CONFIDENTIAL PATIENT INFORMATION

DATE:_____/_____/_____

Island Health & Chiropractic ~ 9431 Coppertop Loop NE STE 204 ~ Bainbridge Island, WA 98110
Jerry Nashman, BSC, DC, CCSP

NAME: ____ GENDER: [ ] Male [ ] Female
Last Name First Name Middle Initial

ADDRESS: ____________________________________ CITY:______________State ___ ZIP______

E-Mail: ____

PHONE: [H] (_____) _____-__________ [W] (_____) _____-__________ [C] (_____) _____-__________

DATE OF BIRTH: ____/____/______ AGE: ____

EMPLOYER: ____________________________ JOB TITLE:____________________ HOW LONG?_____

ADDRESS: ______________________________________ CITY:______________ State ___ ZIP_____

MARITAL: S M D W SEP PARTNER'S NAME: ____

EMERGENCY CONTACT: ________________________________ PHONE:_________________

WHO MAY WE THANK FOR REFERRING YOU TO OUR CLINIC? ____________________________________

AUTHORIZATION TO RELEASE INFORMATION: I hereby authorize the office of **Island Health & Chiropractic** to release to the insurance company agencies any information requested by the insurance company to process a claim for payment of treatment received from this office. I understand that these records may be faxed, delivered by courier, mailed or e-mailed.

ASSIGNMENT OF BENEFITS: I hereby assign payment directly to **Island Health & Chiropractic** for any benefits available under my insurance policy for treatment, expences incurred at this office. Further, I request that all benefits allowable under my insurance policy be issued directly to **Island Health & Chiropractic**.

I understand that I am financially responsible for all costs incurred in the office, whether my insurance pays or not. I also understand that there may be certain procedures that are not covered by my insurance policy/MVA/Labor & Industries/Third Party accidents, and agree that I will be financially responsible for those charges. Examples of possible non-covered charges: supplies, manual traction, manual modalities, re-exams, exercise instruction, maintenance/palliative care, application of heat/ice. I agree that this Assignment of Benefits is irrevocable and that I am waiving the statute of limitations for payment.

INITIAL ____ **FOR CONSENT TO TREATMENT OF MINOR CHILD**: As parent and/or legal guardian, I have the authority to authorize, and do hereby grant the Chiropractor(s) at **Island Health & Chiropractic** to administer chiropractic care as he/she deems necessary to my son/daughter/ward: ____________________________(name of minor)
____________________________________(print adult name).

I understand the Authorization to Release Information, and Assignment of Benefits, and agree to the above paragraphs. My initials above also authorizes the Treatment of a Minor. **By refusing to sign I understand that I and/or my child will not be able to receive care in this office**.

SIGNED: ____ DATE:____/____/____

Island Health & Chiropractic ~ 9431 Coppertop Loop NE STE 204 ~ Bainbridge Island, WA 98110
Jerry Nashman, BSC, DC, CCSP

Phone: (206) 842-6655 ~ Fax: (206) 842-6677

INFORMED CONSENT TO CHIROPRACTIC ADJUSTMENTS

Chiropractic treatment consists of manipulations of joints and soft tissues, using the hand and/or a mechanical instrument. You may feel joint movement, and you may hear joint clicks or other noises. Some patients will feel some stiffness and soreness following the first few days of treatment; these are normal and not a cause for concern. There are different techniques used in Chiropractic spinal manipulations. There are also alternatives to Chiropractic care, including but not limited to: Physical Therapy, Massage therapy, Osteopathic manipulations, and Medical care. There are also material risks inherent in the above listed alternatives, which should be discussed between you and the specialty care provider. You also have the option of not seeking any care. The risk of remaining untreated allows the formation of adhesions and reduces mobility, which sets up a pain reaction further reducing mobility.

I understand and am informed that, as in the practice of medicine, in the practice of chiropractic there are certain risks, which may arise during the exam and treatment. Those complications include: strokes or stroke-like conditions, Horner's syndrome, diaphragmatic paralysis, cervical myelopathy, pathological fracture, cervical disc protrusions, cervical dislocations, costovertebral strains, rib fractures, costochondral separations, compression of the cauda equina. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely on the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known, is in my best interest. The risks of massage are bruising, local tenderness, and the release of toxins in the body. There are also risks in taking nutritional supplements, please contact your Primary Care Physician/health care practitioner before using any nutritional products, including those dispensed in this office.

I have read or have had read to me the above explanation of the nature and purpose of chiropractic adjustments, other alternatives/procedures for care, massage, and possible risks. I have also had the opportunity to ask questions about its content and have had my questions answered to my satisfaction. By signing below I state that I have weighed the risks involved in undergoing treatment and have myself decided that it is in my best interest to undergo the treatment recommended, and listed below. Having been informed of the risks, **I hereby request and consent to the performance of** chiropractic adjustments, other chiropractic procedures, and diagnostic x-rays-if warranted, massage, and the use of natural substances such as vitamins, minerals, or other natural substances on me or on the patient named below, for whom I am legally responsible, by the doctor of chiropractic named below and/or licensed doctors of chiropractic who now or in the future treat me while employed by, working or associated with or servicing as backup for the doctor of chiropractic named below and by the Licensed Massage Therapist listed below, including those working at the clinic or office listed below or any other office or clinic. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

****

To be completed by patient:

____
PRINT Patient's Name

____
Signature of Patient

____
Date

If patient is a **MINOR,** *this section to be complete by patient's legal guardian, legally responsible adult.*

____
PRINT Patient's Name

____
PRINT Name of Patient's Guardian

____
Signature of Patient's Guardian

____
Date

To be completed by
Island Health & Chiropractic

____
Provider's Signature

____
Date

GENERAL INSURANCE AND FINANCIAL POLICY

Island Health and Chiropractic
Jerry Nashman, DC
9431 Coppertop Loop NE STE 204 ~ Bainbridge Island, WA 98110

To our valued patients:

We regret that due to increased hold times and new policies and restrictions implemented by insurance companies that restrict the amount of information our office can procure, our office is unable to verify insurance benefits for our patients. Furthermore, past experiences have demonstrated that when we did verify benefits, our office has not always received payment according to the quoted benefits, thus leaving our patients with greater financial responsibility than expected. As a patient of this office, it is your responsibility to know your benefits when receiving treatment in our office.

We STRONGLY recommend you call your insurance company to verify your chiropractic and rehabilitation benefits.

Our **Financial Policy** is as follows:

1. As a patient of this office you are directly responsible for payment of all charges incurred while under treatment.
2. **If your card lists a co-pay amount on it, then your co-pay is due at the time of each service.** (If our biller can verify that the services are not subject to a co-pay, we will credit your account.)
3. All supports, supplements and supplies must be paid for at the time of service. (No insurance will be billed.)
4. Interest accrues at 1.0% per month on all accounts over 30 days past due.
5. Overdue accounts past ninety (90) days may be assigned to a collection agency of our choice.
6. There is a $20.00 charge on all returned checks.
7. Missed appointments are subject to a $50.00 charge at provider's discretion.

Please read this supplemental information:

1. In addition to chiropractic adjustments, our providers also render services that are often processed under a separate therapy or rehabilitation benefit. Examples of these types of services include:
   a. Roller Table, Exercises, Manual Traction, Myofascial Release, Manual Massage

____ **Initial to indicate you read line item 1**

2. Our office is not contracted with Kitsap Physician Services (KPS). These services are billed as out-of-network.
3. Our providers can never know how your claim will be processed until the payment is received from your insurance company, therefore all services rendered will be billed using the appropriate code(s) per insurance requirements and national billing guidelines.
4. **ATTENTION Premera, Regence, United Healthcare and Cigna patients**...some of these plans require pre-notification or pre-authorization from the health plan. Unfortunately, due to the way these systems were set up by the insurance companies and/or their subcontractors, we are not able to submit these requests until after you have been seen by the doctor. If the request for pre-authorization or pre-notification is denied, you will be financially responsible for your visit costs. A copy of the denial will be made available to you upon request.

ULTIMATELY IT IS YOUR RESPONSIBILITY TO KNOW WHAT YOUR BENEFITS ARE. WE HIGHLY RECOMMEND THAT YOU CALL YOUR INSURANCE COMPANY TO VERIFY YOUR BENEFITS!

______________________	____________	______________________
Patient Signature	Date	Witness (Staff Signature)

Island Health & Chiropractic

9431 Coppertop Loop NE STE 204 ~ Bainbridge Island, WA 98110

Jerry Nashman, DC

Terms of Acceptance

When a patient seeks chiropractic healthcare and we accept a patient for such care, it is essential for both to be working toward the same objective.

It is important that each patient understand both the objective and the method that will be used to attain improved spinal health. This will prevent any confusion or disappointment.

Adjustment: An adjustment is the specific application of forces to facilitate the body's correction of vertebral subluxation. Our chiropractic method of correction is by specific computerized adjustments and or gentle manual adjustments of the spine.

Health: A state of optimal physical, mental, and social well-being, not merely the absence of symptoms.

Vertebral Subluxation: A misalignment of one or more of the twenty-four vertebra in the spinal column which can cause alteration of nerve function and transmission of nerve impulses resulting in a lessening of the body's ability to perform at it's optimal potential.

We only offer to diagnose either vertebral subluxations or neural-musculoskeletal conditions of the body, however, if during the course of the chiropractic spinal examination we encounter non-chiropractic or unusual findings, we will advise you. We have a list of other professional health care providers for referral purposes if indicated. Any legal disputes with Island Health & Chiropractic (I.H.C.), or employees of I.H.C. will be handled via arbitration.

I, ________________________ have read and fully understand the above statements. All questions regarding the doctors' objectives pertaining to my care in this office have been answered to my complete satisfaction. I therefore accept chiropractic care on this basis, and understand that all charges incurred are my responsibility.

__________________________ (patient signature) __________________________ (date)

****Consent to evaluate and adjust a minor child**

I, ____________________ being the parent/legal guardian ______________of have fully read and understand the above terms of acceptance and hereby grant permission for my child to receive chiropractic care from Dr. Vracin or Dr. Rilling.

__________________________ (authorized signature) __________________________ (date)

****Pregnancy Release:**

This is to certify that to the best of my knowledge I am not pregnant and the above doctor and his/her associates have my permission to perform, if needed, an x-ray evaluation. I have been advised that x-rays can be hazardous to an unborn child.

Date of last menstrual period: ________________________

__________________________ (patient signature) __________________________ (date)

**if applicable

Island Health and Chiropractic ~ 9431 Coppertop Loop NE STE 204 ~ Bainbridge Island, WA 98110

INITIAL COMPLAINT

Patient Name:______________________________ **Date:**____/____/____

Primary Care Physician & Clinic: ______________________________ **Phone: ( )** __________

Other Doctors treating you for this condition: ______________________________ **Phone: ( )** __________

Therapists treating you for this condition: ______________________________ **Phone: ( )** __________

Date of initial onset for this condition:__________ **If reoccurrence, date of current aggravation:**__________

Describe what caused the onset of your pain:______________________________

____

When did your problem begin? ☐ **No Specific Incident** ☐ **Multiple Incidents** ☐ **Gradually Developed**

☐ **Immediately after a specific incident - Please list the incident:** ______________________________

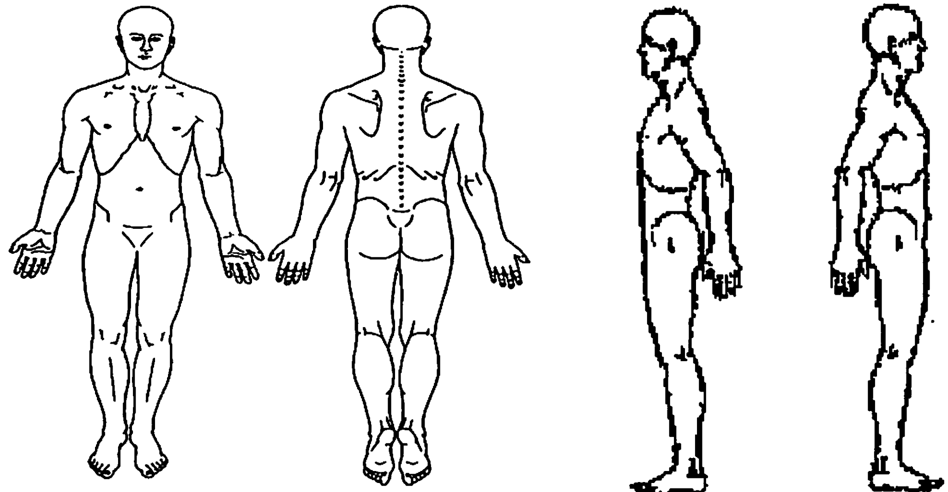
Pain Diagram: Use symbols below to mark the figures.

Description:

XXX = Aching
/// = Numbness
>>> = Stabbing
= Burning
000 = Pins/Needles
TTT = Throbbing

Frequency (overall):

☐ Constant (76-100%)
☐ Frequent (51-75%)
☐ Occasional (26-50%)
☐ Intermittent (25% or less)



Rate Intensity as Follows (This Section):

0 None
1 Maybe
2 Mild, forgotten w/activity
4 Moderate, bothers during work/activities
6 Limiting, prevents full activity
8 Intense, preoccupied, seeks relief instead of activity
10 Severe—on bed rest, stops all activity

Complaint (I.e. Neck Pain, Low Back Pain, etc)	**Place "X" for average pain, "O" worst pain, "☐" pain now**	Is it getting **Better**	**Worse**	**No Change**
1.______________________	0....1.....2.....3.....4.....5.....6.....7.....8.....9.....10	☐	☐	☐
2.______________________	0....1.....2.....3.....4.....5.....6.....7.....8.....9.....10	☐	☐	☐
3.______________________	0....1.....2.....3.....4.....5.....6.....7.....8.....9.....10	☐	☐	☐
4.______________________	0....1.....2.....3.....4.....5.....6.....7.....8.....9.....10	☐	☐	☐

Your general stress level: ☐ No stress ☐ Minimal stress ☐ Moderate stress ☐ Greatly stressed

Physical activity at work: ☐ Sitting more than 50% of day ☐ Light manual labor Manual labor ☐ Heavy manual labor

General physical activity: ☐ No regular exercise program ☐ Light exercise program ☐ Strenuous exercise program

Please describe any other physical/emotional/hormonal medical concerns that you are considering seeking care for, currently receiving care for, or in the past have sought care for: ______________________________

____

Patient signature ______________________ Date __________ →→→→(please see other side)

Island Health and Chiropractic ~ 9431 Coppertop Loop NE STE 204 ~ Bainbridge Island, WA 98110

Patient Name:____ **Initial Condition Continued...**

Patient Initials	**Dr Initial:**
_____ ←**For Re-exams/Updates – Initial ONLY if there has been no change since your last visit.**	_______

For ALL new patients and patients who have had a new injury please answering the following.

If you have ever been treated for a listed condition in the past, please check it in the Past column.
If you are currently under the care of a medical professional for a listed condition, check it in the Present column.

Past	Present	Condition
☐	☐	Neck Pain
☐	☐	Shoulder Pain
☐	☐	Pain in Upper Arm or Elbow
☐	☐	Hand Pain
☐	☐	Wrist Pain
☐	☐	Upper Back Pain
☐	☐	Low Back Pain
☐	☐	Pain in Upper Leg or Hip
☐	☐	Pain in Lower Leg or Knee
☐	☐	Pain in Ankle or Foot
☐	☐	Jaw Pain
☐	☐	Swelling/Stiffness of joint (_________)
☐	☐	Fainting
☐	☐	Visual Disturbances
☐	☐	Convulsions
☐	☐	Dizziness
☐	☐	Headache
☐	☐	Muscle Coordination Problems
☐	☐	Tinnitus (Prolonged Ringing of Ears)
☐	☐	Rapid Heart Beat
☐	☐	Chest Pains
☐	☐	Loss of Appetite
☐	☐	Anorexia
☐	☐	Abnormal Weight Gain Loss
☐	☐	Excessive Thirst
☐	☐	Chronic Cough
☐	☐	Chronic Sinusitis
☐	☐	General Fatigue
☐	☐	Irregular Menstrual Flow
☐	☐	Profuse Menstrual Flow
☐	☐	Breast Soreness/Lumps
☐	☐	Endometriosis
☐	☐	PMS
☐	☐	Loss of Bladder Control
☐	☐	Painful Urination
☐	☐	Frequent Urination
☐	☐	Abdominal Pain
☐	☐	Constipation/Irregular Bowel Habits
☐	☐	Difficulty in Swallowing
☐	☐	Heartburn/Indigestion
☐	☐	Dermatitis/Eczema/Rash
☐	☐	Depression

Past	Present	Condition
☐	☐	Aortic Aneurysm
☐	☐	High Blood Pressure
☐	☐	Angina
☐	☐	Heart Attack
☐	☐	Stroke
☐	☐	Asthma
☐	☐	Cancer
☐	☐	Tumor
☐	☐	Prostate Problems
☐	☐	Blood Disorder
☐	☐	Emphysema (chronic lung disorders)
☐	☐	Arthritis
☐	☐	Rheumatoid Arthritis
☐	☐	Diabetes
☐	☐	Epilepsy
☐	☐	Ulcer
☐	☐	Liver / Gallbladder Problems
☐	☐	Kidney Stones
☐	☐	Hepatitis
☐	☐	Bladder Infection
☐	☐	Kidney Disorders
☐	☐	Colitis
☐	☐	Irritable Colon
☐	☐	HIV/AIDS
☐	☐	Systemic Lupus
☐	☐	Other ______________________

If you or a family member has had any of the following, please mark the appropriate box:

- ☐ Cancer
- ☐ Rheumatoid Arthritis
- ☐ Diabetes
- ☐ Heart Problems
- ☐ Lung Problems
- ☐ High Blood Pressure
- ☐ Epilepsy
- ☐ Chronic Back Problems
- ☐ Chronic Headaches
- ☐ Lupus
- ☐ Joint Replacement (List): ____________________

Yes	No	
☐	☐	Do you have a permanent disability rating?
☐	☐	Location ____________________________
☐	☐	Date rating received ___/___/___
		Rating Percentage _____%

Please check any of the following that apply to you.

Past	Present	Item
☐	☐	Pregnancy
☐	☐	Birth Control Pills
☐	☐	Hormonal/Estrogen Replacement
☐	☐	Medications (please list) ____________________
☐	☐	Vitamins/Herbs ____________________
☐	☐	Hospitalization/Surgical Procedures (please list) ____________________

Past	Present	Item
☐	☐	Tobacco
☐	☐	Alcohol
☐	☐	Drug or Alcohol Dependence
☐	☐	Coffee/Tea/Caffeinated Soft Drinks: Cups/Cans per day ____________________

Current Height: ____ feet ____ inches **Weight:** _____ pounds

Doctor's additional comments/general health concerns: ____

____

____

Patient's signature: ________________________________ **Date** ___/___/___

OSWESTRY LOW BACK DISABILITY QUESTIONNAIRE

Instructions: this questionnaire has been designed to give us information as to how your back pain has affected your ability to manage everyday life. Please answer every section and mark in each section only the ONE box which applies to you at this time. We realize you may consider 2 of the statements in any section may relate to you, but please mark the box which most closely describes your current condition.

1. PAIN INTENSITY

- ☐ I can tolerate the pain I have without having to use pain killers
- ☐ The pain is bad but I manage without taking pain killers
- ☐ Pain killers give complete relief from pain
- ☐ Pain killers give moderate relief from pain
- ☐ Pain killers give very little relief from pain
- ☐ Pain killers have no effect on the pain and I do not use them

2. PERSONAL CARE (e.g. Washing, Dressing)

- ☐ 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 don't get dressed, I was with difficulty and stay in bed

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, i.e. 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

4. WALKING

- ☐ Pain does not prevent me walking any distance
- ☐ Pain prevents me walking more than one mile
- ☐ Pain prevents me walking more than ½ mile
- ☐ Pain prevents me walking more than ¼ mile
- ☐ I can only walk using a stick or crutches
- ☐ I am in bed most of the time and have to crawl to the toilet

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 ½ hour
- ☐ Pain prevents me from sitting more than 10 minutes
- ☐ Pain prevents me from sitting at all

6. STANDING

- ☐ I can stand as long as I want without extra pain
- ☐ I can stand as long as I want but it gives me extra pain
- ☐ Pain prevents me from standing for more than one hour
- ☐ Pain prevents me from standing for more than 30 minutes
- ☐ Pain prevents me from standing for more than 10 minutes
- ☐ Pain prevents me from standing at all

7. SLEEPING

- ☐ Pain does not prevent me from sleeping well
- ☐ I can sleep well only by using medication
- ☐ Even when I take medication, I have less than 6 hrs sleep
- ☐ Even when I take medication, I have less than 4 hrs sleep
- ☐ Even when I take medication, I have less than 2 hrs sleep
- ☐ Pain prevents me from sleeping at all

8. SOCIAL LIFE

- ☐ My social life is normal and gives 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, i.e. dancing, etc.
- ☐ 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 pain

9. TRAVELLING

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

10. EMPLOYMENT/ HOMEMAKING

- ☐ My normal homemaking/ job activities do not cause pain.
- ☐ My normal homemaking/ job activities increase my pain, but I can still perform all that is required of me.
- ☐ I can perform most of my homemaking/ job duties, but pain prevents me from performing more physically stressful activities (e.g. lifting, vacuuming)
- ☐ Pain prevents me from doing anything but light duties.
- ☐ Pain prevents me from doing even light duties.
- ☐ Pain prevents me from performing any job or homemaking chores.

NECK INDEX

Form N1-100

Patient Name:____ Date:______________

This questionnaire will give your provider information about how your neck condition affects your everyday life. Please answer every section by marking the one statement that applies to you. If two or more statements in one section apply, please mark the one statement that most closely describes your problem.

Pain Intensity

⓪ I have no pain at the moment.
① The pain is very mild at the moment.
② The pain comes and goes and is moderate.
③ The pain is fairly severe at the moment.
④ The pain is very severe at the moment.
⑤ The pain is the worst imaginable at the moment.

Sleeping

⓪ I have no trouble sleeping.
① My sleep is slightly disturbed (less than 1 hour sleepless).
② My sleep is mildly disturbed (1-2 hours sleepless).
③ My sleep is moderately disturbed (2-3 hours sleepless).
④ My sleep is greatly disturbed (3-5 hours sleepless).
⑤ My sleep is completely disturbed (5-7 hours sleepless).

Reading

⓪ I can read as much as I want with no neck pain.
① I can read as much as I want with slight neck pain.
② I can read as much as I want with moderate neck pain.
③ I cannot read as much as I want because of moderate neck pain.
④ I can hardly read at all because of severe neck pain.
⑤ I cannot read at all because of neck pain.

Concentration

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

Work

⓪ I can do as much work as I want.
① I can only do my usual work but no more.
② I can only do most of my usual work but no more.
③ I cannot do my usual work.
④ A can hardly do any work at all.
⑤ I cannot do any work at all.

Personal Care

⓪ I can look after myself normally without causing extra pain.
① I can look after myself normally but it causes extra pain.
② It is painful to look after myself and I am slow and careful.
③ I need some help but I manage most of my personal care.
④ I need help every day in most aspects of self care.
⑤ I do not get dressed, I wash with difficulty and stay in bed.

Lifting

⓪ I can lift heavy weights without extra pain.
① I can lift heavy weights but it causes extra pain.
② Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned (e.g., on a table).
③ Pain prevents me from lifting heavy weights off the floor, but I can manage light to medium weights if they are conveniently positioned.
④ I can only lift very light weights.
⑤ I cannot lift or carry anything at all.

Driving

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

Recreation

⓪ I am able to engage in all my recreation activities without neck pain.
① I am able to engage in all my usual recreation activities with some neck pain.
② I am able to engage in most but not all of my usual recreation activities because of neck pain.
③ I am only able to engage in a few of my usual recreation activities because of neck pain.
④ I can hardly do any recreation activities because of neck pain.
⑤ I cannot do any recreation activities at all.

Headaches

⓪ I have no headaches at all.
① I have slight headaches with come infrequently.
② I have moderate headaches which come infrequently.
③ I have moderate headaches which come frequently.
④ I have severe headaches which come frequently.
⑤ I have headaches almost all the time.

Neck Index Score: ______

Index Score = [Sum of all statements selected / (# of sections with a statement selected x 5)] x 100