



**Southwest
Florida Pain Center**
SPINAL DIAGNOSTICS & NEUROMODULATION

Dear Patient,

We are pleased to welcome you to Southwest Florida Pain Center.

We ask that you please arrive 15 minutes prior to your appointment and bring the following documents:

- **Driver's License/ID card**
- **Insurance card(s)**
- **Completed new patient paperwork (*Please use blue or black ink only.*)**

At your initial visit we will have you complete a pain assessment chart. You will then be examined by a physician and a treatment plan will be developed and discussed with you. Please be advised some insurances require pre-authorization prior to a procedure.

Please feel free to call us at (941) 627-9095, if you have any questions.

We look forward to meeting you.

Sincerely,

SW Florida Pain Center Staff

PATIENT INFORMATION

Patient Name: _____ Date: _____
Last First M. (preferred name)

Home Address: _____ Birth Date: ____ / ____ / ____

Gender: Male Female Marital Status: _____ Social Security # _____

Primary Race: White Black or African American American Indian or Alaskan Native Asian
 Native Hawaiian or other Pacific Islander Hispanic Decline to provide this info

Ethnicity: Hispanic or Latino Not Hispanic or Latino Decline to provide this info

Driver's License # _____ Email Address: _____

Phone (Home): _____ (Work): _____ (Cell): _____

Employer Name: _____ Occupation: _____

Employer Address: _____ Phone: _____

In case of emergency contact: _____ Phone: _____

How did you hear about our office? _____ Primary Care Physician: _____

Primary Insurance

Insurance Name: _____

Insurance Address: _____

Insurance Phone # _____

Group # _____ Policy # _____

Insured's _____ Relation: _____
Name

Insured's ____ / ____ / ____ Insured's SS# _____
Birth date

Insured's Employer: _____

Secondary Insurance (if applicable)

Insurance Name: _____

Insurance Address: _____

Insurance Phone # _____

Group # _____ Policy # _____

Insured's _____ Relation: _____
Name

Insured's ____ / ____ / ____ Insured's SS# _____
Birth date

Insured's Employer: _____

Workers' Compensation, Auto Billing Information

Insurance Carrier Name: _____ Phone # _____

Address: _____ Claim # _____ Date of Accident: _____

Adjuster: _____ Phone # _____ Fax # _____

Nurse Case Mgr: _____ Phone # _____ Fax # _____

Attorney: _____ Phone # _____ Fax # _____

Address: _____

I certify that the information I have reported is correct.

Patient Signature

Date

HIPAA OMINIBUS RULE for
SW Florida Pain Center
**PATIENT ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES
AND CONSENT/LIMITED AUTHORIZATION & RELEASE FORM**

You may refuse to sign this acknowledgement and authorization. In refusing we may not be allowed to process your insurance claims.

Date: _____

The undersigned acknowledges receipt of a copy of the currently effective Notice of Privacy Practices for the healthcare facility. A copy of this signed, dated document shall be effective as the original.

MY SIGNATURE WILL ALSO SERVE AS A PHI DOCUMENT RELEASE SHOULD I REQUEST TREATMENT OR RADIOGRAPHS BE SENT TO OTHER ATTENDING DOCTOR/FACILITIES IN THE FUTURE.

Please **print** your name

Please **sign** your name

Parent/Guardian

Description of Authority

Your comments regarding Acknowledgements or Consents:

HOW DO YOU WANT TO BE ADDRESSED WHEN SUMMONED FROM THE RECEPTION AREA?

First Name Only Proper Surname Other _____

PLEASE LIST ANY OTHER PARTIES WHO CAN HAVE ACCESS TO YOUR HEALTH INFORMATION:

(This includes step-parents, grandparents, and any care takers who can have access to this patient's records)

Name: _____ Relationship: _____

Name: _____ Relationship: _____

I AUTHORIZE CONTACT FROM THIS OFFICE TO CONFIRM **MY APPOINTMENTS, TREATMENT & BILLING INFORMATION** VIA:

- Cell Phone Confirmation Text Message to my Cell Phone
 Home Phone Confirmation Email Confirmation
 Work Phone Confirmation **Any of the Above**

I AUTHORIZE **INFORMATION ABOUT MY HEALTH** BE CONVEYED VIA:

- Cell Phone Confirmation Text Message to my Cell Phone
 Home Phone Confirmation Email Confirmation
 Work Phone Confirmation **Any of the Above**

In signing this HIPAA Patient Acknowledgement Form, you acknowledge and authorize that this office may recommend products or services to promote your improved health. This office may or may not receive third party remuneration from these affiliated companies. We, under HIPAA Omnibus Rule, provide you this information with your knowledge and consent.

Office Use Only

As Privacy Officer, I attempted to obtain the patient's (or representatives) signature on this Acknowledgement but did not because:

- ____ It was emergency treatment
____ I could not communicate with the patient
____ The Patient refused to sign
____ The patient was unable to sign because _____
____ Other (please describe) _____

Signature of Privacy Officer

FINANCIAL POLICY

We are dedicated to you, our patient, and our goal is to give you the best care available. We know that dealing with the financial side of your care may be confusing and stressful; therefore, we are providing you with information to clarify your financial responsibility.

- Our **Consent Form** must be updated yearly. This form allows us to submit medical claims for services provided to you to your insurance company, as well as appeal improperly paid claims. *Refusal to sign this form will result in you being considered a self-pay. You will then be responsible for our entire billed amounts.*
- Your personal information (address, phone number, etc.) must be updated whenever there is a change, as well as, your insurance information. You will be asked to produce a picture ID, as well as, proof of insurance. SW Florida Pain Center will verify coverage prior to services being provided. We rely on the information you provide in order to bill third parties for your medical services. **Balances that are not paid due to errors or omission in the information you provide may result in the entire balance becoming your responsibility.** Please be sure to report all potential third party sources of payment (auto, work comp, supplemental, etc.)
- Most insurance policies require patient co-pay for office services. *Payment of your office co-pay is required at the time of service.*
- We accept cash, check and all major credit cards. Your check may be converted to a one-time electronic debit from your checking account. A \$25 fee will be assessed on any checks returned for insufficient funds.
- If a procedure/treatment is indicated, our billing department will provide you with an estimate for our physicians' services. Most policies require a patient co-insurance until your deductible and out-of-pocket requirements have been met. *Payment of the estimated co-insurance is required prior to the procedure.*
- If you are a self-pay, payment in full is expected at the time of service.
- SW Florida Pain Center is contracted with many insurance networks. If you are unsure if we participate with your insurance, please ask to speak with someone in our billing department or contact your insurance company's member services.
- SW Florida Pain Center may not be a participating provider with your insurance company. Your insurance company may send payment for SW Florida Pain Center services directly to you. By signing our **Consent Form**, you agree that it is your financial responsibility to forward any payment received to this office. Failure to send us payments you have received from your insurance company for services provided by SW Florida Pain Center may result in your account being turned over to collections.
- We impose a \$50.00 no-show/late cancellation fee. No-shows and late-cancellations cause problems that go beyond a financial impact on our practice. When an appointment is made, it takes an available time slot away from another patient. No-shows and late cancellations delay the delivery of health care to other patients, most of who are in severe pain. A "no show" is missing a scheduled appointment. A "late cancellation" is cancelling an appointment without calling us to cancel 24 hours in advance of the appointment. We understand that situations such as medical emergencies occasionally arise when an appointment cannot be kept and adequate notice is not possible. These situations will be considered on a case-by-case basis. Please understand that insurance companies consider this charge to be entirely the patient's responsibility.

CONSENT FOR TREATMENT

I give permission to the physicians and staff of SW Florida Pain Center (“the practice”) to administer or perform medical treatment. I acknowledge that risks, if any, will be explained to me as well as any other medical options. I understand that no guarantee can be made as to the efficacy or outcome of treatment. The practice may also use my Protected Health Information (PHI) to treat me or to disclose to other healthcare providers, such as my referring physician or primary care physician, for purposes related to my treatment.

Signature of Patient or Legal Representative

Date

If signed by legal representative, relationship to patient: _____

CONSENT TO RELEASE INFORMATION

I consent that the practice may release any medical information that has been obtained during my course of treatment to any lab, hospital, physician or insurance company to answer any inquiries per federal and state regulations. The practice may use or disclose my PHI internally or disclose my PHI to healthcare providers and entities as necessary to operate their business. The practice may use and disclose my PHI to contact me for appointment reminders and to inform me of potential treatment option or alternatives. The practice may use and disclose my PHI to advise a friend or family member that is involved in my care or assists in taking care of me. My PHI may also be used and disclosed when federal, state or local law requires. The practice may share my PHI with third party “Business Associates” that perform activities on their behalf such as billing software maintenance.

Signature of Patient or Legal Representative

Date

FINANCIAL CONSENT

I hereby authorize direct remittance of payment of insurance benefits to the practice for all covered medical services rendered. I understand and agree this Assignment of Benefits will have continuing effect for as long as I am being treated by the practice and will constitute a continuing authorization, maintained on file with the practice for subsequent and continuing treatment, services, and/or supplies provided to me by the practice. The practice may use and disclose my PHI in order to directly bill and collect payment for services and items I receive, to obtain payment from me or from third parties that may be responsible for such costs, or to assist other health care providers in their billing and collections I accept legal responsibility for charges that my insurance company does not cover and will pay for them at the time of my visit unless prior arrangements have been made. I am also responsible for all legal fees, collection fees, and interest incurred in the event my account becomes delinquent. I understand that the practice may not be a participating provider with my insurance company. Should I receive payment directly from the insurance company, I agree to forward the check and “Explanation of Benefits” to the practice within 10 days of receipt. If I fail to provide this information, I understand that I will be held legally responsible for payment in full for all services or equipment that has been provided.

Signature of Patient or Legal Representative

Date

WRITTEN ACKNOWLEDGMENT OF NOTICE OF PRIVACY PRACTICES

I have received a copy of SW Florida Pain Center’s Notice of Privacy Practices that describes how my health information is used and shared. I understand that the practice has the right to change this notice at any time. I may obtain a current copy by contacting the Privacy Officer at the physician’s office.

Signature of Patient or Legal Representative

Date



Southwest Florida Pain Center

SPINAL DIAGNOSTICS & NEUROMODULATION

PATIENT INFORMATION FORM

Please complete prior to the examination in BLACK/BLUE INK ONLY

Today's Date: _____ Patient's Name _____

Height _____ Patient's Phone #: _____

Weight _____ Patient's Age: _____

Referred by: _____

Primary Care Physician: _____ Phone #: _____

Are you employed? Yes No

Are you currently on disability? Yes No Reason: _____

Workman's Compensation: Yes No

Involved in Pending Litigation: Yes No Lawyer's Name/Phone: _____

PAIN HISTORY

Where is the location of your pain? _____

When and under what circumstances did the pain begin?

Accident at work or home Following a surgery

Motor vehicle accident Following an illness

Other (describe details) _____

What increases the pain? _____

What decreases the pain? _____

What time of the day is your pain worst? _____ What is your pain score? (0 – 10) _____

What time of the day is less severe? _____ What is your pain score? (0 – 10) _____

What statement best describes your pain? **Choose only one**

Always present, always the same intensity

Always present, intensity varies

Usually present, but has short periods from one to several hours

Occasionally present for a brief period of time

Does pain interrupt your sleep? Yes No If yes, how often during the night does it wake you up? _____

WHAT DOES YOUR PAIN FEEL LIKE?

Some of the words below describe your present pain. Look through these categories. CIRCLE ONE SINGLE WORD IN EACH CATEGORY that best describes your pain. Leave out any category that is not suitable.

Flickering		Pricking				Annoying
Quivering	Jumping	Boring	Sharp	Spreading	Fearful	Troublesome
Pulsing	Flashing	Drilling	Cutting	Radiating	Frightful	Miserable
Throbbing	Shooting	Stabbing	Lacerating	Penetrating	Terrifying	Intense
Beating		Lancinating		Piercing		Unbearable
Pounding						
Pinching		Hot	Tingling	Tight	Punishing	Nagging
Pressing	Tugging	Burning	Itchy	Numb	Grueling	Nauseating
Gnawing	Pulling	Scalding	Smarting	Drawing	Cruel	Agonizing
Cramping	Wrenching	Searing	Stinging	Squeezing	Vicious	Dreadful
Crushing				Tearing	Killing	Torturing

MEDICAL HISTORY

Circle YES or NO

YES	NO	Heart Attack	YES	NO	Diabetes
YES	NO	Angina	YES	NO	Thyroid Disease
YES	NO	Irregular heart beat	YES	NO	Hepatitis / Jaundice
YES	NO	Heart murmur	YES	NO	Ulcers, other stomach problems
YES	NO	High / Low Blood pressure	YES	NO	Kidney Disease
YES	NO	Fainting Episodes	YES	NO	Glaucoma
YES	NO	Congestive heart failure	YES	NO	Bleeding Problems
YES	NO	Shortness of Breath/ Lung Disease	YES	NO	Liver Disease
YES	NO	Emphysema / Bronchitis	YES	NO	Hearing Problems
YES	NO	Asthma	YES	NO	Cancer
YES	NO	Recent Upper Respiratory Infection	YES	NO	Joint disease / Arthritis
YES	NO	Seizures, Epilepsy	YES	NO	Bladder Problems
YES	NO	Stroke	YES	NO	Visual Problems
YES	NO	Depression, mental health problems	YES	NO	Bowel Problems
YES	NO	Headaches	YES	NO	Dermatological conditions
YES	NO	Neurological problems	YES	NO	Are you pregnant?
YES	NO	MRSA	YES	NO	Hepatitis or Autoimmune disease

Explanation/Other: _____

SURGICAL HISTORY

TYPE OF SURGERY	DATE

TREATMENT HISTORY:

TREATMENT	YES	NO	HELPFUL / COMPLICATIONS	COMMENTS
Traction				
TENS Unit				
Physical Therapy				
Biofeedback				
Hypnosis				
Counseling				
Chiropractor				
Acupuncture				
Osteopathic TX				
Heat / Ice				
Occupational Therapy				
Nerve Blocks				

INVESTIGATIONS: (TEST TO EVALUATE YOUR PAIN PROBLEM)

TEST	YES	NO	DATE	WHERE / FINDINGS
XRAY				
CT SCAN / MRI				
EMG				
MYELOGRAM				
EPIDUROGRAM				
LAB TESTS				
OTHER:				

MEDICATIONS: (PRESCRIPTION AND OVER THE COUNTER)

MEDICATION	DOSAGE	TIMES A DAY

ALLERGIES:

SOCIAL HISTORY:

Do you smoke? Yes No If yes, how many a day? _____

Do you drink alcohol? Yes No If yes, what type of alcohol and how much a day? _____

Do you currently or have you ever taken or used illegal drugs or substances? Yes No

Do you have a history of drug or alcohol rehabilitation? Yes No

Were there any changes in your life during the year before this pain began? (i.e. job change, buying or selling a house, death or loss of a friend/relative, marital problems): _____

FAMILY HISTORY:

	AGE	HEART DISEASE	CANCER	T.B.	DIABETES	AGE AT DEATH	CAUSE OF DEATH
Father		Yes No	Yes No	Yes No	Yes No		
Mother		Yes No	Yes No	Yes No	Yes No		
Sister (s)		Yes No	Yes No	Yes No	Yes No		
Brother (s)		Yes No	Yes No	Yes No	Yes No		

What are your expectations of this pain center? _____

Have you ever gone to another pain management physician or center? Yes No

Whom, where & when? _____

Reason for leaving _____

SOAPP® VERSION 1.0 SP

The following are questions given to all patients. Please answer each question as honestly as possible. This information is for our records and will remain confidential. Your answers alone will not determine your treatment.

Please answer the questions below using the following scale:

0=Never, 1=Seldom, 2=Sometimes, 3=Often, 4=Very Often

- | | | | | | |
|--|---|---|---|---|---|
| 1. How often do you have mood swings? | 0 | 1 | 2 | 3 | 4 |
| 2. How often do you smoke a cigarette within an hour after you wake up? | 0 | 1 | 2 | 3 | 4 |
| 3. How often have you taken medication other than the way it was prescribed? | 0 | 1 | 2 | 3 | 4 |
| 4. How often have you used illegal drugs (for example: Marijuana, cocaine, etc.) in the past five years? | 0 | 1 | 2 | 3 | 4 |
| 5. How often, in your lifetime, have you had legal Problems or been arrested? | 0 | 1 | 2 | 3 | 4 |

Patient Signature

Date

REVIEW OF SYSTEMS

• CONSTITUTIONAL SYMPTOMS

- Good general health lately No Yes
Recent weight change... ___increase ___decrease No Yes
Fever..... No Yes
Fatigue..... No Yes

• EYES

- Eye disease or injury No Yes
Wear glasses/contact lens..... No Yes
Blurred or double vision No Yes
Glaucoma No Yes

• EARS/NOSE/MOUTH/THROAT

- Hearing loss No Yes
Ringing in ears No Yes
Ear aches or drainage No Yes
Chronic sinus problem or rhinitis No Yes
Nose bleeds No Yes
Sore throat No Yes
Voice change No Yes
Swollen glands No Yes

• CARDIOVASCULAR

- Heart trouble No Yes
Chest pain or angina pectoris..... No Yes
Palpitation No Yes
Shortness of breath with walking or lying flat..... No Yes
Swelling of feet or ankles No Yes
Atrial fibrillation No Yes
Heart valve disease No Yes
Pacemaker No Yes
AICD No Yes

• RESPIRATORY

- Chronic or frequent coughs No Yes
Shortness of breath No Yes
Asthma or wheezing No Yes
COPD..... No Yes

• GASTROINTESTINAL

- Loss of appetite No Yes
Nausea or vomiting No Yes
Diarrhea No Yes
Constipation No Yes
Abdominal pain No Yes
Heartburn..... No Yes
GERD..... No Yes

• GENITOURINARY

- Frequent urination No Yes
Change in force of strain when urinating No Yes
Incontinence or dribbling No Yes
Kidney stones No Yes
Hx Kidney failure..... No Yes

• MUSCULOSKELETAL

- Joint pain..... No Yes
Joint swelling..... No Yes
Weakness of muscles..... No Yes
Muscle pain..... No Yes
Back pain..... No Yes
Neck pain..... No Yes

• INTEGUMENTARY (skin, breast)

- Rash No Yes
Itching No Yes
Varicose veins..... No Yes
Breast pain No Yes
Breast lump..... No Yes
Breast discharge..... No Yes

• NEUROLOGICAL

- Frequent or recurring headaches No Yes
Light headed..... No Yes
Dizzy..... No Yes
Convulsions or seizures No Yes
Numbness or tingling sensations..... No Yes
Tremors..... No Yes
Paralysis..... No Yes
Stroke No Yes
Head injury..... No Yes
Difficulty in Walking..... No Yes
Memory loss or confusion..... No Yes

• PSYCHIATRIC

- Nervousness..... No Yes
Depression..... No Yes
Insomnia..... No Yes

• ENDOCRINE

- Glandular or hormone problem..... No Yes
Excessive thirst or drinking No Yes
Diabetes..... No Yes
Change in hat or glove size No Yes

• HEMATOLOGIC/LYMPHATIC

- Slow to heal after cuts No Yes
Bleeding or bruising tendency No Yes
Anemia No Yes
Phlebitis No Yes
Past transfusion..... No Yes

• ALLERGIC/IMMUNOLOGIC

- History of skin reaction or other adverse reaction to:
Penicillin or other antibiotics..... No Yes
Morphine, Demerol, or other narcotics..... No Yes
Novocaine or other anesthetics..... No Yes
Aspirin or other pain remedies No Yes
Tetanus antitoxin or other serums..... No Yes
Iodine, methiolate or other antiseptic..... No Yes
Other drugs/medications _____
Known food allergies _____

Patient Name: _____

Oswestry Disability Index

Patient name: _____

Date: _____

Please complete this questionnaire. It is designed to tell us how your back pain affects your ability to function in everyday life.

Please answer each section below by checking the one choice that applies the most to you at this time. You may feel that more than one of the statement relates to you at this time, but is very important that you please check only once choice that best describes your problem at this time.

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

- I can look after myself normally without causing extra pain.
- I can look after myself normally but it is very painful.
- 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, wash with difficulty and stay in bed

SECTION 3: Lifting

- I can lift heavy weights without extra pain
- I can lift heavy weights but it causes extra pain
- Pain prevents me from lifting heavy weights off the floor, but I can manage if the weights 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 only very light weights
- I cannot lift or carry anything at all

SECTION 4: Walking

- Pain does not prevent me from walking any distance
- Pain prevents me from walking more than 1 mile
- Pain prevents me from walking more than 1/4 mile
- Pain prevents me from walking more than 100 yards
- I can walk only with crutches or a stick
- I am in bed most of the time and have to crawl to the toilet

SECTION 5: Sitting

- I can sit in any chair as long as I like
- I can sit in my favorite chair for as long as I like
- Pain prevents me from sitting for more than 1 hour
- Pain prevents me from sitting for more than 1/2 hour
- Pain prevents me from sitting for more than 10 minutes
- Pain prevents me from sitting at all

SECTION 6: Standing

- I can stand as long as I want without extra pain
- I have some pain on standing, but it gives me extra pain
- Pain prevents me from standing for more than 1 hour
- Pain prevents me from standing for more than 1/2 an hour
- Pain prevents me from standing for more than 10 minutes
- Pain prevents me from standing at all

SECTION 7: Sleeping

- My sleep is never disturbed by pain
- My sleep is occasionally disturbed by pain
- Because of pain I have less than 6 hours sleep
- Because of pain I have less than 4 hours sleep
- Because of pain I have less than 2 hours sleep
- Pain prevents me from sleeping at all

SECTION 8: Sex Life

- My sex life is normal and causes no extra pain
- My sex life is normal but causes some extra pain
- My sex life is nearly normal but is very painful
- My sex life is severely restricted by pain
- My sex life is nearly absent because of pain
- Pain prevents any sex life at all

SECTION 9: Social Life

- My social life is normal and causes me no extra pain
- My social life is normal, but increases the degree of pain
- Pain has no significant effect on my social life apart from limiting my more energetic interests (e.g., sports, dancing)
- Pain has restricted my social life and I do not go out as often
- Pain has restricted my social life to my home
- I have no social life because of my pain

SECTION 10: Traveling

- I can travel anywhere without pain
- I can travel anywhere, but it gives me extra pain
- Pain is bad but I manage journeys of over 2 hours
- Pain restricts me to journeys less than 1 hour
- Pain restricts me to short necessary journeys under 30 minutes
- Pain prevents me from traveling except to receive treatment

ODI score: _____%

"Point total" / 50 x 100 = percent disability

Oswestry Disability Index (Cervical)

Patient name: _____

Date: _____

Please complete this questionnaire. It is designed to tell us how your pain affects your ability to function in everyday life.

Please answer each section below by checking the one choice that applies the most to you at this time. You may feel that more than one of the statement relates to you at this time, but is very important that you please check only once choice that best describes your problem at this time.

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

- I can look after myself normally without causing extra pain.
- I can look after myself normally but it is very painful.
- 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, wash with difficulty and stay in bed

SECTION 3: Lifting

- I can lift heavy weights without extra pain
- I can lift heavy weights but it causes extra pain
- Pain prevents me from lifting heavy weights off the floor, but I can manage if the weights 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 only very light weights
- I cannot lift or carry anything at all

SECTION 4: Reading

- I can read as much as I want 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 with moderate pain in my neck
- I cannot read as much as I want due to moderate 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 that 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: Sleeping

- My sleep is never disturbed by pain
- My sleep is occasionally disturbed by pain
- Because of pain I have less than 6 hours sleep
- Because of pain I have less than 4 hours sleep
- Because of pain I have less than 2 hours sleep
- Pain prevents me from sleeping at all

SECTION 8: Work

- I can do as much work as I want to
- I can 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 9: Driving

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

SECTION 10: Recreation

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

ODI score: _____%

"Point total" / 50 x 100 = percent disability