox"/> The pain is very severe at the moment</li> <li><input type="checkbox"/> The pain is the worst imaginable</li> </ul>   | <p><b>Section 2: Personal Care (Washing, dressing, etc)</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> I can look after myself normally without causing extra pain</li> <li><input type="checkbox"/> I can look after myself normally, but it causes extra pain</li> <li><input type="checkbox"/> It is painful to look after myself and I am slow and careful</li> <li><input type="checkbox"/> I need some help but manage most of my personal care</li> <li><input type="checkbox"/> I need help every day in most aspects of self-care</li> <li><input type="checkbox"/> I do not get dressed, I wash with difficulty and stay in bed</li> </ul> | <p><b>Section 3: Lifting</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> I can lift heavy weights without extra pain</li> <li><input type="checkbox"/> I can lift heavy weights, but it gives extra pain</li> <li><input type="checkbox"/> Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently placed, eg. on a table</li> <li><input type="checkbox"/> Pain prevents me from lifting heavy weights off the floor, but I can manage light to medium weights if they are conveniently positioned</li> <li><input type="checkbox"/> I can lift very light weights</li> <li><input type="checkbox"/> I cannot lift or carry anything at all</li> </ul> |
| <p><b>Section 4: Walking</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Pain does not prevent me from walking any distance</li> <li><input type="checkbox"/> Pain prevents me from walking more than 1 mile</li> <li><input type="checkbox"/> Pain prevents me from walking more than ½ mile</li> <li><input type="checkbox"/> Pain prevents me from walking more than 100 yards</li> <li><input type="checkbox"/> I can only walk using a stick or crutches</li> <li><input type="checkbox"/> I am in bed most of the time</li> </ul> | <p><b>Section 5: Sitting</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> I can sit in any chair as long as I like</li> <li><input type="checkbox"/> I can only sit in my favorite chair as long as I like</li> <li><input type="checkbox"/> Pain prevents me from sitting more than one hour</li> <li><input type="checkbox"/> Pain prevents me from sitting more than 30 minutes</li> <li><input type="checkbox"/> Pain prevents me from sitting more than 10 minutes</li> <li><input type="checkbox"/> Pain prevents me from sitting at all</li> </ul>  | <p><b>Section 6: Standing</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> I can stand as long as I want without extra pain</li> <li><input type="checkbox"/> I can stand as long as I want but it gives me extra pain</li> <li><input type="checkbox"/> Pain prevents me from standing for more than 1 hour</li> <li><input type="checkbox"/> Pain prevents me from standing for more than 30 minutes</li> <li><input type="checkbox"/> Pain prevents me from standing for more than 10 minutes</li> <li><input type="checkbox"/> Pain prevents me from standing at all</li> </ul>   |



Name: \_\_\_\_\_ Date: \_\_\_\_\_

|  |   |   |
|--|---|---|
| <p><b>Section 7: Sleeping</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> My sleep is never disturbed by pain</li> <li><input type="checkbox"/> My sleep is occasionally disturbed by pain</li> <li><input type="checkbox"/> Because of pain I have less than 6 hours of sleep</li> <li><input type="checkbox"/> Because of pain I have less than 4 hours of sleep</li> <li><input type="checkbox"/> Because of pain I have less than 2 hours of sleep</li> <li><input type="checkbox"/> Pain prevents me from sleeping at all</li> </ul>  | <p><b>Section 8: Sex Life (if applicable)</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> My sex life is normal and causes no extra pain</li> <li><input type="checkbox"/> My sex life is normal but causes some extra pain</li> <li><input type="checkbox"/> My sex life is nearly normal but is very painful</li> <li><input type="checkbox"/> My sex life is severely restricted by pain</li> <li><input type="checkbox"/> My sex life is nearly absent because of pain</li> <li><input type="checkbox"/> Pain prevents any sex life at all</li> </ul> | <p><b>Section 9: Social Life</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> My social life is normal and gives me no extra pain</li> <li><input type="checkbox"/> My social life is normal but increases the degree of pain</li> <li><input type="checkbox"/> Pain has no significant effect on my social life apart from limiting my more energetic interests, eg. sports</li> <li><input type="checkbox"/> Pain has restricted my social life and I do not out as often</li> <li><input type="checkbox"/> Pain has restricted my social life to my home</li> <li><input type="checkbox"/> I have no social life because of pain</li> </ul> |
| <p><b>Section 10: Travelling</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> I can travel anywhere without pain</li> <li><input type="checkbox"/> I can travel anywhere but it gives me extra pain</li> <li><input type="checkbox"/> Pain is bad but I manage journeys over two hours</li> <li><input type="checkbox"/> Pain restricts me to journeys of less than one hour</li> <li><input type="checkbox"/> Pain restricts me to short necessary journeys under 30 minutes</li> <li><input type="checkbox"/> Pain prevents me from travelling except to receive treatment</li> </ul> |   |   |

Score: \_\_\_\_ / 50 =        %

Scoring: For each section the total possible score is 5: if the first statement is marked the section score = 0, if the last statement is marked it = 5 if all ten sections are completed the score is calculated as follows:

Example: 16 (total scored) / 50 (total possible score) x 100 = 32%

If one section is missed or not applicable the score is calculated:

Example: 16 (total scored) / 45 (total possible score) x 100 = 35.5%

Minimum Detectable change (90% confidence): 5 points or 10% points

Name: \_\_\_\_\_ Date: \_\_\_\_\_

### Neck Disability Index

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

|  |  |   |
|--|--|---|
| <p><b>Section 1: Pain Intensity</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> I have no pain at the moment</li> <li><input type="checkbox"/> The pain is very mild at the moment</li> <li><input type="checkbox"/> The pain is mild at the moment</li> <li><input type="checkbox"/> The pain is fairly severe at the moment</li> <li><input type="checkbox"/> The pain is very severe at the moment</li> <li><input type="checkbox"/> The pain is the worst imaginable at the moment</li> </ul>  | <p><b>Section 2: Personal Care (Washing, Dressing, etc)</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> I can look after myself normally without causing extra pain</li> <li><input type="checkbox"/> I can look after myself normally, but it causes extra pain</li> <li><input type="checkbox"/> It is painful to look after myself and I am slow and careful</li> <li><input type="checkbox"/> I need some help but can manage most of my personal care</li> <li><input type="checkbox"/> I need help everyday in most aspects of self-care</li> <li><input type="checkbox"/> I do not get dressed, I wash with difficulty and stay in bed</li> </ul> | <p><b>Section 3: Lifting</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> I can lift heavy weights without extra pain</li> <li><input type="checkbox"/> I can lift heavy weights, but it gives extra pain</li> <li><input type="checkbox"/> Pain prevents me lifting heavy weights off the floor, but I can manage if they are conveniently placed, for example on a table</li> <li><input type="checkbox"/> Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned</li> <li><input type="checkbox"/> I can only lift very light weights</li> <li><input type="checkbox"/> I cannot lift or carry anything</li> </ul> |
| <p><b>Section 4: Reading</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> I can read as much as I want to with no pain in my neck</li> <li><input type="checkbox"/> I can read as much as I want to with slight pain in my neck</li> <li><input type="checkbox"/> I can read as much as I want to with moderate pain in my neck</li> <li><input type="checkbox"/> I can't read as much as I want because of moderate pain in my neck</li> <li><input type="checkbox"/> I can hardly read at all because of severe pain in my neck</li> <li><input type="checkbox"/> I cannot read at all</li> </ul> | <p><b>Section 5: Headaches</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> I have no headaches at all</li> <li><input type="checkbox"/> I have slight headaches, which come infrequently</li> <li><input type="checkbox"/> I have moderate headaches, which come infrequently</li> <li><input type="checkbox"/> I have moderate headaches which come frequently</li> <li><input type="checkbox"/> I have severe headaches, which come frequently</li> <li><input type="checkbox"/> I have headaches all the time</li> </ul>  | <p><b>Section 6: Concentration</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> I can concentrate fully when I want to with no difficulty</li> <li><input type="checkbox"/> I can concentrate fully when I want to with slight difficulty</li> <li><input type="checkbox"/> I have a fair degree of difficulty in concentrating when I want to</li> <li><input type="checkbox"/> I have a lot of difficulty in concentrating when I want to</li> <li><input type="checkbox"/> I have a great deal of difficulty in concentrating when I want to</li> <li><input type="checkbox"/> I cannot concentrate at all</li> </ul>   |

**Name:** \_\_\_\_\_ **Date:** \_\_\_\_\_

|   |   |   |
|---|---|---|
| <p><b>Section 7: Work</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> I can do as much work as I want to</li> <li><input type="checkbox"/> I can only do my usual work, but no more</li> <li><input type="checkbox"/> I can do most of my usual work, but no more</li> <li><input type="checkbox"/> I cannot do my usual work</li> <li><input type="checkbox"/> I can hardly do any work at all</li> <li><input type="checkbox"/> I can't do any work at all</li> </ul>   | <p><b>Section 8: Driving</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> I can drive my car without any neck pain</li> <li><input type="checkbox"/> I can drive my car as long as I want with slight pain in my neck</li> <li><input type="checkbox"/> I can drive my car as long as I want with moderate pain in my neck</li> <li><input type="checkbox"/> I can't drive my car as long as I want because of moderate pain in my neck</li> <li><input type="checkbox"/> I can hardly drive at all because of severe neck pain</li> <li><input type="checkbox"/> I can't drive my car at all</li> </ul> | <p><b>Section 9: Sleeping</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> I have no trouble sleeping</li> <li><input type="checkbox"/> My sleep is slightly disturbed (less than 1 hr sleepless)</li> <li><input type="checkbox"/> My sleep is mildly disturbed (1-2 hrs. sleepless)</li> <li><input type="checkbox"/> My sleep is moderately disturbed (2-3 hrs sleepless)</li> <li><input type="checkbox"/> My sleep is greatly disturbed (3-5 hrs sleepless)</li> <li><input type="checkbox"/> My sleep is completely disturbed (5-7 hrs sleepless)</li> </ul> |
| <p><b>Section 10: Recreation</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> I am able to engage in all my recreation activities with no neck pain at all</li> <li><input type="checkbox"/> I am able to engage in all my recreation activities with some pain in my neck</li> <li><input type="checkbox"/> I am able to engage in most, but not all of my usual recreation activities because of pain in my neck</li> <li><input type="checkbox"/> I am able to engage in a few of my usual recreation activities because of pain in my neck</li> <li><input type="checkbox"/> I can hardly do any recreation activities because of pain in my neck</li> <li><input type="checkbox"/> I can't do any recreation activities at all</li> </ul> |   |   |

Score: \_\_\_\_ / 50 =        %

Scoring: For each section the total possible score is 5: if the first statement is marked the section score = 0, if the last statement is marked it = 5 if all ten sections are completed the score is calculated as follows:

Example: 16 (total scored) / 50 (total possible score) x 100 = 32%

If one section is missed or not applicable the score is calculated:

Example: 16 (total scored) / 45 (total possible score) x 100 = 35.5%

Minimum Detectable change (90% confidence): 5 points or 10% points