

**Voth Family  
Chiropractic, L.L.C.**

**1957 Thompson Rd.  
Coos Bay, OR 97420**

# Electronic Health Records Intake Form

*In compliance with requirements for the government EHR incentive program*

First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_

Email address: \_\_\_\_\_@\_\_\_\_\_

Preferred method of communication for patient reminders (Circle one): Email / Phone / Mail

DOB: \_\_/\_\_/\_\_\_\_ Gender (Circle one): Male / Female Preferred Language: \_\_\_\_\_

Smoking Status (Circle one): Every Day Smoker / Occasional Smoker / Former Smoker / Never Smoked

*CMS requires providers to report both race and ethnicity*

Race (Circle one): American Indian or Alaska Native / Asian / Black or African American / White (Caucasian)  
Native Hawaiian or Pacific Islander / Other / I Decline to Answer

Ethnicity (Circle one): Hispanic or Latino / Not Hispanic or Latino / I Decline to Answer

Are you currently taking any medications? (Please include regularly used over the counter medications)

Medication Name	Dosage and Frequency (i.e. 5mg once a day, etc.)

Do you have any medication allergies?

Medication Name	Reaction	Onset Date	Additional Comments

I choose to decline receipt of my clinical summary after every visit (These summaries are often blank as a result of the nature and frequency of chiropractic care.)

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

<b>For office use only</b>		
Height: _____	Weight: _____	Blood Pressure: _____ / _____

# WELCOME

## PATIENT INFORMATION

Date \_\_\_\_\_

SS/HIC/Patient ID # \_\_\_\_\_

Patient Name \_\_\_\_\_  
Last Name \_\_\_\_\_  
First Name \_\_\_\_\_ Middle Initial \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_

State \_\_\_\_\_ Zip \_\_\_\_\_

E-mail \_\_\_\_\_

Sex  M  F Age \_\_\_\_\_

Birthdate \_\_\_\_\_

Married  Widowed  Single  Minor  
 Separated  Divorced  Partnered for \_\_\_\_\_ years

Occupation \_\_\_\_\_

Patient Employer/School \_\_\_\_\_

Employer/School Address \_\_\_\_\_

Employer/School Phone (\_\_\_\_\_) \_\_\_\_\_

Spouse's Name \_\_\_\_\_

Birthdate \_\_\_\_\_

SS# \_\_\_\_\_

Spouse's Employer \_\_\_\_\_

Whom may we thank for referring you? \_\_\_\_\_

## INSURANCE

Who is responsible for this account? \_\_\_\_\_

Relationship to Patient \_\_\_\_\_

Insurance Co. \_\_\_\_\_

Group # \_\_\_\_\_

Is patient covered by additional insurance?  Yes  No

Subscriber's Name \_\_\_\_\_

Birthdate \_\_\_\_\_ SS# \_\_\_\_\_

Relationship to Patient \_\_\_\_\_

Insurance Co. \_\_\_\_\_

Group # \_\_\_\_\_

**ASSIGNMENT AND RELEASE**  
I certify that I, and/or my dependent(s), have insurance coverage with \_\_\_\_\_ and assign directly to \_\_\_\_\_  
Name of Insurance Company(ies)

Dr. \_\_\_\_\_ all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named doctor may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

Signature of Patient, Parent, Guardian or Personal Representative \_\_\_\_\_

Please print name of Patient, Parent, Guardian or Personal Representative \_\_\_\_\_

Date \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

## PHONE NUMBERS

Home Phone (\_\_\_\_\_) \_\_\_\_\_

Cell Phone (\_\_\_\_\_) \_\_\_\_\_

Best time and place to reach you \_\_\_\_\_

**IN CASE OF EMERGENCY, CONTACT**

Name \_\_\_\_\_

Relationship \_\_\_\_\_

Home Phone (\_\_\_\_\_) \_\_\_\_\_

Work Phone (\_\_\_\_\_) \_\_\_\_\_

## ACCIDENT INFORMATION

Is condition due to an accident?  Yes  No

Date \_\_\_\_\_

Type of accident  Auto  Work  Home  Other

To whom have you made a report of your accident?  
 Auto Insurance  Employer  Worker Comp.  Other

Attorney Name (if applicable) \_\_\_\_\_

## PATIENT CONDITION

Reason for Visit \_\_\_\_\_

When did your symptoms appear? \_\_\_\_\_

Is this condition getting progressively worse?  Yes  No  Unknown

Mark an X on the picture where you continue to have pain, numbness, or tingling.

Rate the severity of your pain on a scale from 1 (least pain) to 10 (severe pain) \_\_\_\_\_

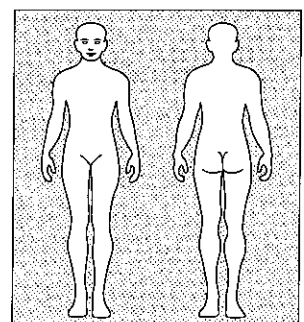
Type of pain:  Sharp  Dull  Throbbing  Numbness  Aching  Shooting  
 Burning  Tingling  Cramps  Stiffness  Swelling  Other

How often do you have this pain? \_\_\_\_\_

Is it constant or does it come and go? \_\_\_\_\_

Does it interfere with your  Work  Sleep  Daily Routine  Recreation

Activities or movements that are painful to perform  Sitting  Standing  Walking  Bending  Lying Down



# HEALTH HISTORY

What treatment have you already received for your condition?  Medications  Surgery  Physical Therapy

Chiropractic Services  None  Other \_\_\_\_\_

Name and address of other doctor(s) who have treated you for your condition \_\_\_\_\_

Date of Last: Physical Exam \_\_\_\_\_ Spinal X-Ray \_\_\_\_\_ Blood Test \_\_\_\_\_  
 Spinal Exam \_\_\_\_\_ Chest X-Ray \_\_\_\_\_ Urine Test \_\_\_\_\_  
 Dental X-Ray \_\_\_\_\_ MRI, CT-Scan, Bone Scan \_\_\_\_\_

Place a mark on "Yes" or "No" to indicate if you have had any of the following:

- |                                                                              |                                                                              |                                                                               |                                                                                       |
|------------------------------------------------------------------------------|------------------------------------------------------------------------------|-------------------------------------------------------------------------------|---------------------------------------------------------------------------------------|
| AIDS/HIV <input type="checkbox"/> Yes <input type="checkbox"/> No            | Diabetes <input type="checkbox"/> Yes <input type="checkbox"/> No            | Liver Disease <input type="checkbox"/> Yes <input type="checkbox"/> No        | Rheumatic Fever <input type="checkbox"/> Yes <input type="checkbox"/> No              |
| Alcoholism <input type="checkbox"/> Yes <input type="checkbox"/> No          | Emphysema <input type="checkbox"/> Yes <input type="checkbox"/> No           | Measles <input type="checkbox"/> Yes <input type="checkbox"/> No              | Scarlet Fever <input type="checkbox"/> Yes <input type="checkbox"/> No                |
| Allergy Shots <input type="checkbox"/> Yes <input type="checkbox"/> No       | Epilepsy <input type="checkbox"/> Yes <input type="checkbox"/> No            | Migraine Headaches <input type="checkbox"/> Yes <input type="checkbox"/> No   | Sexually Transmitted Disease <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Anemia <input type="checkbox"/> Yes <input type="checkbox"/> No              | Fractures <input type="checkbox"/> Yes <input type="checkbox"/> No           | Miscarriage <input type="checkbox"/> Yes <input type="checkbox"/> No          | Stroke <input type="checkbox"/> Yes <input type="checkbox"/> No                       |
| Anorexia <input type="checkbox"/> Yes <input type="checkbox"/> No            | Glaucoma <input type="checkbox"/> Yes <input type="checkbox"/> No            | Mononucleosis <input type="checkbox"/> Yes <input type="checkbox"/> No        | Suicide Attempt <input type="checkbox"/> Yes <input type="checkbox"/> No              |
| Appendicitis <input type="checkbox"/> Yes <input type="checkbox"/> No        | Goiter <input type="checkbox"/> Yes <input type="checkbox"/> No              | Multiple Sclerosis <input type="checkbox"/> Yes <input type="checkbox"/> No   | Thyroid Problems <input type="checkbox"/> Yes <input type="checkbox"/> No             |
| Arthritis <input type="checkbox"/> Yes <input type="checkbox"/> No           | Gonorrhea <input type="checkbox"/> Yes <input type="checkbox"/> No           | Mumps <input type="checkbox"/> Yes <input type="checkbox"/> No                | Tonsillitis <input type="checkbox"/> Yes <input type="checkbox"/> No                  |
| Asthma <input type="checkbox"/> Yes <input type="checkbox"/> No              | Gout <input type="checkbox"/> Yes <input type="checkbox"/> No                | Osteoporosis <input type="checkbox"/> Yes <input type="checkbox"/> No         | Tuberculosis <input type="checkbox"/> Yes <input type="checkbox"/> No                 |
| Bleeding Disorders <input type="checkbox"/> Yes <input type="checkbox"/> No  | Heart Disease <input type="checkbox"/> Yes <input type="checkbox"/> No       | Pacemaker <input type="checkbox"/> Yes <input type="checkbox"/> No            | Tumors, Growths <input type="checkbox"/> Yes <input type="checkbox"/> No              |
| Breast Lump <input type="checkbox"/> Yes <input type="checkbox"/> No         | Hepatitis <input type="checkbox"/> Yes <input type="checkbox"/> No           | Parkinson's Disease <input type="checkbox"/> Yes <input type="checkbox"/> No  | Typhoid Fever <input type="checkbox"/> Yes <input type="checkbox"/> No                |
| Bronchitis <input type="checkbox"/> Yes <input type="checkbox"/> No          | Hernia <input type="checkbox"/> Yes <input type="checkbox"/> No              | Pinched Nerve <input type="checkbox"/> Yes <input type="checkbox"/> No        | Ulcers <input type="checkbox"/> Yes <input type="checkbox"/> No                       |
| Bulimia <input type="checkbox"/> Yes <input type="checkbox"/> No             | Herniated Disk <input type="checkbox"/> Yes <input type="checkbox"/> No      | Pneumonia <input type="checkbox"/> Yes <input type="checkbox"/> No            | Vaginal Infections <input type="checkbox"/> Yes <input type="checkbox"/> No           |
| Cancer <input type="checkbox"/> Yes <input type="checkbox"/> No              | Herpes <input type="checkbox"/> Yes <input type="checkbox"/> No              | Polio <input type="checkbox"/> Yes <input type="checkbox"/> No                | Whooping Cough <input type="checkbox"/> Yes <input type="checkbox"/> No               |
| Cataracts <input type="checkbox"/> Yes <input type="checkbox"/> No           | High Blood Pressure <input type="checkbox"/> Yes <input type="checkbox"/> No | Prostate Problem <input type="checkbox"/> Yes <input type="checkbox"/> No     | Other _____                                                                           |
| Chemical Dependency <input type="checkbox"/> Yes <input type="checkbox"/> No | High Cholesterol <input type="checkbox"/> Yes <input type="checkbox"/> No    | Prosthesis <input type="checkbox"/> Yes <input type="checkbox"/> No           |                                                                                       |
| Chicken Pox <input type="checkbox"/> Yes <input type="checkbox"/> No         | Kidney Disease <input type="checkbox"/> Yes <input type="checkbox"/> No      | Psychiatric Care <input type="checkbox"/> Yes <input type="checkbox"/> No     |                                                                                       |
|                                                                              |                                                                              | Rheumatoid Arthritis <input type="checkbox"/> Yes <input type="checkbox"/> No |                                                                                       |

### EXERCISE

- None  
 Moderate  
 Daily  
 Heavy

### WORK ACTIVITY

- Sitting  
 Standing  
 Light Labor  
 Heavy Labor

### HABITS

- Smoking \_\_\_\_\_ Packs/Day  
 Alcohol \_\_\_\_\_ Drinks/Week  
 Coffee/Caffeine Drinks \_\_\_\_\_ Cups/Day  
 High Stress Level \_\_\_\_\_ Reason \_\_\_\_\_

Are you pregnant?  Yes  No Due Date \_\_\_\_\_

Injuries/Surgeries you have had	Description	Date
Falls	_____	_____
Head Injuries	_____	_____
Broken Bones	_____	_____
Dislocations	_____	_____
Surgeries	_____	_____

### ALLERGIES

### ALLERGIES

### VITAMINS/HERBS/MINERALS

Pharmacy Name _____ Pharmacy Phone (____) _____		
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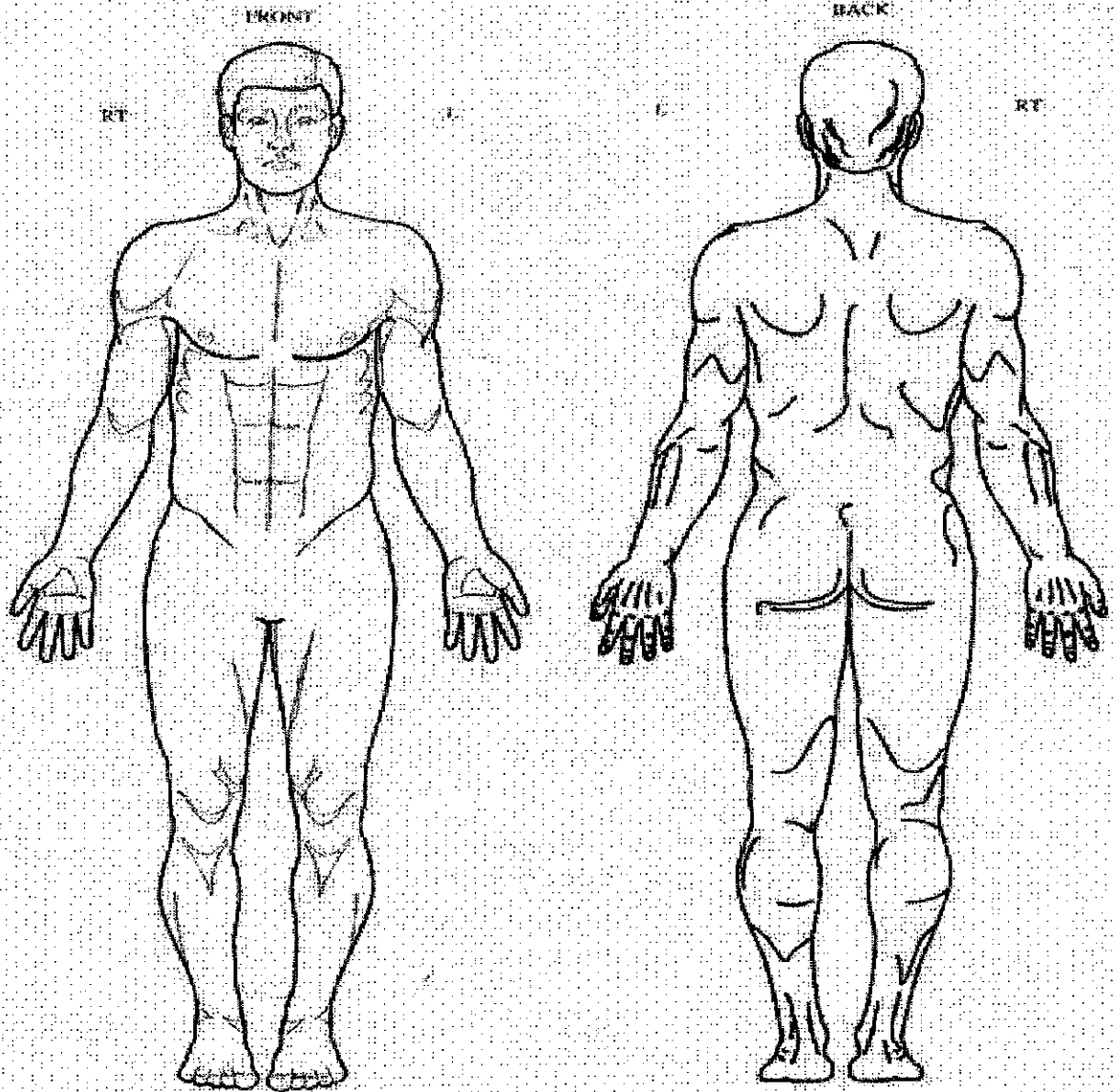
# PAIN DIAGRAM

PATIENT NAME: \_\_\_\_\_ TODAY'S DATE: \_\_\_\_\_

PLEASE COMPLETE THE FOLLOWING "PAIN DIAGRAM" BY USING LETTERS AT THE LEFT TO INDICATE ON THE DIAGRAM YOUR AREAS OF PAIN:

PAIN (P)  
TINGLING (T)  
NUMBNESS (N)  
BURNING (B)  
STIFFNESS (S)

PATIENT'S SIGNATURE: \_\_\_\_\_



# **Voth Family Chiropractic LLC**

**Benjamin L. Voth, D.C.**

1957 Thompson Rd. Suite B Coos Bay, OR 97420

Telephone (541) 266-8000

## **SIGNATURE ON FILE**

I understand that I am responsible for my bill. If it is necessary to refer my account for collection I agree to pay Voth Family Chiropractic L.L.C. reasonable attorney fees and collection costs, including any collection fees charged by a collection agency, even though no suit or action is filed. If a suit or action is filed the amount of such reasonable attorney's fees or collection charges shall be fixed by the court or courts in which the suit or action, including appeal, is tried, heard, or decided.

I authorize use of this form on ALL my insurance submissions.

I authorize release of information to all my insurance companies.

I authorize my doctor to act as my agent in helping me obtain payment from my insurance companies.

I authorize payment directly to my doctor.

I permit a copy of this authorization to be used in place of the original.

---

Signature of patient (or parent or legal guardian)

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Name of patient (please print)

---

Date

**Voth Family Chiropractic LLC**  
**Benjamin L. Voth, D.C.**  
1957 Thompson Rd. Coos Bay, OR 97420  
Telephone (541) 266-8000

## **Consent Form**

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy, on me (or the patient named below for whom I am legally responsible).

I am informed and I understand that, as in the practice of medicine, there are some risks to treatment, including, but not limited to, soreness and a temporary worsening of symptoms. I do not expect the doctor to be able to anticipate and explain all the risks and complications. I understand the results and are not guaranteed. I wish to rely on the doctor to exercise good judgement and prescribe a course of treatment that, based on the facts known, will be in my best interests.

I have read (or have read to me) this consent form. By signing below I agree to the above-named conditions. I intend this consent form to cover the entire treatment for my present condition, and for any future conditions for which I seek treatment at Voth Family Chiropractic LLC.

---

Print patient's name

---

Signature of patient or guardian

---

Date

# Voth Family Chiropractic LLC

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Telephone (541) 266-8000

## FINANCIAL AGREEMENT

I \_\_\_\_\_ understand that I am responsible for payment in full for services provided to me at Voth Family Chiropractic L.L.C.

Please be aware that each modality (therapy) has a reasonable fee. If you do not wish to pay for a particular therapy please let the doctor or a staff member know BEFORE the therapy is performed.

If it is necessary to refer my account for collection I agree to pay Voth Family Chiropractic L.L.C. reasonable attorney fees and collection costs, including any collection fees charged by a collection agency, even though no suit or action is filed. If a suit or action is filed the amount of such reasonable attorney's fees or collection charges shall be fixed by the court or courts in which the suit or action, including appeal, is tried, heard, or decided.

---

I have read (or have had read to me) the above statement and terms, and understand fully the content.

I agree to the terms as stated above.

---

Signature of Patient  
(or parent or legal guardian)

Print patient name

---

Date

## **VOTH FAMILY CHIROPRACTIC**

**Benjamin L. Voth, D.C.**

1957 Thompson Rd. Ste. B Coos Bay, OR 97420

Telephone (541) 266-8000

Fax (541) 266-8022

### **MEDICARE NON-COVERED SERVICES**

This is to advise you that the only chiropractic service covered by Medicare is manipulation of the spine.

Medicare **does not cover exams, x-rays, physical therapy, supplies, etc.** ordered by a chiropractor. Payment for these and other services are the patient's responsibility.

Medicare will only pay for services that it determines to be "reasonable and necessary" under section 1862(a)(1) of the Medicare law. If Medicare determines that a particular service, although it would otherwise be covered, is "not reasonable and necessary" under Medicare program standards, Medicare will deny payment for that service.

Prior to receiving treatment at Voth Family Chiropractic, I have read (or have had read to me) the above statement, and understand fully the content.

---

Patient signature

Date



**VOTH FAMILY CHIROPRACTIC**

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**REVISED OSWESTRY LOW BACK PAIN AND DISABILITY**

Patient Name: \_\_\_\_\_

Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

**Please read instructions carefully:**

This questionnaire has been designed to give the doctor information as to how your low back pain has affected your ability to manage it everyday life. In each section, please fill in ONE circle which most closely describes your problem.

**SECTION 1 - PAIN INTENSITY**

- The pain comes and goes and is very mild.
- The pain is mild and does not vary much.
- The pain comes and goes and is moderate.
- The pain is moderate and does not vary much.
- The pain comes and goes and is very severe.
- The pain is severe and doesn't vary much.

**SECTION 2 - PERSONAL CARE**

- I can look after myself 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 can 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 weight without extra pain.
- I can lift heavy weight but it gives extra pain.
- Pain prevents me from lifting heavy weights off the floor.
- Pain prevents me from lifting heavy weights, but I can manage if they are conveniently positioned.
- Pain prevents me from lifting heavy weights, but I can manage light-medium weights if they are conveniently positioned.
- I can only lift very light weights at the most.

**SECTION 4 - WALKING**

- I have no pain walking.
- I cannot walk more than one mile without increasing pain.
- I cannot walk more than 1/2 mile without increasing pain.
- I cannot walk more than 1/4 mile without increasing pain.
- I can walk with crutches.
- I cannot walk at all without increasing pain.

**SECTION 5 - SITTING**

- I can sit in any chair as long as I like.
- I can only sit in my favorite chair as long as I like.
- Pain prevents me from sitting more than one hour.
- Pain prevents me from sitting more than a half hour.
- Pain prevents me from sitting more than 10 minutes.
- I avoid sitting because it increases pain straight away.

**SECTION 6 - STANDING**

- I can stand as long as I want without pain.
- I have some pain on standing but it does not increase with time.
- I cannot stand for longer than one hour without increasing pain.
- I cannot stand for longer than 1/2 hour without increasing pain.
- I can't stand for longer than 10 minutes without increasing pain.
- I avoid standing because it increases the pain straight away.

**SECTION 7 - SLEEPING**

- I get no pain in bed.
- I get pain in bed but it doesn't prevent me from sleeping well.
- Because of pain my normal night's sleep is reduced by < 1/4.
- Because of pain my normal night's sleep is reduced by < 1/2.
- Because of pain my normal night's sleep is reduced by < 3/4.
- Pain prevents me from sleeping at all.

**SECTION 8 - TRAVELING**

- I get no pain while traveling.
- I get some pain while traveling but none of my usual forms of travel make it any worse.
- I get extra pain while traveling but it does not compel me to seek alternative forms of travel.
- I get extra pain while traveling which compels me to seek alternative forms of travel.
- Pain restricts all forms of travel.
- Pain prevents all forms of travel except that are done lying down.

**SECTION 9 - SOCIAL LIFE**

- My social life is normal and gives me no pain.
- My social life is normal but increases the degree of pain.
- Pain limits my more energetic interests, e.g. dancing, etc.
- Pain has restricted my social life and I do not go out very often.
- Pain has restricted my social life to my home.
- I have hardly any social life because of the pain.

**SECTION 10 - CHANGING DEGREE OF PAIN**

- My pain is rapidly getting better.
- My pain fluctuates but overall is definitely getting better.
- My pain seems to be getting better but improvement is slow.
- My pain is neither getting better nor worse.
- My pain is gradually worsening.
- My pain is rapidly worsening.

2

For office use only - Score: \_\_\_\_\_

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**The Oswestry Neck Disability Index (Confidential)**

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_

Please check only ONE statement in each section that describes how you're feeling **TODAY**

<p><b>Section 1 - Pain Intensity</b></p> <p><input type="checkbox"/> I have no pain at the moment.</p> <p><input type="checkbox"/> Pain is very mild at the moment.</p> <p><input type="checkbox"/> Pain is moderate at the moment.</p> <p><input type="checkbox"/> Pain is fairly severe at the moment.</p> <p><input type="checkbox"/> Pain is very severe at the moment.</p> <p><input type="checkbox"/> Pain is the worst imaginable at the moment.</p>	<p><b>Section 6 - Concentration</b></p> <p><input type="checkbox"/> I can concentrate fully when I want to with no difficulty.</p> <p><input type="checkbox"/> I can concentrate fully when I want to with slight difficulty.</p> <p><input type="checkbox"/> I have a fair degree of difficulty in concentrating.</p> <p><input type="checkbox"/> I have a lot of difficulty in concentrating when I want to.</p> <p><input type="checkbox"/> I have a great deal of difficulty in concentrating.</p> <p><input type="checkbox"/> I cannot concentrate at all.</p>
<p><b>Section 2 - Personal Care (Washing, Dressing, etc)</b></p> <p><input type="checkbox"/> I can look after myself normally without causing extra pain.</p> <p><input type="checkbox"/> I can look after myself normally but it causes extra pain.</p> <p><input type="checkbox"/> It is painful to look after myself and I am slow and careful.</p> <p><input type="checkbox"/> I need some help but manage most of my personal care.</p> <p><input type="checkbox"/> I need help every day in most aspects of self care.</p> <p><input type="checkbox"/> I do not get dressed. I wash with difficulty and stay in bed.</p>	<p><b>Section 7 - Work</b></p> <p><input type="checkbox"/> I can work as much as I want to.</p> <p><input type="checkbox"/> I can only do my usual work but no more.</p> <p><input type="checkbox"/> I can do most of my usual work but no more.</p> <p><input type="checkbox"/> I cannot do my usual work.</p> <p><input type="checkbox"/> I can hardly do any work at all.</p> <p><input type="checkbox"/> I cannot do any work at all.</p>
<p><b>Section 3 - Lifting</b></p> <p><input type="checkbox"/> I can lift heavy weights without extra pain.</p> <p><input type="checkbox"/> I can lift heavy weights but it gives extra pain.</p> <p><input type="checkbox"/> I can lift heavy weight items if conveniently positioned.</p> <p><input type="checkbox"/> I can lift light/medium weights if conveniently positioned.</p> <p><input type="checkbox"/> I can lift very light weights.</p> <p><input type="checkbox"/> I cannot lift or carry anything at all.</p>	<p><b>Section 8 - Driving</b></p> <p><input type="checkbox"/> I can drive my car without any neck pain.</p> <p><input type="checkbox"/> I can drive my car as desired with light neck pain.</p> <p><input type="checkbox"/> I can drive my car as desired with moderate neck pain.</p> <p><input type="checkbox"/> I cannot drive my car much because of moderate neck pain.</p> <p><input type="checkbox"/> I can hardly drive at all because of severe pain in my neck.</p> <p><input type="checkbox"/> I can't drive my car at all.</p>
<p><b>Section 4 - Reading</b></p> <p><input type="checkbox"/> I can read as much as I want to with no pain in my neck.</p> <p><input type="checkbox"/> I can read as much as I want to with slight pain in my neck.</p> <p><input type="checkbox"/> I can just read as much as I want with moderate neck pain.</p> <p><input type="checkbox"/> I cannot read as much because of moderate neck pain.</p> <p><input type="checkbox"/> I can hardly read at all because of severe pain in my neck.</p> <p><input type="checkbox"/> I cannot read at all.</p>	<p><b>Section 9 - Sleeping</b></p> <p><input type="checkbox"/> I have no trouble sleeping.</p> <p><input type="checkbox"/> My sleep is mildly disturbed (less than 1 hour sleepless).</p> <p><input type="checkbox"/> My sleep is mildly disturbed (1-2 hours sleepless).</p> <p><input type="checkbox"/> My sleep is moderately disturbed (2-3 hours sleepless).</p> <p><input type="checkbox"/> My sleep is greatly disturbed (3-5 hours sleepless).</p> <p><input type="checkbox"/> My sleep is completely disturbed (5-7 hours sleepless).</p>
<p><b>Section 5 - Headaches</b></p> <p><input type="checkbox"/> I have no headaches at all.</p> <p><input type="checkbox"/> I have slight headaches which come infrequently.</p> <p><input type="checkbox"/> I have moderate headaches which come infrequently.</p> <p><input type="checkbox"/> I have moderate headaches which come frequently.</p> <p><input type="checkbox"/> I have severe headaches which come frequently.</p> <p><input type="checkbox"/> I have headaches almost all the time.</p>	<p><b>Section 10 - Recreation</b></p> <p><input type="checkbox"/> I can engage in all my recreational activities with no neck pa</p> <p><input type="checkbox"/> I can do all recreation activities with some neck pain.</p> <p><input type="checkbox"/> I can do most, not all recreational activities with some neck p</p> <p><input type="checkbox"/> I can do some recreational activities with neck pain.</p> <p><input type="checkbox"/> I can hardly do recreational activities because of neck pain.</p> <p><input type="checkbox"/> I cannot do recreational activities at all.</p>
<p><b>Section 11 - Rate your overall pain:</b>      0   1   2   3   4   5   6   7   8   9   10</p> <p style="text-align: center;">No pain      mild      discomfort      distressing      horrible      excruciating</p>	