___________________________, M.D.
Neurosurgical Associates, P.C.
710 West 168th Street
New York, NY 10032

UNIT # ___________________________

PATIENT INFORMATION

Date: _____/____/_____
Patient Name:

____
(**Last** Name)

_____________________________________ __________
(**First** Name) (Middle Initial)

Date of Birth: _____/____/_____ Sex: □ M □ F

Address: ____
City: ____
State: ______________ Zip: __________________
Home #: (________) __________-____________
Cell #: (________) __________-____________
Email: ____

Father's First Name: ______________________________
Mother's First Name: ______________________________
Employer's Name: _________________________________
Occupation: ______________________________________
Work #: (________) __________-____________
Fax #: (________) __________-____________

Spouse Name: ____________________________________
(**Last** Name)

____
(**First** Name)
Date of Birth: _____/____/_____

Cell #: (________) __________-____________
Email: ____

<u>If different than patient:</u>
Guarantor's Name: ______________________________
(**Last** Name)

____
(**First** Name)
Date of Birth: _____/____/_____ Sex: □ M □ F

Cell #: (________) __________-____________

INSURANCE

Primary Insurance: ______________________________
Policy #: ____
Group #: ____
Phone #: (________) __________-____________

Secondary Insurance: ____________________________
Policy #: ____
Group #: ____
Phone #: (________) __________-____________

Check if apply and answer the following questions:
□ Workers Compensation
□ Auto Accident/NoFault
Date of Accident: _____/____/_____
Carrier Name: ____________________________________
Representative Name: ______________________________
State of Accident: _________________________________
Policy #: ____
Address: ____
Phone #: (________) __________-____________

REFERRING PHYSICIAN

Referring Physician Name:

____
Address: ____
Phone #: (________) __________-____________

Primary Care Physician Name:

____
Address: ____
Phone #: (________) __________-____________

Pharmacy Name: __________________________________
Address: ____
Phone #: (________) __________-____________

____________________________, M.D.
Neurosurgical Associates, P.C.
710 West 168th Street
New York, NY 10032

UNIT # ____________________________

PATIENT FINANCIAL OBLIGATION AGREEMENT

I understand that all applicable copayments and deductibles are due at the time of services. I agree to be financially responsible and make full payment for all charges not covered by my insurance company. I authorize my insurance benefits to be paid directly to Neurosurgical Associates, P.C. for services rendered. I authorize representatives of Neurosurgical Associates/Columbia University Medical Center to release pertinent medical information to my insurance company when requested or to facilitate payment of a claim. If my current policy prohibits direct payment to the doctor, I will forward the check and explanation of benefits to Neurological Associates.

Patient Signature: ____________________________
Date: _____/____/_____

Guarantor Signature: __________________________
Date: _____/____/_____

I am aware that __________________, M.D. does not participate with my Commercial Insurance and is an Out-of-Network Provider.

Patient Signature: ____________________________
Date: _____/____/_____

NOTICE OF PRIVACY PRACTICES: ACKNOWLEDGEMENT OF RECIEPT

I acknowledge that I was provided with a copy of the ColumbiaDoctors Notice of Privacy Practices (NOPP).

Patient Name: (Print) ____

Patient Signature: ____ Date: _____/_____/_____

If completed by a patient's representative, please print and sign below:

Representative: (Print) ____ Relationship: __________________

Representative Signature: ____ Date: _____/_____/_____

MYCOLUMBIADOCTORS PATIENT PORTAL SIGN UP

Access your personal records securely, 24/7, on a computer, smartphone, or iPad.

□ YES, Send me an invitation to join myColumbiaDoctors. Email: ____
□ **NO, do not** send me an invitation to join myColumbiaDoctors.

Look for an email invite from **noreply@followmyhealth.org** and click the registration link.

Patient's Preferred Language ___________________________ □ I decline to respond.

Patient Signature: ____ Date: _____/_____/_____

COLUMBIA UNIVERSITY
MEDICAL CENTER

Spine Center
New Patient Intake Form

Patient Identification Information

DEMOGRAPHIC INFORMATION

Full name ______________________________ DOB _____________ Age ________

Address____

Email____

Phone numbers (H)_______________ (W)_______________ (C)_______________

Emergency contact____________________________ Phone ______________________

CARE INFORMATION

Primary care physician:____

Address____

Phone_____________________________ Fax________________________________

Referring physician:_______________________________ Specialty ________________

Address____

Phone________________________________ Fax_____________________________

REASON FOR VISIT

Please describe the major problem that brings you in today to see a spine surgeon:

____

____

Is this visit related to worker's compensation? ☐ No ☐ Yes

Is this visit related to any legal actions? ☐ No ☐ Yes

If this problem is the result of an accident, when did the accident occur? ____________________

Was it a motor vehicle accident? ☐ No ☐ Yes

COLUMBIA UNIVERSITY MEDICAL CENTER

Spine Center
New Patient Intake Form

Patient Identification Information

MEDICAL HISTORY

Height _______ feet _______ inches Weight ________ pounds

Please list all **OPERATIONS** you have had. Date:

Please list all **ACTIVE MEDICAL PROBLEMS**. Duration:

Please list all **MEDICATIONS** you take routinely, prescribed or over-the-counter, along with the dosages:

Medication:	Dose:	Frequency:

Are you **ALLERGIC** to any medicines, latex, x-ray dye, or iodine?

If yes, please explain: ____

Have you had any **PROBLEMS WITH ANESTHESIA**?

If yes, please explain: ____

Are you taking any **BLOOD THINNING MEDICATIONS**? ☐ Yes – indicate below ☐ No

- ☐Aspirin or aspirin-containing medication
- ☐Anti-inflammatory medication (for example, Advil, Motrin, Celebrex)
- ☐Plavix
- ☐Coumadin
- ☐Fish oil
- ☐Other:_________________________

COLUMBIA UNIVERSITY MEDICAL CENTER

Spine Center
New Patient Intake Form

Patient Identification Information

REVIEW OF SYSTEMS

CARDIOVASCULAR

	Y	N
Chest pain/pressure	☐Y	☐N
Fainting	☐Y	☐N
Heart attack	☐Y	☐N
Heart defect	☐Y	☐N
Heart murmur	☐Y	☐N
High blood pressure	☐Y	☐N
Low blood pressure	☐Y	☐N
Leg swelling	☐Y	☐N

CONSTITUTIONAL

	Y	N
Altered taste/smell	☐Y	☐N
Change in appetite	☐Y	☐N
Excessive sleepiness	☐Y	☐N
Fatigue	☐Y	☐N
Fever	☐Y	☐N
Depression	☐Y	☐N
Anxiety	☐Y	☐N
Recent sore throat	☐Y	☐N
Sleep apnea	☐Y	☐N
Weight loss or gain	☐Y	☐N

EAR, NOSE, & THROAT

	Y	N
Hearing loss	☐Y	☐N
Mouth sores	☐Y	☐N
Ringing in ears	☐Y	☐N
Sinus disease	☐Y	☐N
Trouble swallowing	☐Y	☐N

EYES

	Y	N
Blurred vision	☐Y	☐N
Cataracts	☐Y	☐N
Double vision	☐Y	☐N
Glaucoma	☐Y	☐N
Macular degeneration	☐Y	☐N
Peripheral vision issue	☐Y	☐N
Visual impairment	☐Y	☐N

GASTROINTESTINAL

	Y	N
Black stool	☐Y	☐N
Constipation	☐Y	☐N
Diarrhea	☐Y	☐N
Gall bladder problems	☐Y	☐N
Ulcer	☐Y	☐N
Vomiting	☐Y	☐N

SKIN

	Y	N
Birth marks	☐Y	☐N
Psoriasis	☐Y	☐N
Skin rashes	☐Y	☐N
Melanoma	☐Y	☐N

RESPIRATORY

	Y	N
Asthma	☐Y	☐N
Bronchitis	☐Y	☐N
Chronic cough	☐Y	☐N
COPD	☐Y	☐N
Emphysema	☐Y	☐N
Pneumonia	☐Y	☐N
Shortness of breath	☐Y	☐N
Trouble breathing	☐Y	☐N
Tuberculosis	☐Y	☐N
Wheezing	☐Y	☐N

MUSCULOSKELETAL

	Y	N
Connective tissue disorder	☐Y	☐N
Low back pain	☐Y	☐N
Neck pain	☐Y	☐N
Joint pain	☐Y	☐N
Joint replacement	☐Y	☐N
Joint swelling	☐Y	☐N

GENITOURINARY

	Y	N
Blood in urine	☐Y	☐N
Change in habits	☐Y	☐N
Urinary infections	☐Y	☐N
Kidney disease	☐Y	☐N
Kidney stones	☐Y	☐N
Loss of control	☐Y	☐N
Painful urination	☐Y	☐N
Urinary urgency	☐Y	☐N
Vaginal bleeding	☐Y	☐N

HEMOLYMPHATIC/ ENDOCRINE

	Y	N
Anemia	☐Y	☐N
Blood disorder	☐Y	☐N
Circulatory problems	☐Y	☐N
Diabetes	☐Y	☐N
Dry eyes/mouth	☐Y	☐N
Endocrine disorder	☐Y	☐N
Low blood sugar	☐Y	☐N
Lymph node swelling	☐Y	☐N
Hepatitis	☐Y	☐N
HIV/AIDS	☐Y	☐N
Pituitary disorder	☐Y	☐N
Sickle cell disease	☐Y	☐N
Thyroid disease	☐Y	☐N

NEUROLOGICAL

	Y	N
Balance difficulty	☐Y	☐N
Choking	☐Y	☐N
Clumsiness	☐Y	☐N
Concussion	☐Y	☐N
Confusion	☐Y	☐N
Concentration difficulty	☐Y	☐N
Dizziness	☐Y	☐N
Drooling	☐Y	☐N
Falls	☐Y	☐N
Hallucinations	☐Y	☐N
Headache	☐Y	☐N
Loss of consciousness	☐Y	☐N
Memory problems	☐Y	☐N
Muscle twitching	☐Y	☐N
Nausea	☐Y	☐N
Numbness	☐Y	☐N
Personality change	☐Y	☐N
Seizure	☐Y	☐N
Shooting pains	☐Y	☐N
Smelling difficulty	☐Y	☐N
Stroke	☐Y	☐N
Tasting difficulty	☐Y	☐N
Tingling sensation	☐Y	☐N
Vertigo	☐Y	☐N
Walking difficulty	☐Y	☐N

Columbia University Medical Center

Spine Center
New Patient Intake Form

Patient Identification Information

SOCIAL HISTORY

Are you married? ☐ No ☐Yes ☐ Separated/divorced ☐Widow(er)

What is your **SMOKING** HISTORY?
- ☐Currently smoke **every day** How much daily? ________________
- ☐Currently smoke **some days** How much weekly? ________________
- ☐Formerly smoked
- ☐Never smoked

Do you drink alcohol? ☐ No ☐Yes Drinks per day: ________________________
Use any recreational drugs? ☐ No ☐Yes Please specify: ________________________
Prior alcohol or drug abuse? ☐ No ☐Yes Please explain: ________________________

Do you participate in activities inside the home (i.e. vacuuming, cooking, general housework)?
☐ No ☐Yes
If yes, describe your level of activity: ☐Sendentary or light ☐Moderate ☐Strenuous
Do you participate in activities outside the home (i.e. gardening, golf, walking, cycling, volunteering)?
☐ No ☐Yes
If yes, describe your level of activity: ☐Sendentary or light ☐Moderate ☐Strenuous

What is the highest level of **EDUCATION** you have achieved? (Check one)
- ☐Less than high school
- ☐High school diploma or GED
- ☐Two-year college degree
- ☐Four-year college degree
- ☐Post-college

Are you currently **EMPLOYED** (paid employee or self-employed)? (Check all that apply)
- ☐ Employed and currently working
  - ☐ Full time
  - ☐ Part time
- ☐ Employed but not working
  - ☐ On short-term disability
- ☐ On leave
- ☐ Unemployed
  - ☐ On disability
  - ☐ Retired
  - ☐ Homemaker
  - ☐ None of the above
- ☐ Attending school

If disabled or unemployed, is this due to your **spinal condition**? ☐ No ☐Yes

Was your spinal condition work related? ☐Yes ☐No ☐Unknown

Which description best characterizes your occupation?
- ☐Sendentary: requires the ability to sit up to 6 hours in an 8-hour work day, lift light objects such as files and paperwork frequently during the day, and objects weighing up to 10 pounds occasionally during the day
- ☐Light: requires the ability to stand up to 6 hours in an 8-hour work day, lift up to 10 pounds frequently and up to 20 pounds occasionally
- ☐Medium: requires the ability to stand up to 6 hours in an 8-hour work day, lift up to 25 pounds frequently and 50 pounds occasionally
- ☐Heavy: requires the ability to stand up to 6 hours in an 8-hour work day, lift up to 50 pounds frequently and lift more than 50 pounds occasionally

Spine Center
New Patient Intake Form

Patient Identification Information

FAMILY HISTORY

If you have any relatives, including children, with serious medical conditions (such as asthma, high blood pressure, heart attacks, kidney problems, diabetes, seizures, strokes, cancer, etc.) please list below.

Relationship________________________________ Age ________ Condition ______________________
Relationship________________________________ Age ________ Condition ______________________
Relationship________________________________ Age ________ Condition ______________________
Relationship________________________________ Age ________ Condition ______________________
Relationship________________________________ Age ________ Condition ______________________
Relationship________________________________ Age ________ Condition ______________________

Do you have children? ☐ No ☐ Yes If yes, age(s) and condition
____
____

SIGNATURES

This form is confidential and is part of your medical record.

Completed by: ___________________________ ___________________________ ___________
Printed Signature Date

Reviewed by: _________________________, M.D. ________________________ ___________
Printed Signature Date

NAME:____ **DATE:**____________________

BIRTHDATE:________/________/________ **HEIGHT:**____**FT.**_____**IN. WEIGHT**________**LBS**

A.

1. Internist or family doctor name and address: ____
2. Chief complaint (check all that apply)
   - □ Neck pain Arm: □ Pain □ Numbness □ Weakness
   - □ Back pain Leg: □ Pain □ Numbness □ Weakness
   - □ Other: ____
3. Your age: ______________ Years ____________ Months
4. Your sex: □ Male □ Female
5. How long has the pain (or your problem) been present? ______________________________
6. Has your problem worsened recently? □ No □ Yes – How recently? ____________________
7. What started the pain (or problem)? ____

B. For patients with NECK OR ARM pain, numbness, or weakness:

(If you are seeing the doctor for back or leg pain, please ask for the BACK OR LEG questionnaire.)

1. What % of your pain is neck pain and what % is arm pain? (check appropriate box)
   - ☐ Neck 0%, Arm 100% ☐ Neck 10%, Arm 90% ☐ Neck 25%, Arm 75%
   - ☐ Neck 40%, Arm 60% ☐ Neck 50%, Arm 50% ☐ Neck 65%, Arm 40%
   - ☐ Neck 75%, Arm 25% ☐ Neck 90%, Arm 10% ☐ Neck 100%, Arm 0%
2. There is: ☐ No arm pain ☐Arm pain is as follows (check the following):
   - a. ☐ Right 0%, Left 100% ☐ Right 10%, Left 90% ☐ Right 25%, Left 75%
     ☐ Right 40%, Left 60% ☐ Right 50%, Left 50% ☐ Right 65%, Left 40%
     ☐ Right 75%, Left 25% ☐ Right 90%, Left 10% ☐ Right 100%, Left 0%
   - b. The arm pain is present in the (check the following):
     Right: ☐ Upper back ☐ Shoulder ☐ Upper arm ☐ Forearm ☐ Hand/finger
     Left: ☐ Upper back ☐ Shoulder ☐ Upper arm ☐ Forearm ☐ Hand/finger
3. Raising the arm: □ Improves the pain □ Worsens the pain □ Does not affect the pain
4. Moving the neck: □ Improves the pain □ Worsens the pain □ Does not affect the pain
5. There is: ☐ No weakness of the arms and hands ☐Weakness of the (check the following):
   - **Right**: ☐ Shoulder ☐ Upper arm ☐ Forearm ☐ Hand/finger
   - **Left**: ☐ Shoulder ☐ Upper arm ☐ Forearm ☐ Hand/finger
6. There is: ☐ No numbness of the arms and hands ☐Numbness of the (check the following):
   - **Right**: ☐ Upper arm ☐ Forearm ☐ Thumb ☐ Index finger ☐ Long finger ☐ Ring finger ☐ Small finger
   - **Left**: ☐ Upper arm ☐ Forearm ☐ Thumb ☐ Index finger ☐ Long finger ☐ Ring finger ☐ Small finger
7. There (☐ is ☐ is not) difficulty picking up small objects like coins or buttoning buttons.
8. There (☐ is ☐ is not) problem with balance or tripping frequently
9. There are (☐ Frequent ☐ Occasional ☐ No) headaches in the back of the head.

PLEASE GO ON TO THE NEXT PAGE

C. 1. Coughing or sneezing (☐ Increases ☐ Sometimes increases ☐ Does not increase) the pain.

2. There is: ☐ No loss of bowel or bladder control ☐ Loss of bowel or bladder control since ________________

3. I have: ☐ Not missed any work because of this problem ☐ Missed (how much?) _____________________work.

4. Treatments have included: ☐ No medicines, therapy, manipulations, injections, or braces.

Neck	Back		Neck	Back	
☐	☐	Physical therapy, exercise	☐	☐	Anti-inflammatory medications
☐	☐	Massage & ultrasound	☐	☐	Narcotic medication
☐	☐	Traction	☐	☐	Epidural steroid injections ____times which
☐	☐	Manipulation			relieved the pain for (how long?) _________
☐	☐	TENS unit	☐	☐	Trigger point injections ____times which
☐	☐	Shoulder injections			relieved the pain for (how long?) _________
☐	☐	Braces	☐	☐	Other: ______________________________

5. List pain medications and dose taken for your spine problem: ☐ None

Medication	Dose

6. Previous doctors seen about this problem: ☐ None

Doctor	Specialty	City (if not New York)	Treatments

D. MEDICAL HISTORY

Please check all that apply ☐ None apply

☐ Heart attack
☐ Heart failure
☐ High blood pressure
☐ Osteoarthritis
☐ Rheumatoid arthritis
☐ Ankylosing spondylitis
☐ Gout
☐ Osteoporosis
☐ Ulcers or hiatus hernia
☐ Dentures/Bridges
☐ Other:____________________________________

☐ Diabetes
☐ Stroke
☐ Seizures
☐ Mental illness
☐ Kidney stones
☐ Kidney failure
☐ Cancer
☐ Alcoholism
☐ Glaucoma
☐ Problems with hearing

☐ Lung disease
☐ HIV
☐ AIDS
☐ Tuberculosis
☐ Asthma
☐ Blood clot in leg
☐ Blood clot in lung
☐ Stomach ulcers
☐ Glasses or contact lenses

☐ Liver trouble
☐ Hepatitis
☐ Thyroid trouble
☐ Bleeding disorders
☐ Anemia
☐ Loose, capped, missing, or chipped teeth
☐ Serious injuries: _____________________

E. SURGICAL HISTORY: Previous surgeries- list procedure, surgeon, and date. ☐ None

OPERATION	SURGEON	DATE

F. MEDICATIONS YOU TAKE: ☐ None

____

____

PLEASE GO ON TO THE NEXT PAGE

G. ALLERGIES TO MEDICATIONS: ☐ No known drug allergies

MEDICATION REACTION

____

____

____

____

____

H. SOCIAL HISTORY

1. Work status: ☐ Homemaker ☐ Retired ☐ Disabled ☐ On leave
   ☐ Unemployed ☐Working: __Full time __Part time
   Occupation: ____________________________________

2. Marital status: ☐ Married ☐ Single ☐Co-habitating
   ☐ Widowed ☐ Divorced

3. Number of living children: _______

4. I live: ☐ Alone ☐ With: ________________________

5. Tobacco use: ☐ Never (skip to #6)
   ☐ Cigar ☐ Chew ☐ Pipe ☐ Cigarettes
   ___________ packs per day for ________ years.
   ☐ Quit – When? _____________________ after smoking
   ___________ packs per day for ________ years (total).

6. Alcohol: ☐ Never or rare
   ☐ Social ☐ Frequently drunk (more than twice a week)
   ☐ Alcoholic ☐ Recovering alcoholic

7. Drug use/abuse: ☐ Never ☐ Currently ☐ In the past

8. Because of this spine problem, I have filed or plan to file:
   ☐ A lawsuit ☐ A Worker's Compensation claim
   ☐ Neither a lawsuit nor a Worker's Compensation claim

I. FAMILY HISTORY: Check all that apply. ☐ None apply

☐ Stroke ☐ Arthritis ☐ Mental illness ☐ Alcoholism
☐ Heart trouble ☐ Gout ☐ Kidney trouble or stones ☐ Other: _______
☐ High blood pressure ☐ Seizures ☐ Cancer ____________
☐ Diabetes ☐ Spine problems ☐ Bleeding disorders ____________

J. REVIEW OF SYSTEMS

1. Do you have any problems with your **HEART** or **CIRCULATION?** Check all that apply
   ☐ Heart murmur or Mitral Valve Prolapse ☐ Irregular Heartbeat
   ☐ Difficulty with Stairs (due to shortness of breath) ☐ Sleeping on more than one pillow
   ☐ Waking at night with shortness of breath ☐ Ankle Swelling
   ☐ Shortness of breath at rest or exercising ☐ Chest pain at rest or exercising

   If yes, please explain: ____

PLEASE GO ON TO THE NEXT PAGE

2. Do you have any problems with your **LUNGS** or **BREATHING?** Check all that apply

☐ Asthma	☐ Pneumonia
☐ Bronchitis	☐ Emphysema
☐ Cough or Coughing up phlegm	☐ Shortness of breath

If yes, please explain: ____

3. Do you have any problems with your **BLOOD?** Check all that apply

☐ Bleeding tendency or easy bruising	☐ Sickle cell disease
☐ Blood transfusions	

If yes, please explain:____

4. Do you have any problems with your **NERVES, MUSCLES** or **BONES?** Check all that apply

☐ Fainting spells	☐ Muscle weakness
☐ Headaches	☐ Dizziness
☐ Double vision	☐ Loss of sensation
☐ Paralysis or weakness of limbs	☐ Loss of balance
☐ Loss of coordination	☐ Muscle wasting
☐ Head, neck, or back injury	☐ Psychiatric illness
☐ Extreme nervousness or anxiety	

If yes, please explain: ____

Are you pregnant? ☐ Yes ☐ No Date of last menstrual period: ______________

MY PAIN/DISCOMFORT IS (circle number)

0	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**
No pain	Slight		Mild		Moderate	Severe		Excruciating		Pain as bad as it could be

_______________________________________ _____________
Patient signature Date

PLEASE GO ON TO THE NEXT PAGE

NECK DISABILITY INDEX

Please read: This questionnaire has been designed to give the doctor 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 which applies to you. We realize you may consider that two of the statements in any one section apply to you, but please just mark the box which most closely describes your problem.

Section 1 – Pain intensity

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

Section 2 – Personal care (Washing, Dressing, etc.)

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

Section 3 – Lifting

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

Section 4 – Reading

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

Section 5 – Headaches

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

Section 6 – Concentration

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

Section 7 – Work

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

Section 8 – Driving

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

Section 9 – Sleeping

- ☐ I have no problem sleeping
- ☐ My sleep is slightly disturbed (less than 1 hour sleepless)
- ☐ My sleep is mildly disturbed (1-2 hours sleepless)
- ☐ My sleep is moderately disturbed (2-3 hours sleepless)
- ☐ My sleep is greatly disturbed (3-6 hours sleepless)
- ☐ My sleep is completely disturbed (5-7 hours sleepless)

Section 10 – Recreation

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