Neck Index

ACN Group, Inc. Form NI-100

ACN Group, Inc. Use Only rev 3/27/2003

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 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 I 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 car 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 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 which 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.

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

Neck Index Score _____

Patient Health Questionnaire - PHQ

ACN Group, Inc. - Form PHQ-202

ACN Group, Inc. Use Only rev 7/18/05

Patient Name _____ **Date** _____

1. Describe your symptoms _____

_____

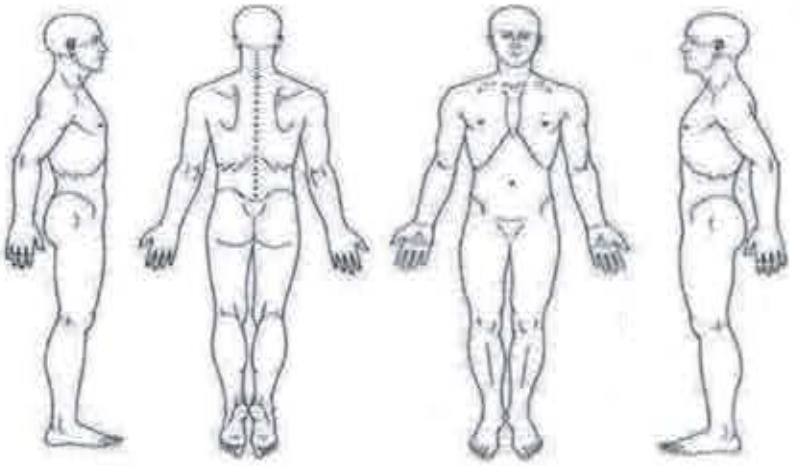
a. When did your symptoms start? _____

b. How did your symptoms begin? _____

2. How often do you experience your symptoms?

① Constantly (76-100% of the day)
② Frequently (51-75% of the day)
③ Occasionally (26-50% of the day)
④ Intermittently (0-25% of the day)

Indicate where you have pain or other symptoms



3. What describes the nature of your symptoms?

① Sharp ④ Shooting
② Dull ache ⑤ Burning
③ Numb ⑥ Tingling

4. How are your symptoms changing?

① Getting Better
② Not Changing
③ Getting Worse

5. During the past 4 weeks:

a. Indicate the average intensity of your symptoms

None ⓪ ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩ Unbearable

b. How much has pain interfered with your normal work (including both work outside the home, and housework)

① Not at all ② A little bit ③ Moderately ④ Quite a bit ⑤ Extremely

6. During the past 4 weeks how much of the time has your condition interfered with your social activities?
(like visiting with friends, relatives, etc)

① All of the time ② Most of the time ③ Some of the time ④ A little of the time ⑤ None of the time

7. In general would you say your overall health right now is...

① Excellent ② Very Good ③ Good ④ Fair ⑤ Poor

8. Who have you seen for your symptoms?

① No One
② Chiropractor
③ Medical Doctor
④ Physical Therapist
⑤ Other

a. What treatment did you receive and when? _____

b. What tests have you had for your symptoms and when were they performed?

① Xrays *date:* _____ ③ CT Scan *date:* _____
② MRI *date:* _____ ④ Other *date:* _____

9. Have you had similar symptoms in the past? ① Yes ② No

a. If you have received treatment in the past for the same or similar symptoms, who did you see?

① This Office
② Chiropractor
③ Medical Doctor
④ Physical Therapist
⑤ Other

10. What is your occupation?

① Professional/Executive
② White Collar/Secretarial
③ Tradesperson
④ Laborer
⑤ Homemaker
⑥ FT Student
⑦ Retired
⑧ Other

_____

a. If you are not retired, a homemaker, or a student, what is your current work status?

① Full-time
② Part-time
③ Self-employed
④ Unemployed
⑤ Off work
⑥ Other

Patient Signature _____ **Date** _____

Below are a list of diseases which may seem unrelated to the purpose of your appointment. However these questions must be answered carefully as these problems can affect your overall course of care.

CHECK ANY OF THE FOLLOWING DISEASES YOU HAVE HAD:

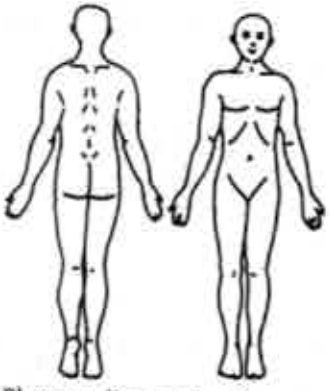
- ❑ ALS
- ❑ Anemia
- ❑ Arthritis
- ❑ Cancer:
  Type:_____
- ❑ Chicken Pox
- ❑ Crohn's
- ❑ Diabetes insulin dependent non-insulin dependent
- ❑ Eczema
- ❑ Epilepsy
- ❑ Heart Disease
- ❑ HIV
- ❑ Lymes Disease
- ❑ Lupus
- ❑ Measles
- ❑ Mental Disorders
  Type:_____
- ❑ MS
- ❑ Mumps
- ❑ Influenza
- ❑ Parkinson's
- ❑ Pleurisy
- ❑ Pneumonia
- ❑ Polio
- ❑ Rheumatic Fever
- ❑ Rheumatoid Arthriti
- ❑ Small Pox
- ❑ Stroke
- ❑ Tuberculosis
- ❑ Whooping Cough
- ❑ Thyroid hyper / hypo
- ❑ Other: _____

INTAKE

- ❑ Caffeinated Beverages _____ per day
- ❑ Alcohol: Amt _____ day /wk/ mo
- ❑ Cigarettes: Amt _____

CHECK ANY OF THE FOLLOWING YOU HAVE HAD IN THE PAST 6 MONTHS:

- ❑ Abdominal Cramps
- ❑ Allergies _____
  _____
- ❑ Ankle Swelling
- ❑ Arm Pain
- ❑ Black/Bloody Stool_____
- ❑ Bladder Trouble
- ❑ Breast Pain/Lumps
- ❑ Chest Pain
- ❑ Cold Extremities
- ❑ Colitis
- ❑ Confusion
- ❑ Constipation
- ❑ Convulsions
- ❑ Dental Problems
- ❑ Depression
- ❑ Diarrhea
- ❑ Difficult Chewing/ Clicking Jaw
- ❑ Discolored Urine
- ❑ Dizziness
- ❑ Ear Aches
- ❑ Excessive Appetite
- ❑ Excessive Thirst
- ❑ Excessive Urination
- ❑ Fainting
- ❑ Fatigue
- ❑ Fever
- ❑ Forgetfulness
- ❑ Frequent Nausea
- ❑ Gall Bladder Problems
- ❑ Gas/Bloating After Meals
- ❑ General Stiffness
- ❑ Headaches
- ❑ Hearing Difficulty
- ❑ Heartburn
- ❑ Heart Problems
- ❑ Hemorrhoids
- ❑ High Blood Pressure
- ❑ Irregular Heartbeat
- ❑ Joint Pain/Stiffness
- ❑ Liver Problems
- ❑ Loss of Sleep
- ❑ Low Back Pain
- ❑ Lung Problems/Congestion
- ❑ Menstrual Cramps
- ❑ Menstrual Irregularity
- ❑ Neck Pain
- ❑ Nervous
- ❑ Numbness
- ❑ Pain Between Shoulders
- ❑ Painful Urination
- ❑ Paralysis
- ❑ Poor Appetite
- ❑ Prostate Problems
- ❑ Sexual Dysfunction
- ❑ Stress
- ❑ Short Breath
- ❑ Stroke
- ❑ Sore Throat
- ❑ Stuffed Nose
- ❑ Tingling Extremities
- ❑ Unexplained Weight Gain
- ❑ Unexplained Weight Loss
- ❑ Vaginal Pain/Infection
- ❑ Varicose Veins
- ❑ Vision Problems
- ❑ Vomiting
- ❑ Walking Problems
- ❑ Other Problems:
  _____
  _____
  _____



Please outline on the diagram the area of your discomfort

FAMILY HISTORY

Place an (X) if any family members has suffered from:

- ❑ Allergy
- ❑ Epilepsy
- ❑ Gout
- ❑ High Blood Pressure
- ❑ Mental Illness
- ❑ MS
- ❑ Kidney Disease
- ❑ Rheumatoid Arthritis
- ❑ Tuberculosis
- ❑ Arthritis
- ❑ Cancer who _____ type _____
- ❑ Diabetes who _____ type _____
- ❑ Heart Attack who _____
- ❑ Lupus
- ❑ Migraines who _____
- ❑ Parkinson's
- ❑ Spinal Disorder who _____ type _____
- ❑ Other, list _____

FEMALES ONLY

When was your last period?

_____

Are you on oral contraceptives?

❑ Yes ❑ No

Are you pregnant?

❑ Yes ❑ No ❑ Not Sure

Patient (Parent) Signature: _____ Date: _____

Confidential Patient Health Record DATE: _____

PERSONAL HISTORY

Name: _____ Address: _____
City: _____ State: _____ Zip _____
Home Phone: _____ Cell Phone: _____ Birth Date: _____ Age: ____ Sex: ❑ M ❑ F
Social Security: _____ Driver's License Number: _____
Circle One: Married Single Widowed Divorced Separated E-mail: _____
Business Employer: _____
Business Phone: _____ Type of Work: _____
Name of Spouse (Parent): _____ Spouse's (Parent) Social Security #: _____
Spouse's (Parent) Employer: _____ Business Phone: _____
Type of Work: _____ Ages of Children _____
How Did You Hear About Our Office? _____
Name of Emergency Contact: _____ Phone: _____ Relationship: _____
Who Is Responsible For Your Bill, You and ❑ Spouse ❑ Workers' Comp. ❑ Auto Insurance ❑ Medicare
❑ Personal Health Insurance (Name) _____ ❑ Health Card # _____
Insured Person's Name _____ Date of Birth _____

CURRENT HEALTH CONDITION

Unwanted Health Condition _____
Other Doctors Seen For This Condition: ❑ Yes ❑ No _Who? _____
Type of Treatment: _____ Results: _____
When Did This Condition Begin? _____ Has This Condition Occurred Before? ❑ Yes ❑ No
Is Condition: ❑ Job Related ❑ Auto Accident ❑ Home Injury ❑ Fall ❑ Other: _____
Date of Accident: _____ Time of Accident: _____
Have You Made A Report of Your Accident To Your Employer: ❑ Yes ❑ No
Drugs You Now Take: ❑ Nerve Pills ❑ Pain Killers/Muscle Relaxers ❑ Blood Pressure Medicine
❑ Insulin ❑ Other _____
Do You Wear A Shoe Lift? ❑ Yes ❑ No
Do You Suffer From Any Condition Other Than That Which You Are Now Consulting Us? _____
_____

PAST HEALTH HISTORY

Please Check and Describe:
Major Surgery/Operations: ❑ Pacemaker ❑ Appendectomy ❑ Tonsillectomy ❑ Gall Bladder ❑ Heart Surgery
❑ Hernia ❑ Back Surgery ❑ Broken Bones ❑ Other _____
Major Accident or Falls: _____
_____
Hospitalization (Other Than Above): _____
_____
Previous Chiropractic Care: ❑ None ❑ Doctor's Name & Approximate Date of Last Visit _____

Back Index

ACN Group, Inc. Form BI-100

ACN Group, Inc. Use Only rev 3/27/2003

Patient Name _____ **Date** _____

This questionnaire will give your provider information about how your back 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 The pain comes and goes and is very mild.
① The pain is mild and does not vary much.
② The pain comes and goes and is moderate.
③ The pain is moderate and does not vary much.
④ The pain comes and goes and is very severe.
⑤ The pain is very severe and does not vary much.

Sleeping

⓪ I get no pain in bed.
① I get pain in bed but it does not prevent me from sleeping well.
② Because of pain my normal sleep is reduced by less than 25%.
③ Because of pain my normal sleep is reduced by less than 50%.
④ Because of pain my normal sleep is reduced by less than 75%.
⑤ Pain prevents me from sleeping at all.

Sitting

⓪ I can sit in any chair as long as I like.
① I can only sit in my favorite chair as long as I like.
② Pain prevents me from sitting more than 1 hour.
③ Pain prevents me from sitting more than 1/2 hour.
④ Pain prevents me from sitting more than 10 minutes.
⑤ I avoid sitting because it increases pain immediately.

Standing

⓪ I can stand as long as I want without pain.
① I have some pain while standing but it does not increase with time.
② I cannot stand for longer than 1 hour without increasing pain.
③ I cannot stand for longer than 1/2 hour without increasing pain.
④ I cannot stand for longer than 10 minutes without increasing pain.
⑤ I avoid standing because it increases pain immediately.

Walking

⓪ I have no pain while walking.
① I have some pain while walking but it doesn't increase with distance.
② I cannot walk more than 1 mile without increasing pain.
③ I cannot walk more than 1/2 mile without increasing pain.
④ I cannot walk more than 1/4 mile without increasing pain.
⑤ I cannot walk at all without increasing pain.

Personal Care

⓪ I do not have to change my way of washing or dressing in order to avoid pain.
① I do not normally change my way of washing or dressing even though it causes some pain.
② Washing and dressing increases the pain but I manage not to change my way of doing it.
③ Washing and dressing increases the pain and I find it necessary to change my way of doing it.
④ Because of the pain I am unable to do some washing and dressing without help.
⑤ Because of the pain I am unable to do any washing and dressing without help.

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.
③ Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned (e.g., on a table).
④ Pain prevents me from lifting heavy weights off the floor, but I can manage light to medium weights if they are conveniently positioned.
⑤ I can only lift very light weights.

Traveling

⓪ I get no pain while traveling.
① I get some pain while traveling but none of my usual forms of travel make it worse.
② I get extra pain while traveling but it does not cause me to seek alternate forms of travel.
③ I get extra pain while traveling which causes me to seek alternate forms of travel.
④ Pain restricts all forms of travel except that done while lying down.
⑤ Pain restricts all forms of travel.

Social Life

⓪ My social life is normal and gives me no extra pain.
① My social life is normal but increases the degree of pain.
② Pain has no significant affect on my social life apart from limiting my more energetic interests (e.g., dancing, etc).
③ Pain has restricted my social life and I do not go out very often.
④ Pain has restricted my social life to my home.
⑤ I have hardly any social life because of the pain.

Changing degree of pain

⓪ My pain is rapidly getting better.
① My pain fluctuates but overall is definitely getting better.
② My pain seems to be getting better but improvement is slow.
③ My pain is neither getting better or worse.
④ My pain is gradually worsening.
⑤ My pain is rapidly worsening.

Back Index Score _____