7720 S. Broadway Suite 320
Phone- 720-452-3355 Fax-303-955-2513

CSS
COLORADO
SPINE & SCOLIOSIS

Patient Information

Patient Last Name-_____ First- _____ Middle Initial-_____

Address- _____ City- _____ State- _____ Zip Code- _____

Home Phone- _____ Cell Phone-_____ Work Phone- _____

Email Address-_____ Social Security #_____

Date of Birth- _____ Sex- M or F Martial Status-_____

Employer- _____ Phone- _____

Emergency Contact- _____ Relationship- _____

Primary Care Physician- _____ Phone- _____ Fax- _____

Is this a work or auto injury? Yes No

Primary Insurance-

Insurance Name-_____ Policy# _____ Group# _____

Insurance Address-_____

Insurance Phone# _____ Copay$_____ Effective Date- _____

Name of Person Insured- _____ Relationship- _____

Social Security- _____ Date of Birth-_____

Employer-_____ Address- _____

Secondary Insurance (if applicable)

Insurance Name-_____ Policy#_____ Group#_____

Insurance Address- _____

Insurance Phone- _____ Copay$_____ Effective Date- _____

Name of Insured- _____ Relationship- _____

Social Security Number- _____ Date of Birth- _____

Employer- _____ Address- _____

I hereby authorize **Colorado Spine & Scoliosis** to treat the patient identified above. I acknowledge that I am responsible to pay all charges for all treatments administered by the physician to the patient. I understand that insurance may not pay for all charges and I understand that I am obligated to pay for all charges not paid by insurance. I also agree to pay reasonable attorney fees if my account is turned over to an attorney or collection agency. **Assignment and Release-** I hereby authorize my insurance benefits to be paid directly to the physician and I am financially responsible for non-covered services. I also authorize the physician to release my information required in processing of this claim and all future claims.

Patient / Authorized Signature-_____ **Date-**_____

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COLORADO SPINE & SCOLIOSIS

Financial Policy

This is an agreement between **Colorado Spine and Scoliosis** and the Patient/Debtor named on this form.

In this agreement the words "you", "your", and "yours" mean the Patient/Debtor. The word "account" means the account that has been established in your name to which charges are made and payments credited. The words "we", "us", and "our" refer to Colorado Spine and Scoliosis.

By executing this agreement, you are agreeing to pay for all services that are received.

Contracted Insurance- If we are contracted with your insurance company, we must follow our contract and their requirements. If you have a co-pay or deductible, you must pat that at time of service. It is the insurance company that makes the final determination of your eligibility. If your insurance company requires a referral, you are responsible to obtaining it. Failure to do so may result in a lower payment from the insurance company.

Non-Contracted Insurance- Insurance is a contract between you and your insurance company. We are NOT a party to this contract, in most cases. We will bill your primary insurance company as a courtesy to you. Although we may estimate what your insurance company may pay, it is the insurance company that makes the final determinations of your eligibility. You agree to pay any portion of the charges not covered by insurance. If your insurance company requires a referral, you are responsible for obtaining it.

Required payments- Any co-payments required by an insurance company must be paid at the time of service.

Worker's Compensation- We require approval/authorization by your worker's compensation carrier prior to your initial visit. If your claim is denied, you will be responsible for payment in full.

Personal Injury- If you are being treated as part of a personal injury lawsuit or claim, we require verification from your attorney prior to your initial visit. In addition to this verification, we require that you allow us to bill your health insurance. In the absence of insurance, other financial arrangements may be discussed. Payment of the balance remains the patient's responsibility. We will not bill your attorney for charges incurred due to a personal injury case.

Payment Options if you have no insurance-
You choose to pay by_cash,_check,_or credit card on the day that treatment is rendered.

Returned Checks- There is a fee of $25 for any checks returned by your bank.

Statement- If you have a balance on your account, we will send you a monthly statement. It will show separately the previous balance, any new charges to the account, and any payments or credits applied to your account during the month.

Payments- Unless other arrangements are approved by us in writing the balance on your statement is due and payable when the statement is issued and is past due if not paid by the end of the month.

Credit History- We have the option to report your account status to any credit reporting agency such as a credit bureau.
Past due accounts- We have the right to deny any future visits and have the right to require patients with a balance pay their balance to zero ($0.00) prior to receiving further services by our practice. If your account becomes past due, we will take necessary steps to collect this debt. If we must refer your account to a collection agency, you agree to pay all the collection costs which are incurred. If we must refer collection of the balance toa lawyer, you agree to pay all lawyers fees which we incur plus all court cost.

Waiver of confidentiality- You understand if this account is submitted to an attorney or collection agency. If we must litigate in court, or if you are past due status is reported to a credit reporting agency, the fact that you receive treatment at our office may become a matter of public record.

Co-signature- If this or another financial policy is signed by another person, that co-signature remains in effect until canceled in writing. If written cancellation is received, it becomes effective with any subsequent charges.

Once you have signed this agreement, you agree to all the terms and conditions contained herein and the agreement will be in full force and effect.

Patient Name-_____ Responsible Party-_____

Signature-_____ Date-_____

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COLORADO
SPINE & SCOLIOSIS

HIPPA Privacy Notice

This notice describes how medical information about you may be used and disclosed and how you can get access to this information.

We understand that the privacy of your personal information is important to you. As you physician, we believe your right to privacy is a fundamental part of your treatment; as such, we want you to understand our privacy practices and procedures. Should you have any questions regarding these policies, please do not hesitate to call our office at 720-452-3355.

Information We Collect About You

We collect personal information about you and your family as part of our registration process, during the course of your care, and from other health care entities you utilize such as hospitals, laboratories, other physicians, imaging facilities and your insurance company. The personal information includes items such as your name, address, phone number, birth date, social security number, employer, health history, insurance policy and coverage information. During your treatment, we will collect health information regarding diagnosis, treatment plans, progress and any test results or imaging.

How Your Information Is Used

The personal and health information gathered may be used and disclosed with your general consent for purposes of treatment, payment, or routine healthcare operations. This means we may send your information to other physicians or facilities involved in your treatment, as well as to your insurance company or a collection agency to obtain payment. Any uses of your information require a signed authorization by you, the patient or guardian, and can be revoked at any time with a written request. Colorado Spine & Scoliosis does not sell patient information to marketing or pharmaceutical companies. In certain cases of public health interest, we may be required to disclose certain information to local, state, or national health organization or government agencies.

We may contact you to provide appointment reminder of information about treatment alternatives or other health related benefits and services that may be of interest to you.

Safeguarding Your Personal and Health Information

We required by law to (1) make sure that medical information that identifies you is kept private, (2) provide you with our privacy policy, and (3) follow the terms laid out in the privacy policy. As a means of protecting your privacy, we restrict access to your personal and health information to only those employees who require the information to complete their jobs and provide quality service to you. Colorado Spine & Scoliosis maintains physical, electronic, and procedural safeguards to comply with state and federal regulations that guard your personal and health information. If you feel that your privacy has been violated, you have the right to file a complaint with the Denver Health and Human Services. The complaint in no way influences your course of treatment with Colorado Spine & Scoliosis.

Changes of Our Privacy Policy

All new patients will receive a copy of our privacy policy. Colorado Spine & Scoliosis occasionally reviews its privacy policy and reserves the right to amend it. Notifications of changes will be available at the from desk prior to the effective date of any changes.

Your Right to Restrict Use of Information

You have the right to request restrictions to our uses of disclosures of your personal or health information, although we are not required to agree to those restrictions. Once your request has been processed, it will remain in effect until you request a change.

Patient Acknowledgement

I, _____, have received and reviewed a copy of Colorado Spine & Scoliosis HIPPA Privacy Notice.

Signature-_____ Date-_____

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CSS
COLORADO
SPINE & SCOLIOSIS

Medical Information Release Form
(HIPPA Release Form)

Name-_____ Date of Birth-_____

Patient Disclosure Record-

In general, the HIPPA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individuals are also provided the right to request confidential communications, or that a communication of PHI be made by alternative means, such as correspondence to the individual's office instead of the individual's home.

___ Patient Initials (I have read the above policy)

Release of Information-

I authorize the release of information including the diagnosis, records, examinations rendered to me and claims information. This information may be released to:

___ Spouse _____

___Child(ren) _____

___ Other _____

___ Information is *NOT* to be release to anyone.

Contact Information-

Please call:
___ Cell
___ Home
___ Work

If Unable to reach me:
___ Leave a detailed message
___ Leave a message asking to return your call
___ Other _____

Written Correspondence-
___ Home Address
___ Work Address

This **Release of Information** will remain in effect until terminated by me in writing.

Signed-_____ Date- _____

COLORADO
SPINE & SCOLIOSIS

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Cancellation / No Show Policy

1. *Cancellation/ No Show for Appointment-* We understand that there are times when you must miss an appointment due to emergencies or obligations for work or family. However, when you do not call to cancel an appointment, you may be preventing another patient from getting much needed treatment. Conversely, the situation may arise where another patient fails to cancel and we ae unable to schedule you for a visit, due to a seemingly "full" schedule. If an appointment is not cancelled at least 24hrs. in advance you will be charged a $50.00 (fifty dollars) fee, this will not be covered by your insurance company.

2. *Scheduled Appointments-* We understand that delays can happen however we must try and keep the other patient's appointment and doctor on time. If you are 15minutes past their scheduled time, we will have to reschedule your appointment.

3. *Cancellation/ No show for Surgery-* Due to the large block of time needed to schedule surgery, last minute cancellations can cause problems and added expenses for the office. If surgery is not cancelled at least 10 days in advance you will be charged a $100.00 (one hundred) fee; this will not be covered by your insurance company.

Patient Name-_____

Signature-_____

Date- _____

ANANT KUMAR, M.D.

New Patient Questionnaire
Cervical Spine

Please answer all questions completely

Colorado Back and Spine – Dr. Anant Kumar

Patient Name:_____

Referring doctor name and address:_____

If you were not referred by a physician, how did you find our office?_____

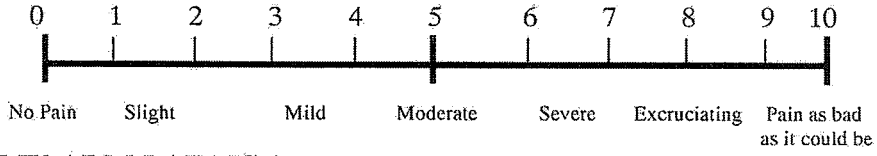
Primary care doctor name and address:_____

1. Your age:_____ Years Gender: ☐ Male ☐ Female
2. Symptoms: ☐ Neck pain ☐Arm pain ☐ Numbness ☐ Weakness ☐ Poor balance ☐ Other_____
3. How long have you had your symptoms?_____
4. What caused your symptoms? ☐ Unknown ☐ Injury ☐ Other _____
5. Have your symptoms improved or worsened recently? ☐ Improved ☐ Worsened
6. When did and what caused your symptoms improve or worsen?_____

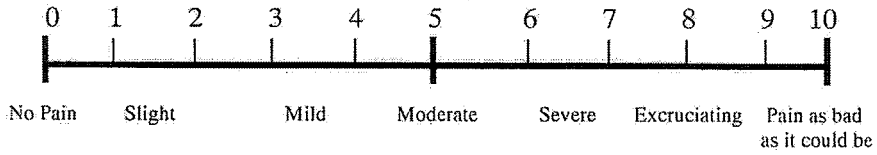
What % of your symptoms is in the NECK and ARM? (please check one box)	**What % of your symptoms is in each ARM? (please check one box)**
☐ Neck 0%, Arm 100%	☐ No ARM symptoms
☐ Neck 10%, Arm 90%	☐ Right 0%, Left 100%
☐ Neck 25%, Arm 75%	☐ Right 10%, Left 90%
☐ Neck 50%, Arm 50%	☐ Right 25%, Left 75%
☐ Neck 75%, Arm 25%	☐ Right 50%, Left 50%
☐ Neck 90%, Arm 10%	☐ Right 75%, Left 25%
☐ Neck 100%, Arm 0%	☐ Right 90%, Left 10%
	☐ Right 100%, Left 0%

Where in your ARM do you have PAIN or TINGLING?		**Where in your ARM do you have NUMBNESS**		**Where in your ARM do you have WEAKNESS**	
Right	**Left**	**Right**	**Left**	**Right**	**Left**
☐ None	☐ None	☐ None	☐ None	☐ None	☐ None
☐ Upper back	☐ Upper back	☐ Upper arm	☐ Upper arm	☐ Shoulder	☐ Shoulder
☐ Shoulder	☐ Shoulder	☐ Forearm	☐ Forearm	☐ Arm	☐ Arm
☐ Upper arm	☐ Upper arm	☐ Thumb	☐ Thumb	☐ Forearm	☐ Forearm
☐ Forearm	☐ Forearm	☐ Index finger	☐ Index finger	☐ Hands	☐ Hands
☐ Hand	☐ Hand	☐ Ring/small	☐Ring/small		

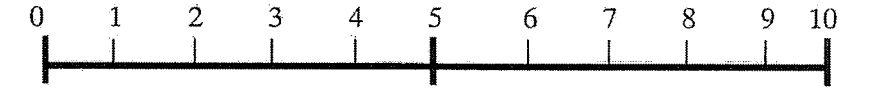
MY NECK PAIN IS (circle number)

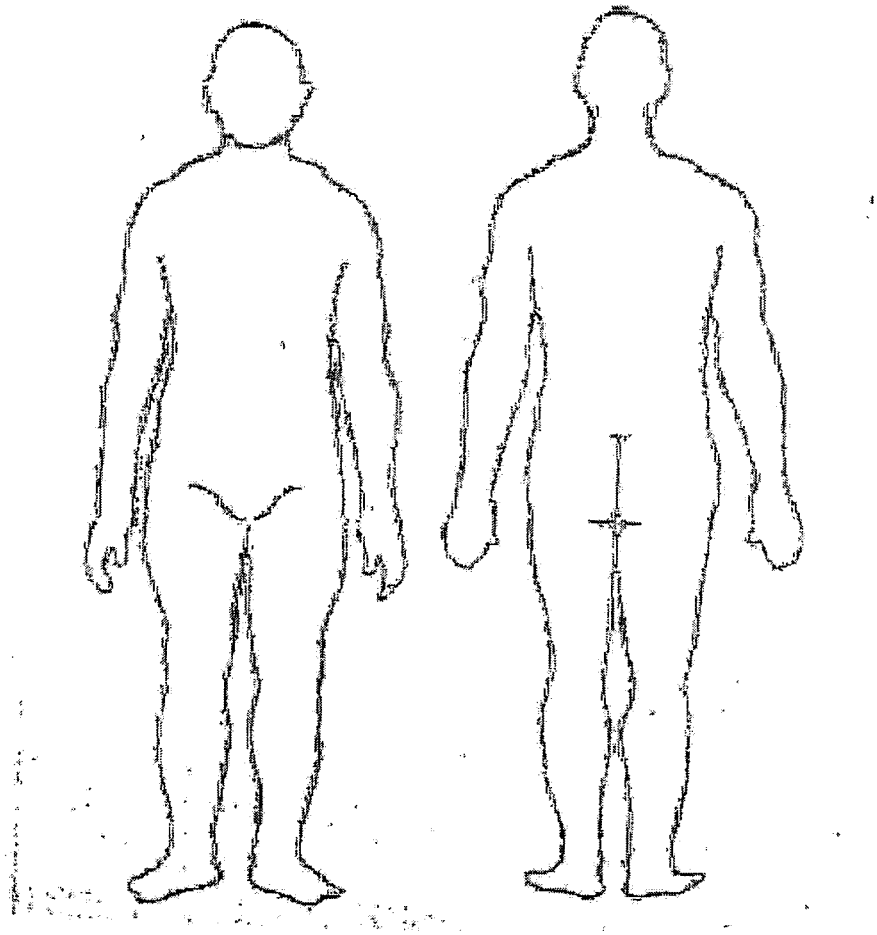


MY ARM PAIN IS (circle number)



MY HEADACHE PAIN IS (circle number)





Please mark the areas on the diagram where you are having symptoms and the location where the symptoms radiate.

Please use the following symbols to indicate the type of symptoms and the location of the symptoms:

Pain= ----------

Pins and Needles= 00000000

Numbness= XXXXXXXXXXX

7. **How does your pain travel:** ☐ Stays in my NECK ☐ Starts in the NECK and goes down the ARM
8. **Raising my arm:** ☐ Improves the pain ☐ Worsens the pain ☐ Does not affect the pain
9. **Moving my neck:** ☐ Improves the pain ☐ Worsens the pain ☐ Does not affect the pain
10. **Do your hands feel clumsy?** ☐ Yes ☐ No
11. **Do you have a problem with balance or tripping?** ☐ Yes ☐ No
12. **Do you have headaches in the back of your head?** ☐ Yes ☐ No
13. **Does coughing or sneezing increase your symptoms?** ☐ Yes ☐ No
14. **Do you have difficulty with bowel or bladder control?** ☐ No ☐ Yes; since_____
15. **Have you missed work because of your symptoms?** ☐ No ☐ Yes; how much time _____
16. **Previous treatments for my condition have included:** (check any boxes that apply)
    - ☐ **Nothing** (no medicines, therapy, manipulations, injections, or braces)
    - ☐ Physical therapy: did it help relieve your symptoms?_____
    - ☐ Chiropractic manipulation; did it help relieve your symptoms?_____
    - ☐ Braces; did it help relieve your symptoms?_____
    - ☐ Spine injections: How many injections have you had?_____
      For how long did the injections relieve your pain?_____
    - ☐ Surgery
      How many surgeries have you had on your NECK?_____
      When was/were the surgery(ies) on your NECK?_____
      Did surgery relieve your symptoms?_____
    - ☐ Other treatment:_____
17. **Previous doctors seen for your spine problem:** ☐ None

Doctor	Specialty	City	Recommendations/Treatments

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

Medication	Dose

MEDICAL CONDITIONS THAT YOU HAVE OR HAD IN THE PAST: (check all that apply)

☐ None apply

☐ Heart attack	☐ Diabetes	☐ Lung disease	☐ Liver trouble
☐ Heart failure	☐ Stroke	☐ HIV	☐ Hepatitis
☐ High blood pressure	☐ Seizures	☐ AIDS	☐ Thyroid trouble
☐ Osteoarthritis	☐ Mental illness	☐ Tuberculosis	☐ Bleeding disorders
☐ Rheumatoid arthritis	☐ Kidney stones	☐ Asthma	☐ Anemia
☐ Ankylosing spondylitis	☐ Kidney failure	☐ Blood clot in ARM	☐ Blood clot in lung
☐ Gout	☐ Stomach ulcers	☐ Alcoholism	☐ Drug use
☐ Osteoporosis			

☐ Cancer (type)_____

☐ Serious injuries (explain) _____

☐ Other (explain)_____

MEDICATIONS YOU TAKE (please list): ☐ None

_____

_____

_____

_____

_____

ARE YOU ALLERGIC TO MEDICINE? ☐ No known drug allergies

Medication	Reaction
_____	_____
_____	_____
_____	_____

Are you allergic to latex? ☐ Yes ☐ No

Have you had complications with anesthesia? ☐ Yes ☐ No

PAST SURGICAL HISTORY

Please list previous surgeries, surgeon and date. ☐ None

OPERATION	SURGEON	DATE

FAMILY HISTORY: (check all that apply)

☐ None apply

☐ Scoliosis ☐ Spine problems ☐ Arthritis ☐ Mental illness ☐ Alcoholism

☐ Heart trouble ☐ Stroke ☐ High blood pressure ☐ Diabetes ☐ Seizures

☐ Cancer ☐ Bleeding disorders ☐ Blood clots ☐ Other _____

Colorado Back and Spine – Dr. Anant Kumar

SOCIAL HISTORY: (check all that apply)

1. Work status: ☐ Working: __Full time __ Part time ☐ Retired ☐ Disabled ☐ Unemployed
   Occupation:_____
2. Marital status: ☐ Married ☐ Single ☐ Co-habitating ☐Widowed ☐ Divorced
3. I live: ☐ Alone ☐ With:_____
4. Number of living children:_____
5. Tobacco and nicotine use: ☐ Never ☐ Cigar ☐ Chew ☐ Pipe
   ☐ Cigarettes _____ packs per day for _____ years.
   ☐ Quit – When?_____after smoking_____ packs per day for _____ years
6. Alcohol intake: ☐ Never ☐ <2 drinks/month ☐ 1-2 drinks/week ☐ 1-2 drinks/day
7. Drug use: ☐ Never ☐ Currently ☐ In the past
8. If you have scoliosis how old were you when you started your menstrual cycle?_____
9. Because of my spine problem, I have filed or plan to file:

   ☐ A lawsuit ☐ A Worker's Compensation claim ☐ Neither

REVIEW OF SYSTEMS: (check all that apply)

Constitutional ☐ None apply ☐ Recent weight change ☐ Poor appetite ☐ Hot or cold spells ☐ Fever or chills

Eyes ☐ None apply ☐ Change of vision ☐ Reading glasses

Cardiac ☐ None apply ☐ Abnormal heartbeat ☐ Heart or chest pain ☐ Swollen ankles

Respiratory ☐ None apply ☐ Shortness of breath ☐ Morning cough

Gastrointestinal ☐ None apply ☐ Frequent Constipation ☐ Frequent diarrhea ☐ Stomach pain ☐Ulcers ☐ Nausea or vomiting

Genitourinary ☐ None apply ☐ Frequent urination ☐ Burning with urination ☐ Difficulty starting urination

Neurologic ☐ None apply ☐ Frequent headaches ☐ Blackouts ☐ Seizures ☐ Weakness ☐ Numbness

Skin ☐ None apply ☐ Frequent rash ☐ Acne

ENMT ☐ None apply ☐ Gum trouble ☐ Toothache ☐ Loss of hearing ☐ Cavities ☐ Missing teeth ☐ Dentures ☐ Ear pain/infection ☐ Nosebleeds ☐ Hoarseness ☐ Difficulty swallowing

Heme/Lymph ☐ None apply ☐ Anemia ☐ Blood clots☐ Easily bruising ☐ Bleeding disorder

Psychiatric ☐ None apply ☐ Depression ☐ Schizophrenia ☐ Bipolar disorder ☐ Alcoholism ☐ Drug abuse

Patient Signature _____Date _____

Physician Signature _____Date _____

Colorado Back and Spine – Dr. Anant Kumar

Physical Examination (**FOR OFFICE USE ONLY** – Patients continue to the next page)

1. Constitutional:
   a. Vital Signs: Height _____Weight_____Pulse_____Resp_____
   b. Appearance: Nutrition_____Habitus_____Deformity_____Grooming_____
2. Neurological
   a. Orientation (PERSON/PLACE/TIME) Mood/ Affect (depression, anxiety, agitation)
3. SKIN (scars, ulcerations, etc; location); Neck_____Back_____BUE_____BLE_____
4. Adams forward bend: PT_____ MT_____ TL/L_____
5. Pain Range of Motion Cervical/Thoracolumbar Spine (Yes/No)_____
6. Pain palpation Cervical/Thoracolumbar Spine (Yes/No; Location)_____
7. GAIT: Tandem gait: (steady / unsteady); Able to Heel walk: (+ / -); Able to Toe walk:(+ / -)
8. Motor: Delt Bi Tri WE WF FF INT Psoas Quad DF EHL PF INV EVER
   R
   L
9. Sensation: (symmetric, deficits, region of deficit):
10. DTR: Biceps Triceps BR Knee Ankles Babinski Hoffman's Clonus Umbilicus
    R
    L
11. Cardiovascular: DP PT Vascular changes Swelling
    R
    L

Straight LEG raise	
Femoral Stretch Test	
Pain hip ROM	
Pain knee ROM	
Pain Shoulder ROM	
Coordination	
SI pain	
Rhomberg	
Carpal/Cubital tunnel exam	

Lab/EMG Results:

Exam type	Date obtained	Findings

Diagnostic Imaging

Exam type	Date obtained	Findings

Assessment_____

Recommendations: Prescription Drug (mod-mgmt)_____Physical Therapy (low-mgmt)
Injections (high DxP) Surgery (high)

Colorado Back and Spine – Dr. Anant Kumar

mJOA Questionnaire

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 that applies to you. We realize you may consider that two of the statements in any one section related to you, but please just mark the box that most closely describes your problem.

I. Arms

☐ Impossible to write
☐ Unreadable handwriting
☐ Writing only in capitals
☐ Disfigured handwriting
☐ None – No difficulties performing the above task(s)

II. Legs

☐ Unable to walk
☐ Can walk on flat floor with walking aid
☐ Can walk up or down stairs with handrail
☐ Lack of stability and smooth gait
☐ None – No difficulties performing the above task(s)

III. Sensation

☐ Upper extremity, severe sensory loss or pain
☐ Upper extremity, mild sensory loss
☐ Upper extremity, None – No difficulties performing the above task(s)

☐ Lower extremity, severe sensory loss or pain
☐ Lower extremity, mild sensory loss
☐ Lower extremity, None – No difficulties performing the above task(s)

☐ Trunk, severe sensory loss or pain
☐ Trunk, mild sensory loss
☐ Trunk, None – No difficulties performing the above task(s)

IV. Bladder function

☐ Unable to void – Complete retention
☐ Marked difficulty in urination – Inadequate evacuation, straining, dribbling of urine
☐ Difficulty in urination – Urinate frequently, hesitation in urination
☐ None – No difficulties performing the above task

_____

Patient Signature

_____

Date

Colorado Back and Spine – Dr. Anant Kumar

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 related 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 difficulty 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 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 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 able 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

_____.

Patient Signature **Date**

CURRENT SYMPTOMS

1. Please indicate those areas that have bothered you or limited your function in the **past week**.
(Mark **all that apply**)

○ Shoulder	○ Head	○ Hip
○ Arm above the elbow	○ Neck	○ Leg above the knee
○ Elbow	○ Upper back	○ Knee
○ Arm below the elbow	○ Middle back	○ Leg below the knee
○ Wrist/hand	○ Lower back	○ Ankle/foot
	○ Buttocks	

In the **past week**, how often have you suffered:

Fill in **one** circle on each line	None of the time	A little of the time	Some of the time	A good bit of the time	Most of the time	All of the time
2. Neck pain?	○	○	○	○	○	○
3. Arm pain?	○	○	○	○	○	○
4. Numbness or tingling in arm and/or hand?	○	○	○	○	○	○
5. Weakness in arm and/or hand?	○	○	○	○	○	○
6. Low back and/or buttocks pain?	○	○	○	○	○	○
7. Leg pain?	○	○	○	○	○	○
8. Numbness or tingling in leg and/or foot?	○	○	○	○	○	○
9. Weakness in leg and/or foot?	○	○	○	○	○	○

In the **past week**, how bothersome have these symptoms been?

Fill in **one** circle on each line	Not at all bother-some	Slightly bother-some	Somewhat bother-some	Moderately bothersome	Very bother-some	Extremely bother-some
10. Neck pain?	○	○	○	○	○	○
11. Arm pain?	○	○	○	○	○	○
12. Numbness or tingling in arm and/or hand?	○	○	○	○	○	○
13. Weakness in arm and/or hand?	○	○	○	○	○	○
14. Low back and/or buttocks pain?	○	○	○	○	○	○
15. Leg pain?	○	○	○	○	○	○
16. Numbness or tingling in leg and/or foot?	○	○	○	○	○	○
17. Weakness in leg and/or foot?	○	○	○	○	○	○

18. Generally speaking, are your symptoms getting better or worse? (Fill in **one** circle)

○ Getting much better	○ Getting somewhat better	○ Staying about the same
○ Getting somewhat worse	○ Getting much worse	

19. If you had to spend the rest of your life with the symptoms you have right now, how would you feel about it? (Fill in **one** circle)

○ Very dissatisfied	○ Somewhat dissatisfied	○ Neutral
○ Somewhat satisfied	○ Very satisfied	

_____ _____

Patient Signature Date