

NEW PATIENT HISTORY – Dr. Gabriel - NECK

Patient Name: _____ Age: _____ DOB: ___/___/_____ Date: ___/___/20__

Reason for today's visit: _____

Hand Dominance: Right Left Date of Onset: _____ Date of Injury: _____

Injury occurred at: ___ Home ___ Work ___ MVA Other: _____

This condition is: ___ New ___ Chronic ___ Recurring ___ Reinjured

WHAT MAKES YOUR PAIN WORSE?

- ___ Sitting
- ___ Standing
- ___ Walking
- ___ Bending
- ___ Lying
- ___ Stooping
- ___ Twisting
- ___ Coughing
- ___ Sneezing
- ___ Other

WHAT MAKES YOUR PAIN BETTER?

- ___ Sitting
- ___ Standing
- ___ Walking
- ___ Bending
- ___ Lying
- ___ Stooping
- ___ Twisting
- ___ Coughing
- ___ Sneezing
- ___ Other

Do you lose your balance, feel unsteadiness, frequent falls, clumsiness? ___ No ___ Yes

Do you have trouble with writing, zippers, buttons, dropping small objects? ___ No ___ Yes

___ Difficulty with sleeping ___ Increased headaches Are you on aspirin or another blood thinner? ___ No ___ Yes

Allergies: _____

Past medical history: _____

Past surgical history: _____

Family history: _____

Social history: Do you **smoke**? ___ No ___ Yes ___ Quit ___ Packs/Day ___ How many years?

Illicit drug abuse/overuse: ___ Never ___ Currently ___ In the past **Alcohol**: ___ No ___ Yes ___ Occasional

Working: ___ No ___ Yes Retired: ___ No ___ Yes Occupation: _____

(please circle) **NO PAIN** 0-----1-----2-----3-----4-----5-----6-----7-----8-----9-----10 **SEVERE PAIN**

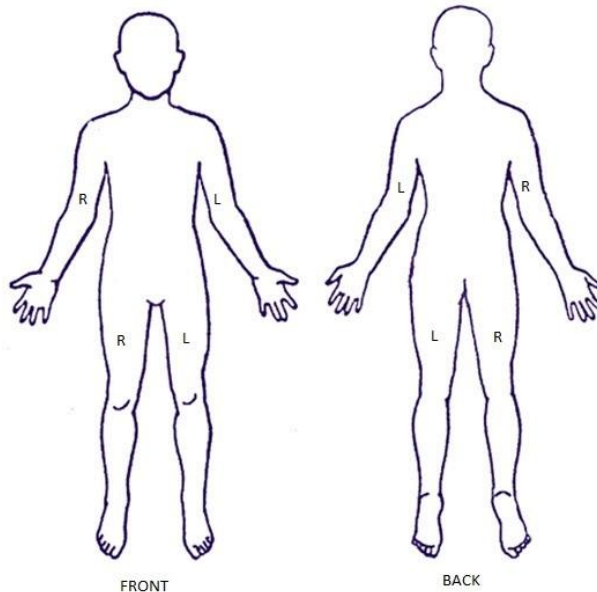
Types of pain:

Dull:
uuuuuuu

Pins and Needles:
+++++

Sharp:
!!!!!!!!!!

Numbness:
oooooo



Pain is:
___ Constant
___ Intermittent

Patient signature _____ Asst initials _____ Date ___/___/20__

Vital Signs: Temp ___ BP ___/___ Pulse ___ Respirations ___ Weight ___ lbs Height ___ in. BMI ___

REVIEW OF SYSTEMS

Check all that apply

Patient Name: _____

Date: ____/____/20____

General:

- ___ Fevers
- ___ Fatigue

- ___ Chills
- ___ Malaise

- ___ Sweats
- ___ Weight gain

- ___ Anorexia
- ___ Weight loss

Eyes:

- ___ Wears glasses
- ___ Change in vision
- ___ Vision loss

- ___ Wears contacts
- ___ Wears bifocals
- ___ Eye pain

- ___ Blurring vision
- ___ Discharge
- ___ Photophobia

- ___ Double vision
- ___ Watering
- ___ Glaucoma

Ears/Nose/Throat

- ___ Ear ache
- ___ Sinus problems
- ___ Difficulty swallowing
- ___ Change in your voice

- ___ Ear discharge
- ___ Nosebleeds
- ___ Nasal polyps

- ___ Ringing in ear
- ___ Sore throat
- ___ Mouth lesions

- ___ Hearing loss
- ___ Hoarseness
- ___ Bleeding gums

Cardiovascular:

- ___ Chest pain
- ___ Peripheral edema
- ___ Stroke

- ___ Palpitations
- ___ Heart murmur
- ___ Heart disease

- ___ Dyspnea on exertion
- ___ Hypertension

- ___ Syncope
- ___ Heart attack

Respiratory:

- ___ Cough
- ___ Wheezing
- ___ Inspiration pain

- ___ Short of breath
- ___ Tuberculosis
- ___ Snoring

- ___ Excessive sputum
- ___ Recent pneumonia
- ___ Asthma

- ___ Cough up blood
- ___ Chest tightness
- ___ COPD

Genitourinary:

- ___ Difficulty with urination
- ___ Urinary hesitancy
- ___ Urination at night
- ___ Decreased libido

- ___ Blood in urine
- ___ Urinary urgency
- ___ Burning on urination
- ___ Pregnant

- ___ Discharge
- ___ **Urinary retention**
- ___ **Bowel incontinence**
- ___ **Bladder incontinence**

- ___ Frequent urination
- ___ Flank pain
- ___ Genital sores

Gastrointestinal:

- ___ Nausea
- ___ Vomiting
- ___ Difficulty swallowing
- ___ Change in bowel habits
- ___ Jaundice

- ___ Heartburn
- ___ Gastric reflux
- ___ Bloody stool
- ___ Hepatitis
- ___ History of Ulcers

- ___ Loss of appetite
- ___ Abdominal pain
- ___ Diarrhea
- ___ Black tarry stool

- ___ Hemorrhoid
- ___ Hematocheza
- ___ Melena
- ___ Constipation

Musculoskeletal:

- ___ Back pain
- ___ Muscle cramps
- ___ Redness to joints

- ___ Stiffness
- ___ Muscle weakness
- ___ Joint feels hot

- ___ Joint pain
- ___ Arthritis

- ___ Joint swelling
- ___ Instability

Skin:

- ___ Rash
- ___ Excessive bruising

- ___ Itching
- ___ Skin changes

- ___ Dryness
- ___ Redness

- ___ Suspicious lesions
- ___ Poor healing

Circulatory:

- ___ Swollen ankles

- ___ Calf cramps with walking

Neurologic:

- ___ Transient paralysis
- ___ Dizziness
- ___ Weakness

- ___ Vertigo
- ___ Blackouts
- ___ Numbness

- ___ Seizures
- ___ Headaches
- ___ Tingling

- ___ Tremors
- ___ Migraines

Psychiatric:

- ___ Depression
- ___ Suicidal ideations

- ___ Anxiety
- ___ hallucinations

- ___ Mental disturbance
- ___ Paranoia

- ___ Memory loss
- ___ Chronic pain

Endocrine:

- ___ Cold intolerance
- ___ Recent weight change

- ___ Heat intolerance
- ___ History of diabetes

- ___ Frequently thirsty
- ___ Changes in skin texture

- ___ Frequently hungry
- ___ Thyroid disease

Heme/Lymphatic:

- ___ Abnormal bruising

- ___ Enlarged lymph nodes

- ___ Takes blood thinners

- ___ Bleeding

Allergic/Immunologic:

- ___ Hives

- ___ Hay fever

- ___ Persistent infections

- ___ HIV exposure

MEDICAL HISTORY QUESTIONNAIRE

Please check any of the following that apply to your medical history

Patient Name _____ DOB _____ Date _____

- | | | |
|---|--|--|
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Shortness of Breath | <input type="checkbox"/> Hives |
| <input type="checkbox"/> Migraines | <input type="checkbox"/> Wheezing | <input type="checkbox"/> Chronic Rash |
| <input type="checkbox"/> Seizures/Epilepsy | <input type="checkbox"/> Asthma | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Cancer |
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Tuberculosis (TB) | <input type="checkbox"/> Weight Loss |
| <input type="checkbox"/> Mental health issues | <input type="checkbox"/> Heartburn/Indigestion | <input type="checkbox"/> Weight Gain |
| <input type="checkbox"/> Insomnia | <input type="checkbox"/> Ulcer | <input type="checkbox"/> Measles |
| <input type="checkbox"/> Sleep Apnea | <input type="checkbox"/> Abdominal Pain | <input type="checkbox"/> Mumps |
| <input type="checkbox"/> Hearing Loss | <input type="checkbox"/> Bowel Irregularity | <input type="checkbox"/> Chickenpox |
| <input type="checkbox"/> Ringing in the Ears | <input type="checkbox"/> Rectal Bleeding | <input type="checkbox"/> Whooping Cough |
| <input type="checkbox"/> Glaucoma/Cataracts | <input type="checkbox"/> Hemorrhoids | <input type="checkbox"/> Polio |
| <input type="checkbox"/> Fatigue | <input type="checkbox"/> Gallbladder Disease | <input type="checkbox"/> Tetanus |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Bladder Infections | <input type="checkbox"/> Erectile Difficulties |
| <input type="checkbox"/> Thyroid Disease | <input type="checkbox"/> Incontinence | <input type="checkbox"/> Blood Transfusion |
| <input type="checkbox"/> Dizziness/Fainting | <input type="checkbox"/> Prostate Problems | <input type="checkbox"/> Leg Pain/Swelling |
| <input type="checkbox"/> Weakness | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Back Pain |
| <input type="checkbox"/> Chest Pain | <input type="checkbox"/> STD | <input type="checkbox"/> Bursitis/Tendonitis |
| <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> HIV +/- AIDS | <input type="checkbox"/> History of + Antibodies |
| <input type="checkbox"/> Heart Palpitations | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Sexual Dysfunction | |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Infertility | |
| <input type="checkbox"/> Low Blood Pressure | <input type="checkbox"/> Arthritis | |
| <input type="checkbox"/> Circulation Problems | <input type="checkbox"/> Osteoporosis | |
| <input type="checkbox"/> Bleeding Tendency | <input type="checkbox"/> Gout | |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Neck Pain | |

SPINE INSTITUTE OF OHIO

New Patient Registration Form

PATIENT INFORMATION

Name: _____
Nickname: _____
Address: _____
City: _____ State: _____ Zip: _____
Phone – Home: _____
Phone – Cell: _____
Pharmacy Name: _____
Phone: _____ Fax: _____

PATIENT EMPLOYMENT

() Employed () Disabled () Retired
() Not employed () Student () Other
Occupation: _____
Work phone: _____
Employer: _____
() Work Comp () Liability Claim () Auto
Case/Injury #: _____

PRIMARY INSURANCE

() Same as patient () Same as guarantor () Other
Insured's Name: _____
Subscriber's Name: _____
Subscriber's SSN: _____
Subscriber's Date of Birth: _____
Insurance ID #: _____
Insurance Carrier: _____
Policy Group #: _____

SECONDARY INSURANCE

() Same as patient () Same as guarantor () Other
Insured's Name: _____
Subscriber's Name: _____
Subscriber's SSN: _____
Subscriber's Date of Birth: _____
Insurance ID #: _____
Insurance Carrier: _____
Policy Group #: _____

Patient Confidentiality Release:

In the event that we/Spine Institute of Ohio cannot reach you, we would like your permission to leave a message on your voicemail or home answering machine regarding upcoming appointments, tests, surgical procedures, and test results.

() I agree to this authorization
() I deny this authorization

Patient/Guardian Signature: _____

Date: _____
Co-pay \$ _____ EMR ID#: _____
Email: _____
Sex: () Male () Female
Date of Birth: _____
Social Security #: _____
Marital Status: () Married () Divorced () Single
() Widowed () Separated
Emergency Contact: _____
Relationship: _____ Phone: _____
Race: _____ Ethnicity: _____ Language: _____
Smoking Status: () Never () Current
() Former () Packs per Day _____

CONTACTS

Family Physician: Dr. _____
Referring Physician: Dr. _____
Other Physician: Dr. _____

GUARANTOR

() Same as patient () Same as guarantor () Other
Insured's Name: _____
Subscriber's Name: _____
SSN: _____
Date of Birth: _____
Insurance ID #: _____
Insurance Carrier: _____
Policy Group #: _____

Authorization to Provide Care:

() I authorize the providers of the Spine Institute of Ohio to provide any medical care deemed necessary according to their professional opinions.

I also authorize my Physician(s) and Spine Institute of Ohio to photograph me for medically related documentation purposes.

Notice to Patients: Receipt of Privacy Practices

We are required to provide you with a copy of our Notice of Privacy Practices, which states how we may use and/or disclose your health information. Please sign this form to acknowledge receipt of the notice. You may refuse to sign the acknowledgement, if you wish.

() I acknowledge that I have received a copy of the Spine Institute of Ohio's notice of Privacy Practices.
() I was offered a copy of the Spine Institute of Ohio's notice of Privacy Practices, but declined it.



MEDICATION POLICY

Due to the increased scrutiny by State and Federal regulators, it has become necessary to further enhance our compliance program as it relates to controlled substance prescriptions and the management of your pre and post-operative pain. Therefore, **one or all of the following conditions of treatment may be in effect** in order to receive your prescriptions with our office:

1. A signed Medication Policy Agreement
2. Random/scheduled toxicology screenings
3. Random pill count
4. Any other practice imposed conditions of care.

By signing this Medication Policy you are agreeing to the following;

- I do not have current problems with substance abuse or dependence (addiction).
- I am not currently involved in the sale, diversion, illegal possession or transport of controlled substances.
- I agree to take my medications exactly as prescribed by my doctor.
- I agree to submit a urine specimen at my doctor's request to test for compliance.
- I agree to allow my doctor to contact family members or friends to help monitor my progress if necessary.
- I will allow other relevant healthcare providers to communicate with my physician regarding my medication use.
- I understand that NO ALLOWANCE will be made for lost or stolen prescriptions of drugs.
- If I am a female, I certify that I am not pregnant and will use appropriate measures to prevent pregnancy during the course of this treatment.
- I agree to follow the advice of healthcare providers in regard to stopping controlled substances if it is felt necessary.
- No refills of medications will be made after hours, during weekends, or during holiday periods.
- I am responsible for making an appointment or calling the office for a refill at least **72 hours** before running out of my medication.
- I will obtain my prescriptions from the following pharmacy: _____ located at _____ and give Spine Institute of Ohio permission to contact any other pharmacy to enquire about additional medications.

I have read this document, understand it, and have had all questions answered satisfactorily. I consent to the use of medications to help control my pain and I understand that this treatment will be conducted in accordance with the conditions stated above.

Patient Signature: _____

Date: _____ / _____ / _____

Sharing of Medical Information

SPINE INSTITUTE OF OHIO

I give the physician(s)/office staff of Spine Institute of Ohio permission to discuss my medical condition with the following individuals:

Name: _____

Relationship: _____

Name: _____

Relationship: _____

Patient Authorization for Pharmacy Benefits Manager

I authorize the physician and/or staff of Spine Institute of Ohio to request and obtain my prescription medication history from other healthcare providers, the pharmacy benefit manager, and/or any third party pharmacy payors for treatment purposes.

Patient Authorization for Medicare Patients

I authorize the physician and/or staff of Spine Institute of Ohio to release to Social Security Administration, Health Care Financing Administration, or its Intermediaries or Carriers any information needed for this or any Medicare claim. I permit a copy of this Authorization to be used in place of the original and request payment of medical insurance benefits either to myself or to the party who may cause Medicare payment information to cross over automatically to my supplement insurer. I understand that I am financially responsible for any services deemed non-covered by Medicare.

Patient Authorization for PPO and HMO Patients

I authorize the physician and/or staff of Spine Institute of Ohio to release to my insurance company or its representative any information including the diagnosis and records of any treatment or examination rendered to me during medical or surgical care. I authorize and request my above named Insurance Company to pay directly to Spine Institute of Ohio the amount due for medical or surgical services. I understand that I am financially responsible for any services deemed non-covered by my Insurance company.

Financial Policy for All Patients

We will file your insurance claim to the insurance company as a courtesy to you. After hearing from your insurance company we will sent you a bill that reflects your balance due. Payment in full is expected at this time. Copayments are due at the time of the visits. Patients without insurance will be required to pay for services at the time of the visit. If necessary, payment arrangement for the remainder of the balance will be made. For personal injury involving legal action, we will not hold your account for settlement of a legal suit. We accept cash, check, Visa, and MasterCard. There will be a \$30.00 fee for all returned checks. Refunds from services charged on a credit card will be returned to the same credit card. I understand that I am financially responsible for services rendered in the office and surgical procedures. Failure to pay for services or any residual account balance that is not pain will be placed to a collection agency and possibly negatively affect my credit report. I authorize my insurance benefits to be paid directly to Spine Institute of Ohio. I authorize the release of any information by the Spine Institute of Ohio and/or Billing Contractor Agency to my insurance carrier, pertinent to my health insurance claim. I understand that I am financially responsible for this account unless other arrangements have been made. Also, to release any medical information that may be necessary to request claim reimbursement from the insurance carriers or other payers to whom claims have been or are being submitted.

If you are a no show for your appointment, you must pay a \$25.00 rescheduling fee prior to rescheduling your next appointment. Payment can be made via cash or credit card only.

I, the undersigned, agree that if payment on this patient's account is not made, I will pay reasonable attorney's fees and collection fees incurred for the collection process. I authorize the release of credit information to the appropriate information gathering services.

There will be a fee for filling out forms of \$25.00 per form (disability, etc.), the fee to be paid in advance. It may take up to a week to fill out the form, and we will notify you when it is done.

I certify that I have read the forgoing and I am the patient or am duly authorized to execute the above agreement for the patient and accept its terms.

Responsible Party: _____ Relationship to patient: Self Parent Guardian

Patient Signature: _____ Printed Name: _____ Date: _____

Special Accommodation Authorization

If a patient requires an accommodation for their appointment, the individual or his/her representative must notify Spine Institute of Ohio of the needed accommodation one week prior to the first new patient appointment. Subsequent appointments also require one week's notice. Under the American with Disabilities Act, "Providers are responsible for incurring all costs of providing reasonable aid and cannot pass that charge onto the patient or to his/her insurance company." If a patient who has requested accommodations does not provide a minimum of 24 hours notice to cancel the appointment or does not show to the scheduled appointment, all charges incurred by Spine Institute of Ohio is the patient's responsibility.

Signature

Patient Signature: _____ Date: _____

Parent/Guarantor/Guardian Signature: _____

SF-12©**Patient Questionnaire**

Patient Initials: _____

Date of Birth: _____

Patkey: _____

Surgeon Name: Josue P. Gabriel, M.D.

Date: _____

Examination Period: _____ Preop (1) _____ 1 Year (3)
_____ Immediate postop (2) _____ 3 Year (4)_____ 5 Year (5)
_____ Other (specify)(6): _____**SF-12©**

This information will help your doctors keep track of how you feel and how well you are able to do your usual activities. Answer every question by placing a checkmark on the line in front of the appropriate answer. It is not specific for arthritis. If you are unsure about how to answer a question, please give the best answer you can and make a written comment beside your answer.

1. In general, would you say your health is:

- _____ Excellent (1) _____ Fair (4)
_____ Very Good (2) _____ Poor (5)
_____ Good (3)

The following two questions are about activities you might do during a typical day. Does YOUR HEALTH NOW LIMIT YOU in these activities? If so, how much?

2. MODERATE ACTIVITIES, such as moving a table, pushing a vacuum cleaner, bowling or playing golf:

- _____ Yes, limited a lot (1)
_____ Yes, limited a little (2)
_____ No, not limited at all (3)

3. Climbing SEVERAL flights of stairs:

- _____ Yes, limited a lot (1)
_____ Yes, limited a little (2)
_____ No, not limited at all (3)

During the PAST 4 WEEKS have you had any of the following problems with your work or other regular activities AS A RESULT OF YOUR PHYSICAL HEALTH?

4. ACCOMPLISHED LESS than you would like:

- _____ Yes (1) _____ No (2)

5. Were limited in the KIND of work or other activities:

- _____ Yes (1) _____ No (2)

During the PAST 4 WEEKS, were you limited in the kind of work you do or other regular activities AS A RESULT OF ANY EMOTIONAL PROBLEMS (such as feeling depressed or anxious)?

6. ACCOMPLISHED LESS than you would like:

- _____ Yes (1) _____ No (2)

7. Didn't do work or other activities as CAREFULLY as usual:

- _____ Yes (1) _____ No (2)

8. During the PAST 4 WEEKS, how much did PAIN interfere with your normal work (including both work outside the home and housework)?

- _____ Not at all (1) _____ Quite a bit (4)
_____ A little bit (2) _____ Extremely (5)
_____ Moderately (3)

The next three questions are about how you feel and how things have been DURING THE PAST 4 WEEKS. For each question, please give the one answer that comes closest to the way you have been feeling. How much of the time during the PAST 4 WEEKS –

9. Have you felt calm and peaceful?

- _____ All of the time (1) _____ Some of the time (4)
_____ Most of the time (2) _____ A little of the time (5)
_____ A good bit of the time (3) _____ None of the time (6)

10. Did you have a lot of energy?

- _____ All of the time (1) _____ Some of the time (4)
_____ Most of the time (2) _____ A little of the time (5)
_____ A good bit of the time (3) _____ None of the time (6)

11. Have you felt downhearted and blue?

- _____ All of the time (1) _____ Some of the time (4)
_____ Most of the time (2) _____ A little of the time (5)
_____ A good bit of the time (3) _____ None of the time (6)

12. During the PAST 4 WEEKS, how much of the time have your PHYSICAL HEALTH OR EMOTIONAL PROBLEMS interfered with your social activities (like visiting with friends, relatives, etc.)?

- _____ All of the time (1) _____ Some of the time (4)
_____ Most of the time (2) _____ A little of the time (5)
_____ A good bit of the time (3) _____ None of the time (6)

Surgeon Signature _____

Date _____

Neck Disability Index

Patient Name _____ DOB _____ Date _____

Please read: This questionnaire is designed to give us information as to how your back pain has affected your ability to manage everyday life activities. Please answer every section and circle the ONE CHOICE that most applies to you. We realize that you may feel that more than one statement relate to you, but please just circle the one choice which closely describes your problem *right now*.

Section 1 – Pain intensity

- A. I have no pain at the moment
- B. The pain is mild at the moment.
- C. The pain comes and goes and is moderate.
- D. The pain is moderate and does not vary much.
- E. The pain is severe but comes and goes.
- F. The pain is severe and does not vary much.

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

- A. I can look after myself without causing extra pain.
- B. I can look after myself normally, but it causes extra pain.
- C. It is painful to look after myself and I am slow and careful.
- D. I need some help but manage most of my personal care.
- E. I need help everyday in most aspects of self-care.
- F. I do not get dressed. I wash with difficulty and stay in bed.

Section 3 – Lifting

- A. I can lift heavy weights without extra pain.
- B. I can lift heavy weights but it gives extra pain.
- C. Pain prevents me from lifting heavy weights off the floor, but I can if they are conveniently positioned, for example on a table.
- D. Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
- E. I can lift very light weights.

Section 4 – Reading

- A. I can read as much as I want to with no pain in my neck.
- B. I can read as much as I want with slight pain in my neck.
- C. I can read as much as I want with moderate pain in my neck.
- D. I cannot read as much as I want because of moderate pain in my neck.
- E. I cannot read as much as I want because of severe pain in my neck.
- F. I cannot read at all.

Section 5 – Headache

- A. I have no headaches at all.
- B. I have slight headaches which come infrequently.
- C. I have moderate headaches which come infrequently.
- D. I have moderate headaches which come frequently.
- E. I have severe headaches which come frequently.
- F. I have headaches almost all the time.

Score % _____

Signature: _____

Section 6 – Concentration

- A. I can concentrate fully when I want to with no difficulty.
- B. I can concentrate fully when I want to with slight difficulty.
- C. I have a fair degree of difficulty in concentrating when I want to.
- D. I have a lot of difficulty in concentrating when I want to.
- E. I have a great deal of difficulty in concentrating when I want to.
- F. I cannot concentrate at all.

Section 7 – Work

- A. I can do as much work as I want to.
- B. I can only do my usual work but no more.
- C. I can do most of my usual work but no more.
- D. I cannot do my usual work.
- E. I can hardly do any work at all.
- F. I cannot do any work at all.

Section 8 – Driving

- A. I can drive my car without neck pain.
- B. I can drive my car as long as I want with slight pain in my neck.
- C. I can drive my car as long as I want with moderate pain in my neck.
- D. I cannot drive my car as long as I want because of moderate pain in my neck.
- E. I can hardly drive my car at all because of severe pain in my neck.
- F. I cannot drive my car at all.

Section 9 – Sleeping

- A. I have no trouble sleeping.
- B. My sleep is slightly disturbed (less than 1 hour sleepless).
- C. My sleep is mildly disturbed (1-2 hours sleepless).
- D. My sleep is moderately disturbed (2-3 hours sleepless).
- E. My sleep is greatly disturbed (3-5 hours sleepless).
- F. My sleep is completely disturbed (5-7 hours sleepless).

Section 10 – Recreation

- A. I am able to engage in all recreational activities with no pain in my neck at all.
- B. I am able to engage in all recreational activities with some pain in my neck.
- C. I am able to engage in most but not all recreational activities because of pain in my neck.
- D. I am able to engage in few of my usual recreational activities because of pain in my neck.
- E. I can hardly do any recreational activities because of pain in my neck.
- F. I cannot do any recreational activities at all

