Services Agreement

I, ____, being a patient of Anderson Bauman Chiropractic located at 733 North Pine St, Burlington, WI, acknowledge that it has been explained to me that the following **services may not be covered or are not covered** by the benefits available to me under the terms of my Health Plan or insurance policy:

- Exams
- Spinal Manipulations
- Massages
- Extremity Manipulations
- Hot/Cold packs
- Interferential
- X-Rays
- Therapeutic activities/exercises
- Manual Therapy Techniques
- Orthotics
- Traction
- Ultrasound
- Supplies/Supports

The reason for this is that:

- This service is excluded from my plan coverage or
- This service has not been authorized by my health plan or
- This service or services may be determined to be a maintenance, preventive, or wellness care

I agree to pay for these services myself and to make financial arrangements, if needed, with Anderson Bauman Chiropractic.

Patient/Guardian
signature:____Date:_____________

Informed Consent to Chiropractic Treatment at Anderson Bauman Chiropractic

The Nature of Chiropractic Examination and Treatment: The doctor will perform a physical examination. X-rays may be taken to evaluate your condition. The doctor will use his/her hands in order to move your joints. You may feel a "click" or "pop" similar to the noise produced 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 traction may also be used. Exercise and massage therapy may be recommended.

Benefits of Chiropractic Treatment: Many or most patients will feel improvement in motion, decreased muscle and joint pain and improved well-being after a series of chiropractic adjustments.

Possible Risks: As with any health care procedure, complications are possible following chiropractic treatment. Complications could conceivably include fracture of bone, muscular strain, ligamentous sprain, dislocations of joints, or injury to intervertebral discs, nerves, or spinal cord. A minority of patients may notice stiffness or soreness after the first few days of treatment. The ancillary procedures could produce skin irritation, burns, or other minor complications. X-rays produce ionizing radiation. There are reported cases of stroke associated with visits to medical doctors and chiropractors. The best quality scientific evidence does not establish a cause and effect relationship between chiropractic treatment and the occurrence of stroke; rather, it indicates that patients may be consulting medical doctors and/or chiropractors for symptoms of headache and neck pain when they are in the early stages of a stroke. The possibility of such injuries occurring in associated with chiropractic treatment is extremely remote.

Probability of Risks Occurring: The risks of complications due to chiropractic treatment have been described as "rare" to "extremely rare".

Other Treatment Options which could be considered include the following:

1. *Over-the-counter analgesics*. The risks of these medications include irritation to the stomach, liver, and kidneys, increased cardiovascular risk, and other side effects in a significant number of cases.
2. *Medical care,* typically anti-inflammatory drugs, tranquilizers, and analgesics. Risks of these prescription drugs include all side effects as above, plus patient dependence in a significant number of cases.
3. *Hospitalization* in conjunction with medical care adds additional risk of exposure to medical error, infection and other complications in a significant number of cases.
4. *Surgery* in conjunction with medical care adds the risks of adverse reaction to anesthesia, as well as an extended convalescent period in a significant number of cases.

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 further rehabilitation more difficult.

Unusual Risks: I have had the following unusual risks of my case explained to me:

________ Patient or Parent/Legal Guardian Initials

I have read the above explanation 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. This informed consent will remain in effect unless there are significant changes in my diagnosis. I have the right to withdraw my consent at any time, upon written notice. I have the right to refuse treatment at any time.

____

Printed Name | Patient or Parent/Legal Guardian Signature | Date

Anderson Bauman Chiropractic

Dr. Michael Anderson
Dr. Ryan Bauman
Dr. Susan Reinke
733 N Pine Street
Burlington, WI 53105
www.notjustbackpain.com

Authorization for Verbal Communication And/ or To Leave Voice Mail Messages

This Does not authorize release of copies of medical records

____
Date (MM/DD/YYYY)

Patient Last Name ______ Patient Middle Initial ______ Patient First Name ______

____
Patient DOB (MM/DD/YYYY)

Information to be disclosed: Verbal Communication Only Re: Patient care and Scheduling

Communication Between: ______________________________

____

Can we leave a voicemail or send a text to all people named above? ◯ Yes ◯ No

Information to be disclosed: Verbal communication only Re: patient account and billing

Communication Between: ______________________________

Can we leave a voicemail or send a text to all people named above? ◯ Yes ◯ No

(List Names of Health care facilities, Schools, Work, medical transportation, assisted living, and family with their phone numbers)

This authorization will expire:

◯ Indefinite ◯ One year from signed date

In accordance with the conditions listed above, I authorize the use and/or disclosure of the medical information. This authorization incudes disclosure of information regarding all aspects of my medical health. If you choose indefinite, you can let us know at any time if you need to change the information above and we can fill out a new paper,

Signature of Patient/ Parent or Guardian: ______________________ Date: ______________

Anderson Bauman Chiropractic Financial Policy

We strive to provide the highest quality health care, all the while maintaining affordability for you, the patient. We understand that even with insurance, most patients will experience at least some out of pocket expense.

Participating Insurance

Our office will accept your insurance on assignment and do participate as preferred providers for many insurance plans. However, it must be fully understood that your insurance policy is a contract between you and your insurance company. Our office will not enter into a dispute with your insurance company over policy limitations or issues. This is your responsibility and obligation. All charges incurred are your responsibility. If you have a question or concern with your reimbursement, you will need to contact your employer or insurance company. Our office will file your claims for you and assist you in every way possible to ensure benefit recovery. We cannot be certain if your insurance covers chiropractic care, although most policies do provide coverage. The amount they pay varies from one policy to another. We will call to verify benefits on your insurance; however, the benefits quoted to us by your insurance company are not a guarantee of payment. It is our policy and agreed that any services rendered are charged to you directly and you are responsible for payment of any non-covered services, deductibles or copays.

You are also responsible for updating health insurance information with the front desk any time it changes, terminates, or new coverage begins. Our office is subject to a "timely filing period" which means that if you do not supply us with health insurance information in a timely fashion, the claim may be denied and you agree to pay for these services.

High Deductible Insurance Plans

We will gladly bill your insurance company for you, and will call to determine your chiropractic benefits. We do require patients with high deductible plans to make a weekly payment on their account during active care. The amount to be paid will be discussed and agreed upon by you and the front desk staff.

Patients without Insurance or Self-Pay Patients

We require that you pay at the time of service unless other arrangements have been made (ie. a monthly payment plan or CAP agreement). Patients that are put on a CAP agreement (discussed & decided between the patient and the doctor) will be required to make their agreed upon monthly payments. If the monthly payments are not made, a 1.5% interest charge will be applied. You will continue to receive a statement in the mail until the CAP amount is fully paid. Once the CAP amount has been paid in full, your remaining balance will be written off. We are happy to accept cash, check, Mastercard, Visa, and HSA cards. No insurance will be billed.

Medicare Patients

Our office accepts assignment from Medicare. Reimbursement is sent directly to our office in payment for chiropractic services that Medicare will cover. Medicare will **ONLY** cover manipulation of the spine. Medicare pays 80% of the allowable fee once the deductible has been met. You are required to pay the deductible and the remaining fees for services Medicare does not reimburse. These non-covered services include, but are not limited to, x-rays, examinations, therapies, orthotics, supplies/supports, massages, and/or nutritional supplements. Medicare patients are fully responsible for charges of non-covered services. Secondary or supplemental insurance may or may not pay for these non-covered services.

Secondary/Supplemental Insurance

Please inform us of any secondary or supplemental insurance you may have. We will file and collect from your secondary insurance for services covered by the secondary payer.

Flex Plans/Medical Savings Accounts

Please inform us if you have a medical savings account, or a 'flex spending plan'. We will be happy to provide you with a statement of your charges for reimbursement.

Please read the following office policy regarding assignments:

1. At the beginning of your treatment in our office, we will verify your policy benefits. However, phone or fax verification of coverage is never a guarantee of payment.
2. Returned checks will be subject to an additional fee.
3. You will be charged a 1.5% interest rate on any payment plans that aren't kept current.
4. Your insurance will be filed as a courtesy to you. We file insurance claims on a weekly basis and it takes 3-4 weeks to hear back on said claims from insurance.
5. You will be responsible for your full deductible and co-payment or co-insurance. Payment is due when services are rendered (unless other arrangements have been made). If your insurance company does not pay something that was anticipated, you will be responsible for the amount as soon as we/you are aware of the denial (we sent out denial letters as we receive them and patient statements once per month).

I have read and understand this financial policy. I realize that I am responsible for all charges incurred by me/or my child at Anderson Bauman Chiropractic and agree to the above terms.

Patient Name (printed):

Guardian Name (printed):

Patient/Guardian Signature: Date:

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HEALTH INFORMATION

Anderson Bauman Chiropractic

Dr. Michael Anderson
Dr. Ryan Bauman
Dr. Susan Reinke
733 N Pine Street
Burlington, WI 53105
www.notjustbackpain.com

Please allow our staff to photocopy your driver's license and insurance detail. All information you supply is confidential. We comply with all federal privacy standards.
Please Print Clearly

____
Today's Date

______________________ Whom may we thank for referring you

Have you seen a Chiropractor before? Yes ◯ No ◯

__________ When?

__________ If so, Whom?

______ Age

Gender
Male ◯ Female ◯

Race
◯ American Indian ◯ American Native ◯ Asian ◯ Black or African American
◯ Native Hawaiian ◯ Other Pacific Islander ◯ other ◯ White Decline to answer

__________ Ethnicity

____
Birth Date (MM/DD/YYYY)

______________________ Patient Last Name

______________________ Patient Nickname

______________________ Patient Social Security Number

______________________ Patient First Name

______________________ Patient Middle Name (or Initial)

Marital Status ◯ Married
◯ Single ◯ Separated
◯ Divorced ◯ Widowed

______________________ Address

______________________ Spouse Name

__________ City

__________ State/Province

__________ ZIP/Postal Code

______________________ Child Name

__________ Home Phone

__________ Cell Phone

______________________ Child Name

______________________ Email Address

______________________ Child Name

______________________ Emergency Contact Name

______________________ Emergency Contact Phone Number

Preferred Method of Contact?
◯ Cell Phone ◯ Home Phone
◯ Email ◯ Work Phone

______________________ Patient Occupation

______________________ Work Phone

______________________ Patient Employer

______________________ Primary Physician & Location

Can we contact you at Work?
◯ Yes ◯ No

Please check one:

◯ Insurance: If you wish to have your services billed to insurance, please present your insurance card to a staff member at this time
Are you the primary holder of this insurance? ◯ Yes ◯ No
If No, Name of Holder __________________ Date of Birth of Holder __________ Relationship__________________

◯ Non- Insurance: I agree to pay in full at the time of service

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HEALTH INFORMATION

Anderson Bauman Chiropractic

Dr. Michael Anderson
Dr. Ryan Bauman
Dr. Susan Reinke
733 N Pine Street
Burlington, WI 53105
www.notjustbackpain.com

Current Health Conditions:

____

What health condition(s) bring you into our office?

Have you received care for this problem before? ◯Yes ◯No

____

If Yes, please explain:

____

When did the condition(s) first begin?

______________________ ______________________

What makes the problem better? **What makes the problem worse?**

System Review Questions:

Have you had any problems with the following areas now or in the Past? (Y=Yes and N= No) If yes, circle all that apply.

____ Eyes (Glasses, Contacts, Cataracts, Glaucoma, Etc.)
____ Gastro-intestinal (Acid Reflux, Ulcers, Gall Bladder, IBS, Etc.)
____ Ears, Mouth, Nose, Throat (Hearing Loss, Sinus, Etc.)
____ Genito-Urinary (Male/Female Reproductive, Kidney, Bladder Etc.)
____ Cardiovascular (Heart, High BP, High Cholesterol, Etc.)
____ Musculoskeletal (Breaks, Arthritis, Osteoporosis, Discs, Etc.)
____ Respiratory (Lungs, Breathing, Asthma, COPD, Etc.)
____ Skin (Rashes, Skin Cancer, Dryness, Psoriasis, Eczema, Hair, Etc.)
____ Neurological (Nerve Issues, Weakness, Numbness, Etc.)
____ Psychiatric (Anxiety, Depression, Bipolar, ADD/ADHD, Etc.)
____ Endocrine (Thyroid, Hormonal, Imbalances, Liver, Etc.)
____ Others: ______________________

Are you Pregnant? ◯Yes ◯No if yes, Due Date: ______________________
How Many? Pregnancies__________ Live Births__________ Miscarriages__________ C-Section/ Vaginal Birth? __________
Any Major Operations & State year? ______________________

Medications:

◯Steroids ◯Blood Pressure ◯Diabetic Meds. ◯Birth Control ◯Muscle Relaxant ◯Antibiotics
◯ Antidepressant ◯Antianxiety ◯Pain Medication ◯Heart Meds. ◯Cholesterol Meds.
◯ Others: ______________________
Vitamin/Herbs/Minerals/Supplements You are currently Taking: ______________________

Allergies:

◯ Pollen ◯ Dust ◯Ragweed ◯Latex ◯Animals ◯Shellfish ◯ Other: ______________________

Habits:

Smoking Status:
◯ Never a Smoker ◯ Former Smoker ◯Current Every Day Smoker ◯Current Some Day Smoker ◯ Heavy Smoker ◯Light Smoker

Alcohol Use:
◯Daily ◯Weekly How Much? ______________________

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HEALTH INFORMATION

Anderson Bauman Chiropractic
Dr. Michael Anderson
Dr. Ryan Bauman
Dr. Susan Reinke
733 N Pine Street
Burlington, WI 53105
www.notjustbackpain.com

Family History:

Relative	Age (if living)	State of Health Good- Poor		Illnesses	Age of Death	Cause Of Death Natural-Illness	
Mother	______	○	○	______	______	○	○
Father	______	○	○	______	______	○	○
Sister	______	○	○	______	______	○	○
Sister	______	○	○	______	______	○	○
Brother	______	○	○	______	______	○	○
Brother	______	○	○	______	______	○	○

Are there any other hereditary health issues that you know about? ______________________________

____

Activities of Daily Living:

How does this condition currently interfere with your life & ability to function?

	No Effect	Mild Effect	Moderate Effect	Severe Effect
Sitting	○	○	○	○
Rising Out Of Chair	○	○	○	○
Standing	○	○	○	○
Walking	○	○	○	○
Lying Down	○	○	○	○
Bending Over	○	○	○	○
Climbing Stairs	○	○	○	○
Using a Computer	○	○	○	○
Getting In/Out Of Car	○	○	○	○
Driving a Car	○	○	○	○
Looking Over Shoulder	○	○	○	○
Caring For Family	○	○	○	○

	No Effect	Mild Effect	Moderate Effect	Severe Effect
Grocery Shopping	○	○	○	○
Household Chores	○	○	○	○
Lifting Objects	○	○	○	○
Reaching Overhead	○	○	○	○
Showering or Bathing	○	○	○	○
Dressing Myself	○	○	○	○
Love Life	○	○	○	○
Getting to Sleep	○	○	○	○
Staying Asleep	○	○	○	○
Concentrating	○	○	○	○
Exercising	○	○	○	○
Yard Work	○	○	○	○

What is your major stressor in life? ______________________ **How much sleep do you average a night?** ________**Hours**

Acknowledgements:

To set clear expectations, improve and help you get the best results in the shortest amount of time, please read each statement and initial your agreement

Initials_____ I instruct the chiropractor to deliver the care that, in his or her professional judgment, can best help me in the restoration of my health. I also understand that the chiropractor care offered in this practice is based on the best available evidence and designed to reduce or correct vertebral subluxation. Chiropractic is a separate and distinct healing art form medicine and does not proclaim to cure any named disease or entity.

Initials____ I may request a copy of the privacy policy and understand it describes how my personal health information is protected and released on my behalf for seeking reimbursement from any involved third parties.

Initials_____ I grant permission to be called to confirm or reschedule an appointment and to be send occasional cards, letters, emails or health information to me as an extension of my care in this office.

Initials_____ I acknowledge that any insurance I may have is an agreement between the carrier and me and that I am responsible for the payment of any covered or non-covered services I receive.

Initials_____ To the best of my ability, the information I have supplied is complete and truthful. I have not misrepresented the presence, severity or cause of my health concern.

______________________________ ______________________________

Patient (Or Guardian's) Signature Date (MM/DD/YYYY)

Department of Workforce Development
Worker's Compensation Division
201 E. Washington Ave., Rm. C100
P.O. Box 7901
Madison, WI 53707-7901
Telephone: (608) 266-1340
Fax: (608) 267-0394
http://dwd.wisconsin.gov/wc
e-mail: DWDDWC@dwd.wisconsin.gov

MEDICAL REPORT ON INDUSTRIAL INJURY

Provision of your Social Security Number (SSN) is voluntary. Failure to provide it may result in an information processing delay. Personal information you provide may be used for secondary purposes [Privacy Law, s. 15.04 (1)(m), Wisconsin Statutes].

PATIENT

WC Claim Number:
Employee Name:
Employee Social Security Number:
Employee Address:

Injury

Date:
Employer Name:
Insurance Company:

HISTORY

History as described by patient:

DIAGNOSIS (Please be as detailed as possible)

PERMANENT DISABILITY (Describe permanent elements of disability, such as limitation of motion, pain, weakness, etc., and describe effect on working ability.)

What amputation present?
Comparative x-rays taken? ☐ Yes ☐ No
Stump: ☐ hardy or ☐ tender
Has permanent disability resulted? ☐ Yes ☐ No
Date of Last Exam:
Has healing period ended? ☐ Yes ☐ No
Patient discharged? ☐ Yes ☐ No
Description of permanent disability (Record finger motion losses on reverse.)

Was surgery performed as a result of accident? ☐ Yes ☐ No If Yes, state type of surgery:

If healing has not ended, what is minimum permanent disability expected?

PRIOR DISABILITY

What previous disability?

PROGNOSIS

Prognosis:

Date injured was or will be able to return to a limited type of work:
State any limitations:

Date injured was or will be able to return to full-time work subject only to permanent limitations:

What further treatment should be given?

Additional comments, if any:

Date	City	Physician or Chiropractor Signature (in own writing)
	Burlington	
	Phone Number	**Typed or Printed Name**
	(262) 763-7373	Dr. Michael J. Anderson, DC

Anderson Chiropractic Office, S.C.

Dr. Michael J. Anderson

733 N. Pine St. | Burlington, WI 53105
Phone: (262) 763-7373 | Fax: (262) 763-8184
www.notjustbackpain.com

Date:____________

Employee Name:______________________________________

Date Of Injury:______________________________________

Employer's Name:_____________________________________

Employer's Phone:_____________________________________

Description Of The Accident:____

____

____

Employee Signature:_____________________________________

To Whom It May Concern:

The above name patient is being treated in our office for a Workers Comp injury. In order for us to process these claims we need the following information:

WC Injury Reported? (Please check one)Yes:__No:__ (If no please explain reason)

____

Claim Number:____

Insurance Company Name:____

Insurance Company Address:____

City:____________________State____________________ZIP__________

Name Of Employer Contact Person:_____________________________________

Phone Number of Contact Person:_____________________________________

Please be aware that all charges will be the patient responsibility until the above information is received. If you have any further questions please feel free to contact me at 262.763.7373 or 262.763.8399. You may fax this form to my attention at: 262.763.8184 or email: andchiro733@gmail.com or baumanchiro733@gmail.com. **This form MUST be returned within 7 days of the first date seen.**

Thank you in advance for your cooperation.

Carol Anderson
Accounts Manager

OSWESTRY CHRONIC UPPER BACK/LOW BACK PAIN DISABILITY QUESTIONNAIRE

Please Print

Name: ______________________________ Date: __________

Occupation: ______________________________

How long have you had lower/upper back pain? ___years ____months ____weeks

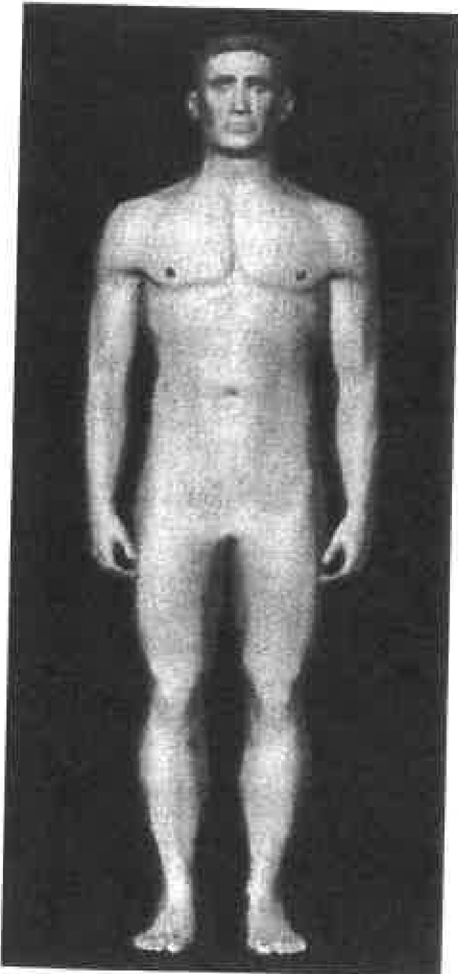
Is this your first episode of lower/upper back pain? ______________________________

Use the letters below to indicate on the body the type And location of your sensations right now

A = Ache
P = Pins & Needles

B = Burning
S = Stabbing

N = Numbness
O = Other



Pain Severity Scale

On the above scale, please circle the number that represents your current pain level

(Over) →

From: N. Hudson, K. Tome-Nicholson, A. Breen; 1989

OSWESTRY CHRONIC UPPER BACK/LOW BACK PAIN DISABILITY QUESTIONNAIRE

This questionnaire is designed to enable us to understand how much your low back pain has affected your ability to manage your everyday activities. Please answer each section by circling the **ONE CHOICE** that most applies to you. We realize that you may feel that more than one statement may relate to you, but please just circle the one choice which most closely describes your problem right now.

Section 1 – 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 severe
5 – The pain is severe and does not vary much

Section 2 – Personal Care

0 – I would 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 or dressing without help

Section 3 – 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, but I can manage light to medium weights if they are conveniently positioned
5 – I can only lift very light weights, at the most

Section 4 – Walking

0 – Pain does not prevent me from walking any distance
1 – Pain prevents me from walking more than one mile
2 – Pain prevents me from walking more than ½ mile
3 – Pain prevents me from walking more than ¼ mile
4 - I can only walk while using a cane or on crutches
5 – I am in bed most of the time and have to crawl to the toilet

Section 5 – Sitting

0 – I can sit in any chair as long as I like without pain
1 – I can only sit in my favorite chair as long as I like
2 – Pain prevents me from sitting more than one hour
3 – Pain prevents me from sitting more than ½ hour
4 – Pain prevents me from sitting more than 10 min
5 – Pain prevents me from sitting at all

Section 6 – 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 one hour without increasing pain
3 – I cannot stand for longer than ½ hour without increasing pain
4 – I cannot stand for longer than ten minutes without increasing pain
5 – I avoid standing, because it increases the pain

Section 7 – 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 the pain, my normal night's sleep is reduced by less than 1 quarter
3 – Because of pain, my normal night's sleep is reduced by less than 1 half
4 – Because of pain, my normal night's sleep is reduced by less than three quarters
5 – Pain prevents me from sleeping at all

Section 8 – Social Life

0 – My social life is normal and gives me no pain
1 – My social life is normal, but increases the degree of my pain
2 – Pain has no significant effect 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

Section 9 - 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 any worse
2 – I get extra pain while traveling, but it does not compel me to seek alternative forms of travel
3 – I get extra pain while traveling which compels me to seek alternative forms of travel
4 – Pain restricts all forms of travel
5 – Pain prevents all forms of travel except that done lying down

Section 10 – 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 at present
3 – My pain is neither getting better nor worse
4 – My pain is gradually worsening
5 – My pain is rapidly worsening

Patient signature:____________________
Date:____________

NECK PAIN DISABILITY QUESTIONNAIRE
Please Print

Name: ______________________________ Date: ____________

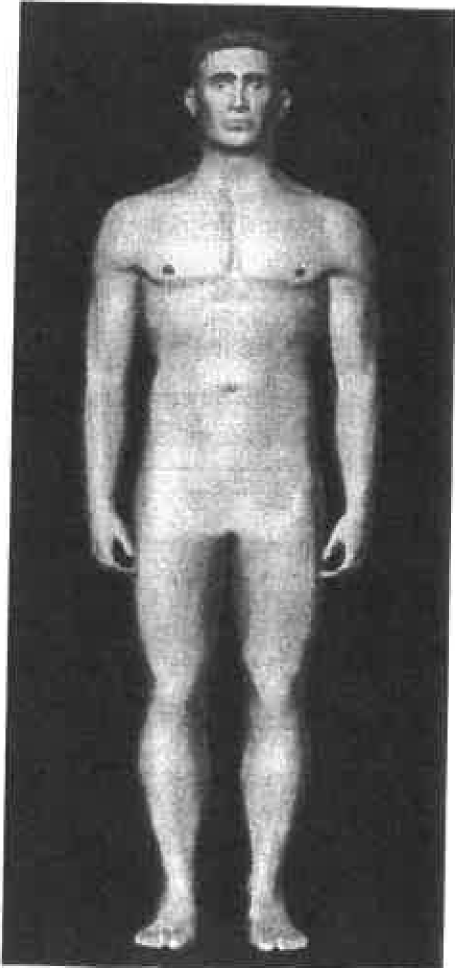
Occupation: ______________________________

How long have you had neck pain? ____years ____months ____weeks

Is this your first episode of neck pain? ______________________________

Use the letters below to indicate on the body the type And location of your sensations right now

A = Ache
P = Pins & Needles
B = Burning
S = Stabbing
N = Numbness
O = Other



Pain Severity Scale

On the above scale, please circle the number that represents your current pain level

(Over) →

NECK PAIN DISABILITY QUESTIONNAIRE

This questionnaire is designed to enable us to understand how much your neck pain has affected your ability to manage your everyday activities. Please answer each section by circling the **ONE CHOICE** that most applies to you. We realize that you may feel that more than one statement may relate to you, but please just circle the one choice which most closely describes your problem right now.

From: N. Hudson, K. Tome-Nicholson, A. Breen; 1989

Section 1 – 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 severe
5 – The pain is severe and does not vary much

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

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 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

Section 3 – 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, but I can manage light to medium weights if they are conveniently positioned
5 – I can not lift or carry anything at all

Section 4 – Reading

0 – I can read as much as I want to with no pain in my neck
1 – I can read as much as I want to with slight pain in my neck
2 – I can read as much as I want with moderate pain in my neck
3 – I cannot read as much as I want because of moderate pain in my neck
4 - I cannot read as much as I want because of severe pain in my neck
5 – I cannot read at all

Section 5 – 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

Section 6 – Concentration

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

Section 7 – Work

0 – I can do as much work as I want to
1 – I can only do my usual work, but no more
2 – I can 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

Section 8 – Driving

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

Section 9 - 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)

Section 10 – Recreation

0 – I am able to engage in all of my recreational activities, with no neck pain at all
1 – I am able to engage in all of my recreational activities, with some pain in my neck
2 – I am able to engage in most, but not all of my usual recreational activities because of pain in my neck
3 – I am able to engage in a few of my usual recreational activities because of pain in my neck
4 – I can hardly do any recreational activities because of pain in my neck
5 – I cannot do any recreational activities at all

Patient signature:______________________________

Date:______________