Neurology Consultants of Arizona

WORK INJURY QUESTIONNAIRE

PATIENT NAME: _____ DATE: _____

Date of Birth: _____ ❑Male ❑Female | Height: _____ Weight: _____ lbs.

DATE OF WORK INJURY: _____ Time of Day of Injury: _____

Have you retained an ATTORNEY? ❑Yes ❑No NAME: _____

EMPLOYER'S NAME: _____

WORK COMP INSURANCE COMPANY NAME: _____

WORK COMP CLAIM #: _____ POLICY #: _____

Were you examined by a MEDICAL PROVIDER RECOMMENDED BY YOUR EMPLOYER

❑Yes ❑No | If YES, LIST NAME: _____ DATE(S) SEEN: _____

OTHER MEDICAL CARE RECEIVED (OTHER THAN WHERE EMPLOYER SENT YOU):

❑Yes ❑No | If YES, LIST NAME: _____ DATE(S) SEEN: _____

DESCRIBE HOW INJURY OCCURRED: _____

_____

_____

COMPLETE THE ● QUESTIONS IF YOU WERE DRIVING A VEHICLE WHEN INJURED:

- ●Type of Injury: ❑Rear-End Collision ❑Head-On Collision ❑Broad-Side Collision
- ●Were you the: ❑Driver ❑Passenger | ❑Front Seat ❑B ack Seat
- ●Was your vehicle moving at the time of the crash? ❑Yes ❑No | Estimated Speed _____ mph
- ●How fast was the AT-FAULT VEHICLE traveling at time of the crash? Estimated Speed _____ mph
- ●Did you brace for impact? ❑ Yes ❑No | Were you wearing your seatbelt? ❑Yes ❑No
- ●Position of your head at the time of impact? ❑Head turned | Looking ❑forward ❑back
- ●Do you recall striking your head or other body part at impact? ❑Yes ❑No | Describe: _____
- ●Were you taken by ambulance to the hospital? ❑ Yes ❑No Hospital Name: _____

CHECK INJURIES / SYMPTOMS APPARENT SINCE THE WORK INJURY:

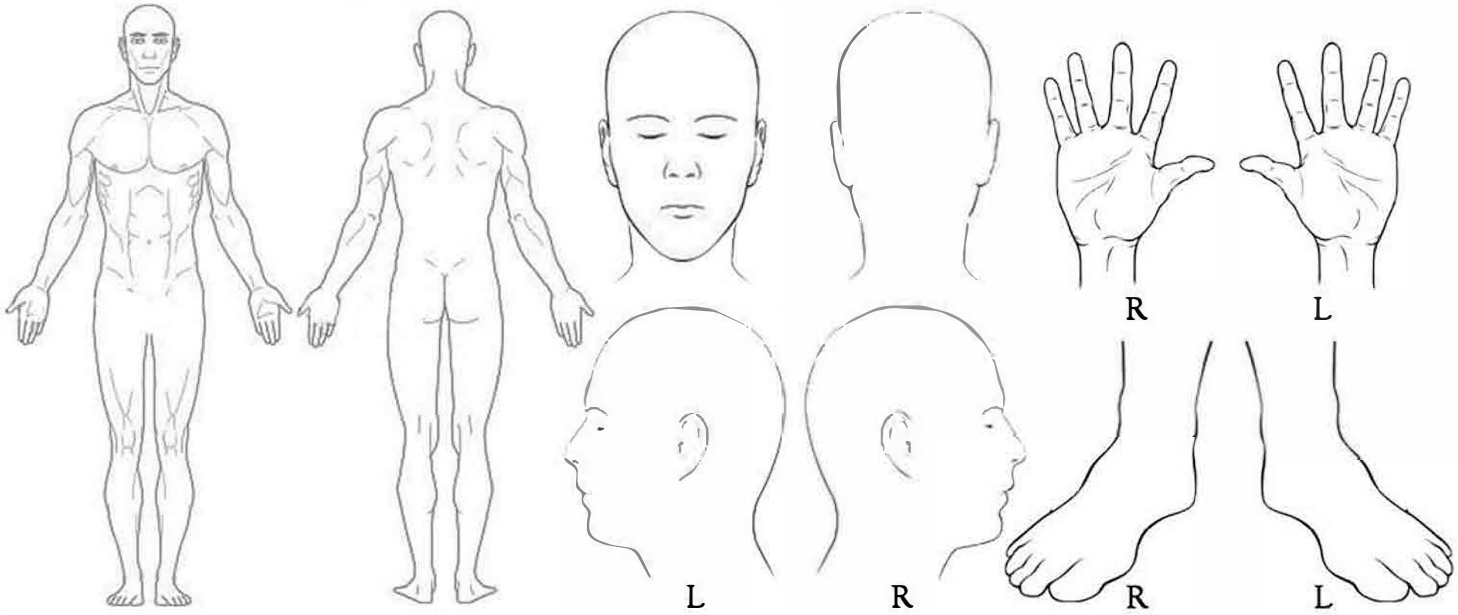
❑Headaches	❑Visual Disturbance	❑Irritability	❑Anxiety/Depression
❑Neck Pain	❑Arm Pain	❑Dizziness	❑Lack of Coordination
❑Mid Back Pain	❑Leg Pain	❑Lightheaded	❑Difficulty Concentrating
❑Low Back Pain	❑Shoulder Pain	❑Ear Ringing	❑Difficulty with Walking
❑Hip Pain	❑Bowel/Bladder Issues	❑Jaw Pain	❑Sleep Disturbance

❑Bruising/Abrasions - Location(s): _____ ❑OTHER: _____

Neurology Consultants of Arizona

WORK INJURY QUESTIONNAIRE (PAGE 2)

PLEASE MARK ALL AREAS OF COMPLAINT SINCE THE WORK INJURY



MARK: CIRCLE = AREAS OF PAIN, X = AREAS OF NUMBNESS,
Z = AREAS OF TINGLING, W = AREAS OF WEAKNESS,
C = BRUISING/CONTUSIONS/ABRASIONS

Did you have any of the current physical complaints BEFORE the work injury? ❑ Yes ❑ No

If YES, Explain: _____

Have you lost time from work as a result of this injury? ❑ Yes ❑ No

If YES, please complete: Last day worked:_____

If back to work - how many days did you miss?_____ How many days on light duty?_____

If working at this time, please complete:

*If 0% is no capacity/unable to perform and 100% is full capacity (normal) with no restrictions, please list your % work ability since the work injury:_____ %

Please list THREE activities of daily living that have been affected since the injury (duties under duress):

(for example: unable to play with kids, unable to drive, unable to do laundry, etc.)

1)_____ 2)_____ 3)_____

Patient's Printed Name:_____

Patient's Signature:_____ Date:_____

Neurology Consultants of Arizona

Patient Name: _____
Date of Birth: _____
Date of Loss: _____

I, _____, do hereby consent to receiving medical services from Neurology Consultants of Arizona which includes any assigned employee(s) or independent contractor(s) of Neurology Consultants of Arizona, and Dr. Luay Shayya.

For good and valuable consideration received authorize and direct the insurance company (1st party - medical payment benefits, personal injury protection, and/or un/under-insured coverage; and/or 3rd party coverage - e.g., at-fault insurance company; and/or other covered insurance) to pay directly to Neurology Consultants of Arizona any sums as may be due and owing this office for services rendered me, by reason of this accident, and to withhold such sums from any disability benefits, medical payment benefits, no-fault benefits, health and/or accident benefits, workers compensation benefits, or any other insurance benefits or reimbursement whatsoever for which you may be obligated to reimburse me, or from any settlement, judgment or verdict on my behalf as may be necessary to adequately protect said Neurology Consultants of Arizona.

I hereby authorize and direct my attorney and/or legal firm (if represented) to pay directly to Neurology Consultants of Arizona such sums as may be due and owing for medical services rendered me by reason of this accident and to withhold such sums from any settlement, judgment, or verdict as may be necessary to adequately protect Neurology Consultants of Arizona. I hereby further give a lien on my case to Neurology Consultants of Arizona against any and all proceeds of any settlement or judgment that may be paid to my attorney(s) or myself as the result of injuries in connection herewith. I understand that no settlement, verdict, or judgment proceeds can be dispersed to me without first satisfying this lien. I agree to fully protect Neurology Consultants of Arizona by disallowing the use of the common/general fund dispersal and/or a reduction based upon LaBombard v. Samaritan Health System (195 AZ 543, 991 P.2d App. 1998) or Andrews v. Samaritan Health System (201 AZ 379, 36 P.3d 57 App. 2001).

In consideration for Neurology Consultants of Arizona waiting for payment, including but not limited to any applicable co-payments, co-insurance, or deductibles, this lien is irrevocable and can only be satisfied by full payment of all sums due for medical services rendered. I understand and authorize the use of balance billing, if Neurology Consultants of Arizona deems necessary, to be utilized in order to acquire the balance owed. I understand that Neurology Consultants of Arizona can, at any time, request the balance owed to be paid and if the balance is not paid when requested, Neurology Consultants of Arizona may use any collection method available to help secure the outstanding balance.

I fully understand that I remain directly and fully responsible to Neurology Consultants of Arizona for all medical bills submitted for services rendered me and on my behalf in preparing my case for trial or settlement and that this agreement is made solely for Neurology Consultants of Arizona's additional protection and in consideration of Neurology Consultants of Arizona waiting for payment. I direct that this lien will remain valid even if I change attorneys or choose to represent myself regarding my claim(s).

_____ _____
Patient Signature Date Signed

ASSIGNMENT OF HEALTH-CARE-INSURANCE RECEIVABLES, UCC LIEN, & AUTHORIZATION FOR DIRECT PAYMENTS BY MY PAYERS TO NEUROLOGY CONSULTANTS OF ARIZONA

1. My name is: _____. This agreement is a legally binding enforceable agreement, called an "assignment." This assignment will refer to me as "Patient."

2. I am, or soon will be, a Patient of **Neurology Consultants of Arizona,** an Arizona medical clinic that this assignment will refer to as "Doctor."

3. This assignment will refer to my insurance company as "Insurer." (This assignment also applies to all other health-care insurance companies that have a duty to pay for any health-care services for me. So the word "Insurer" refers to all of those companies as well).

4. My health-care insurance covers all or part of the medical and other health-care services and goods that Doctor has provided – or will provide –for me. This assignment will refer to those medical and related health-care services and goods as "Services."

5. I understand that, under my contract with Insurer, I have a right to require that Insurer pay for all or part of the Services. I might be able to have Insurer pay me or someone else for the Services, and I would then need to pay that same money to Doctor.

6. Instead of paying me or someone else for the Services, I understand I have the right to require my Insurer to pay Doctor for the Services directly. I understand that this is called "assigning" or "making an assignment." I also understand that Section 47-9408 of the Arizona Revised Statutes gives me the right to make that assignment to Doctor.

7. I understand that the word "receivables" means money that one person or company owes to another person or another company.

8. With these understandings, I assign to Doctor all of my rights to have my Insurer pay for the Services. I direct and require my Insurer to pay Doctor for those Services directly, instead of paying me or anyone else. I authorize Doctor to submit Doctor's bills for the Services directly to Insurer, which must then pay Doctor directly, instead of paying me or anyone else other than Doctor. Let me make this clear: Insurer is to pay Doctor directly for the Services, not me or anyone else.

9. I understand that health-care insurance companies do not always do what their customers tell them to do. I thus agree to cooperate fully with Doctor if Doctor must take administrative, legal, or other action to force Insurer to honor the terms of this assignment. I give to Doctor my full permission and legal right to enforce this assignment against Insurer or anyone else – and to enforce the terms of my health-care insurance contract and health-care insurance policy as needed to force Insurer to pay Doctor for the Services directly.

10. To help Doctor enforce this assignment, I authorize Doctor to file this assignment with the Arizona Secretary of State, County Recorder, and to record it elsewhere. I authorize Doctor to enforce this assignment under the terms of the Arizona Uniform Commercial Code or Arizona statutory law. I understand that this assignment is a "lien," that is, a legal and enforceable right for Doctor to obtain health-care insurance money for the Services from Insurer or from anyone else (including me) who has received (or may receive) that health-care insurance money.

11. To collect under this assignment, Doctor may need information from Insurer. I direct and order Insurer to immediately give any information to Doctor that Doctor requests and to immediately give to Doctor any documents of any kind that Doctor requests. I understand that I may have privacy rights in some or all of the documents or information. I waive all of those privacy rights. I want Doctor to have full access to all information and documents from Insurer with no delays or restrictions.

12. To collect under this assignment, Doctor may need to reveal or provide information or documents about me, including chiropractic, medical, and/or physical therapy bills and records. I understand that I may have privacy rights in the information and documents. I waive all of those privacy rights.

13. I may have a lawyer representing me because I was injured. I will refer to that lawyer and his or her law firm as "Attorney." It is possible that Insurer intends to pay, or might have paid, health-care insurance money to Attorney as part of a settlement, award, verdict, or judgement. I order Attorney to pay that money to Doctor directly, fully, and immediately. I order Attorney to give any health-insurance money to Doctor with no deductions or reductions of any kind, unless Doctor agrees to them in advance.

14. I want this assignment to be as strong as possible and for Doctor to be able to enforce it as strongly as Arizona law allows. I agree that no one can evade, revoke, or change this assignment unless Doctor agrees to that. If a court, judge, or official ever rules that any part of this assignment is invalid, illegal, or unenforceable, on that part will be affected. The rest of the assignment will remain valid, legal, and enforceable.

15. The laws of the State of Arizona control this assignment and its interpretation. If there is ever any dispute over this assignment, I agree to personal jurisdiction and venue over the dispute in Maricopa County Superior Court. I understand that legal disputes can have time limits called "statutes of limitations." I waive any statute of limitations that might apply to this assignment.

16. I am making this assignment to make it possible to obtain Services from Doctor. I have had the opportunity to obtain legal advice about this assignment. I have read it fully and carefully, understand its terms, and am signing it knowingly and voluntarily.

_____ _____

Patient Signature Date

Neurology Consultants of Arizona

NEW PATIENT REGISTRATION

EMAIL:_____

Name:_____ ❑MALE ❑FEMALE

Address:_____ _____
Street City, State, Zip Code

Birth Date:_____ Age:_____ SSN:_____

Home Ph Number:_____ Cell Ph Number:_____

Employment Status: ❑Employed ❑Student ❑Homemaker

Occupation:_____ Employer:_____

RESPONSIBLE PARTY INFORMATION

(not required if insurance card has been copied by the front desk)

Name (Guarantor):_____

Relationship to Patient:_____

Insurance Co:_____

Policy Number:_____ Group Number:_____

Insurance Address/Phone:_____

As a service we can provide diagnosis and treatment info to your primary care physician (PCP). If you would like us to provide this info please check the YES box and initial. ❑YES / ____ (initials) / PCP NAME:_____

PATIENT AGREEMENT AND ASSIGNMENT OF BENEFITS

I, the undersigned, authorize the release of any information including diagnosis and the records of any treatment rendered to me or those I am responsible for during the period of such care to third party payers, other health practitioners, and/or legal representation. I authorize and request my insurance company and/ or legal representation to pay directly to Neurology Consultants of Arizona all medical benefits payable for service rendered. I authorize the use of this signature on all my insurance submissions and to obtain records. I agree to pay all charges for medical and health care services not covered by my insurance company. **By signing below I certify that I have read this form & Patient Agreement / Assignment of Benefits and understand its content.**

_____ _____

Signature of Patient or Other Legally Authorized Person Date Signed

INDUSTRIAL COMMISSION OF ARIZONA
800 W WASHINGTON STREET
PHOENIX, ARIZONA 85007
(602) 542-4661
WORKER'S & PHYSICIAN'S REPORT OF INJURY

IMMEDIATELY UPON COMPLETION PLEASE MAIL COPIES AS SHOWN BELOW

INJURED WORKER'S RIGHT TO CHOOSE DOCTOR

An employer who is not self-insured can direct you to a doctor of their choice for ONE visit. After the **ONE** visit, you may report to a doctor of your choice. **REMEMBER:** If you make a **SECOND** visit to the employer's doctor, you have established that doctor as your treating doctor. If your employer is self-insured, you may not be allowed to change doctors. **SEE INFORMATION SHEET ATTACHED TO THIS FORM FOR FURTHER INSTRUCTIONS.**

WORKER'S REPORT

NAME OF INJURED WORKER
LAST NAME FIRST M.I.

SOCIAL SECURITY NO.

PHONE NO.

ICA USE ONLY
INJURY CODE: _____

1.

2. ADDRESS CITY STATE ZIP

3. DATE OF BIRTH 4. SEX: MALE ○ FEMALE ○

5. SINGLE ○ WIDOWED ○ DIVORCED ○ MARRIED ○ IF SO, IS SPOUSE EMPLOYED YES ○ NO ○

6. OCCUPATION WHEN INJURED DATE OF INJURY TIME OF INJURY

7. EMPLOYER SUPERVISOR PHONE NO.

8. OFFICE ADDRESS CITY STATE ZIP

9. EMPLOYER'S INSURANCE CARRIER POLICY NO.

10. MAILING ADDRESS

11. DESCRIBE **WHERE** AND **HOW** ACCIDENT OR CAUSE OF DISABILITY OCCURRED (INCLUDING LOCATION AND/OR DEPARTMENT)

BY THIS INSTRUMENT I MAKE APPLICATION FOR ALL BENEFITS TO WHICH I MAY BE ENTITLED UNDER THE LAW AND I DO HEREBY CERTIFY, WITH FULL KNOWLEDGE THAT IT IS A CRIME TO MAKE WILLFUL, FALSE STATEMENTS TO OBTAIN COMPENSATION, THAT ALL OF MY STATEMENTS ON THIS FORM ARE TRUE, ACCURATE AND COMPLETE. I UNDERSTAND I MUST FOLLOW THE INSTRUCTIONS OF MY DOCTOR AND MUST HAVE WRITTEN APPROVAL FROM THE INDUSTRIAL COMMISSION TO LEAVE THE STATE OF ARIZONA OR MY LOCALITY FOR MORE THAN 14 DAYS, FAILURE TO DO SO MAY CAUSE FORFEITURE OF COMPENSATION BENEFITS.

WORKER EMAIL ADDRESS DATE OF SIGNING AT CITY STATE

EMPLOYER EMAIL ADDRESS

IMPORTANT: INJURED WORKER'S SIGNATURE REQUIRED HERE **X** _____

PHYSICIAN'S INITIAL REPORT

12. DATE FIRST TREATMENT HOUR 13. LOCATION: HOSPITAL ○ OFFICE ○ OTHER ○

14. DATE WORKING DISABILITY BEGAN 15. WHO ENGAGED YOUR SERVICES? PATIENT ○ EMPLOYER ○ OTHER ○

16. WAS PATIENT TREATED BY ANYONE ELSE? YES ○ NO ○ IF YES, BY WHOM?

17. COMPLAINTS AND PHYSICAL FINDINGS IN DETAIL:

18. ICD- CODE : DIAGNOSIS:

19. DESCRIBE ANY PRE-EXISTING IMPAIRMENT OR DISEASE AFFECTING PRESENT CONDITION

20. PATIENT IS RIGHT ○ LEFT ○ HANDED

21. DESCRIBE TREATMENT GIVEN BY YOU:

22. WERE X-RAYS TAKEN? YES ○ NO ○ IF YES, BY WHOM? WHEN

23. WAS LABORATORY WORK DONE? YES ○ NO ○ IF YES, BY WHOM WHEN

24. X-RAY DIAGNOSIS (ATTACH ROENTGENOLOGICAL REPORT FORM)

25. WAS PATIENT HOSPITALIZED? YES ○ NO ○ IF YES, WHERE

26. DATE OF ADMISSION TO HOSPITAL 27. DATE OF DISCHARGE

28. IS FURTHER TREATMENT NEEDED? YES ○ NO ○ IF YES, FOR HOW LONG

29. IS PATIENT, AS A RESULT OF CONDITIONS DUE TO THIS ACCIDENT: (A) SUBJECT TO SUSTAIN A PERMANENT DEFECT OF IMPAIRMENT? YES ○ NO ○

(B) ABLE TO DO THE SAME TYPE OF WORK HE PERFORMED AT TIME OF INJURY? YES ○ NO ○ IF YES, DATE ABLE IF NOT, ANTICIPATED DATE

(C) ABLE TO DO A LIGHTER OR DIFFERENT TYPE OF WORK THAN PERFORMED AT TIME OF INJURY? YES ○ NO ○ IF YES, DATE ABLE

IF NOT, ANTICIPATED DATE ABLE

30. REMARKS:

NAME OF PHYSICIAN BILLING CODE NO.

ADDRESS ZIP PHONE

IRS. NO. PROFESSIONAL CORP? YES ○ NO ○

DATE OF THIS REPORT PHYSICIAN'S SIGNATURE REQUIRED HERE **X** _____

THIS FORM APPROVED BY THE INDUSTRIAL COMMISSION OF ARIZONA FOR CARRIER USE.

Neurology Consultants of Arizona
Records Release Form

Return Fax: 480-977-6845

MEDICAL AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

I hereby voluntarily authorize the use and/or disclosure of my health information as described below, to the requestor. This information will be used on my behalf for health care provider review. To the extent that action has been taken in reliance of this authorization, I understand that I may revoke this authorization at any time by giving written notice to this provider. Unless revoked earlier, this authorization will terminate upon the fulfillment of the below stated purpose. I understand that I have the right to inspect the information to be disclosed upon the proper notification to and under conditions established by Provider. I also understand that I may receive a copy of this form. I authorize that a photocopy of this assignment shall be considered as valid and effective as the original.

INSTRUCTIONS: Make sure all blanks are filled in. Failure to do so may prevent or delay release of information.

PATIENT IDENTIFICATION:

NAME: _____

DATE OF BIRTH: _____

PREVIOUS NAME(S): _____

PROVIDER:

- [X] ALL PHYSICIANS
- [X] ALL HOSPITALS
- [X] ALL OTHER HEALTH CARE PROVIDERS WHO HAVE PROVIDED TREATMENT, CARE, OR BENEFITS TO THE ABOVE-NAMED PATIENT.

REQUESTOR:

Neurology Consultants of Arizona
7425 E Shea Blvd, Suite 114
Scottsdale, AZ 85260

INFORMATION REQUESTED

- [X] Please fax or send the complete records in the possession of Provider and/or Its Agent
- [ ] Please fax or send records from the dates of _____ through _____
- [ ] Specific Information (Please specify) _____

ACCORDING TO A.R.S. §1401(27)(RR) THESE RECORDS MUST BE MADE PROMPTLY AVAILABLE

_____ _____

Signature of Patient or Authorized Representative Date Signed

Neurology Consultants of Arizona

INFORMED CONSENT TO MEDICAL / PHYSICAL THERAPY TREATMENT

I hereby request and consent to the performance of medical, chiropractic, and physical therapy procedures, including examination tests, diagnostic x-ray(s) and physical therapy techniques, chiropractic adjustments on me (or on the patient named below for which I am legally responsible) which are recommended by the doctors of medicine, chiropractic, physical therapists, massage therapists, and/or assistants that are associated with Neurology Consultants of Arizona.

I understand that, as with any health care procedure, there are certain complications, which may arise during medical, physical therapy, and/or chiropractic treatment (e.g., an "adjustment" or manipulation). Those complications include but are not limited to: soreness, fractures, disc injuries, dislocations, and strain/ sprains. Some types of manipulation of the neck have been associated with injuries to the arteries in the neck leading to or contributing to serious complications including stroke. I do not expect the doctor to be able to anticipate all risks and complications and I wish to rely on the doctor to exercise judgment during the course of the procedure(s) which the doctor feels at the time, based upon the facts then known, are in my best interest.

I have had an opportunity to discuss with a doctor and/or a therapist at Neurology Consultants of Arizona the nature, purpose and risks of the recommended procedures and have had my questions answered to my satisfaction. I also understand that there is no guarantee or warranty for a specific cure or result.

I have read or have had read to me the above explanation of the medical, chiropractic, and physical therapy related treatment. 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. Having been informed of the risks, I hereby give my consent to that treatment. I intend this consent form to cover the entire course of treatment for my present condition and for any future conditions for which I seek treatment.

DO NOT SIGN UNTIL YOU HAVE READ AND UNDERSTAND THE ABOVE.

_____ _____

PATIENT SIGNATURE OR LEGAL GUARDIAN DATE

_____

PRINTED NAME OF PATIENT

Neurology Consultants of Arizona

PATIENT CONSENT
FOR USE AND/OR DISCLOSURE OF PROTECTED HEALTH INFORMATION TO CARRY OUT TREATMENT, PAYMENT AND HEALTHCARE OPERATIONS

_____ hereby states that by signing this Consent, I acknowledge and agree as follows:

1. Neurology Consultants of Arizona Privacy Notice has been provided to me prior to my signing this Consent. The Privacy Notice includes a complete description of the uses and/or disclosures of my protected health information ("PHI") necessary for Neurology Consultants of Arizona to provide treatment to me, and also necessary for Neurology Consultants of Arizona to obtain payment for that treatment and to carry out its health care operations. Neurology Consultants of Arizona explained to me that the Privacy Notice will be available to me in the future at my request. Neurology Consultants of Arizona has further explained my right to obtain a copy of the Privacy Notice prior to signing this Consent, and has encouraged me to read the Privacy Notice carefully prior to my signing this Consent.

2. Neurology Consultants of Arizona reserves the right to change its privacy practices that are described in its Privacy Notice, in accordance with applicable law.

3. I understand that, and consent to, the following appointment reminders that will be used by Neurology Consultants of Arizona:
   a) a postcard mailed to me at the address provided by me; and b) telephoning my home and leaving a message on my answering machine or with the individual answering the phone, or by e-mail.

4. Neurology Consultants of Arizona may use and/or disclose my PHI (which includes information about my health or condition and the treatment provided to me) in order for Neurology Consultants of Arizona to treat me and obtain payment for that treatment, and as necessary for Neurology Consultants of Arizona to conduct its specific health care operations.

5. I understand that I have a right to request that Neurology Consultants of Arizona restrict how my PHI is used and/or disclosed to carry out treatment, payment and/or health care operations. However, Neurology Consultants of Arizona is not required to agree to any restrictions that I have requested. If Neurology Consultants of Arizona agrees to a requested restriction, then the restriction is binding on Neurology Consultants of Arizona.

6. I understand that this Consent is valid for seven years. I further understand that I have the right to revoke this Consent, in writing, at any time for *all future* transactions, with the understanding that any such revocation shall not apply to the extent that Neurology Consultants of Arizona has already taken action in reliance on this consent.

7. I understand that if I revoke this consent at any time, Neurology Consultants of Arizona has the right to refuse to treat me.

8. I understand that if I do not sign this Consent evidencing my consent to the uses and disclosures described to me above and contained in the Privacy Notice, then SHM will not treat me.

I have read and understand the foregoing notice, and all of my questions have been answered to my full satisfaction in a way that I can understand.

_____
Name of Patient/Individual (Please print)

_____
Signature of Patient/Individual

_____
Signature of Legal Representative
(e.g., Attorney-In-Fact, Guardian, Parent if a minor)

_____
Relationship to Patient

_____
Date Signed

_____
Witness

HEADACHE DISABILITY INVENTORY (HDI)

Please CHECK the correct response:

1. I have headaches: ❑1 per month ❑more than 1 but less than 4 per month ❑more than 1 per week
2. My headache is: ❑mild ❑moderate ❑severe

INSTRUCTIONS: (Please read carefully): The purpose of the scale is to identify difficulties that you may be experiencing because of your headache. Please CIRCLE "YES," "SOMETIMES," or "NO" to each item. Answer each question as it pertains to your headache only.

E1.	Because of my headaches I feel handicapped.	❑Yes	❑Sometimes	❑No
F2.	Because of my headaches I feel restricted in performing my routine daily activities.	❑Yes	❑Sometimes	❑No
E3.	No one understands the effect my headaches have on my life.	❑Yes	❑Sometimes	❑No
F4.	I restrict my recreational activites (eg. sports, hobbies) because of my headaches.	❑Yes	❑Sometimes	❑No
E5.	My headaches make me angry.	❑Yes	❑Sometimes	❑No
E6.	Sometimes I feel that I am going to lose control because of my headaches.	❑Yes	❑Sometimes	❑No
F7.	Because of my headaches I am less likely to socialize.	❑Yes	❑Sometimes	❑No
E8.	My spouse (significant other), or family and friends have no idea what I am going through because of my headaches.	❑Yes	❑Sometimes	❑No
E9.	My headaches are so bad that I feel that I am going to go insane.	❑Yes	❑Sometimes	❑No
E10.	My outlook on the world is affected by my headaches.	❑Yes	❑Sometimes	❑No
E11.	I am afraid to go outside when I feel that a headache is starting.	❑Yes	❑Sometimes	❑No
E12.	I feel desperate because of my headaches.	❑Yes	❑Sometimes	❑No
F13.	I am concerned that I am being penalized at work or home because of my headaches.	❑Yes	❑Sometimes	❑No
E14.	My headaches place stress on my relationships with family or friends.	❑Yes	❑Sometimes	❑No
F15.	I avoid being around people when I have a headache.	❑Yes	❑Sometimes	❑No
F16.	I believe my headaches are making it difficult for me to achieve my goals in life.	❑Yes	❑Sometimes	❑No
F17.	I am unable to think clearly because of my headaches.	❑Yes	❑Sometimes	❑No
F18.	I get tense (eg. muscle tension) because of my headaches.	❑Yes	❑Sometimes	❑No
F19.	I do not enjoy social gatherings because of my headaches.	❑Yes	❑Sometimes	❑No
E20.	I feel irritable because of my headaches.	❑Yes	❑Sometimes	❑No
F21.	I avoid traveling because of my headaches.	❑Yes	❑Sometimes	❑No
E22.	My headaches make me feel confused.	❑Yes	❑Sometimes	❑No
E23.	My headaches make me feel frustrated.	❑Yes	❑Sometimes	❑No
F24.	I find it difficult to read because of my headaches.	❑Yes	❑Sometimes	❑No
F25.	I find it difficult to focus my attention away from my headaches and on other things.	❑Yes	❑Sometimes	❑No

Questionnaire completed by person signing below:

Patient's Printed Name:_____

Patient's Signature:_____

Date Completed:_____

NECK DISABILITY INDEX (NDI)

INSTRUCTIONS: (Please read carefully): 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 ONE box which applies to you.** We realize you may consider that two of the statements in any one section relate 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

- ❑ 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.
- ❑ 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 with moderate pain.
- ❑ I can't read as much as I want because of moderate pain.
- ❑ 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 slight headaches which come frequently.
- ❑ I have moderate headaches which come infrequently.
- ❑ 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 can't do any work at all.

SECTION 8 - DRIVING

- ❑ I 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 can't drive my car as long as I want because of moderate pain in my neck.
- ❑ I can hardly drive my car at all because of severe pain in my neck.
- ❑ I can't drive my car at all.

SECTION 9 - SLEEPING

- ❑ I have no trouble sleeping.
- ❑ My sleep is slightly disturbed (less than 1 hr sleepless).
- ❑ My sleep is moderately disturbed (1-2 hrs sleepless).
- ❑ My sleep is moderately disturbed (2-3 hrs sleepless).
- ❑ My sleep is greatly disturbed (3-4 hrs sleepless).
- ❑ My sleep is completely disturbed (5-7 hrs sleepless).

SECTION 10 - RECREATION

- ❑ I am able to engage in all my activities with no neck pain.
- ❑ I am able to engage in all my activities with some neck pain.
- ❑ I am able to engage in most, but not all activities because of pain.
- ❑ I am able to engage in a few of my activities because of neck pain.
- ❑ I can hardly do any activities because of neck pain.
- ❑ I can't do any recreation activities at all.

Questionnaire completed by person signing below:

Patient's Printed Name:_____

Patient's Signature:_____

Date Completed:_____

LOW BACK DISABILITY QUESTIONNAIRE (REVISED OSWESTRY)

INSTRUCTIONS: (Please read carefully): This questionnaire has been designed to give the doctor information as to how your back pain has affected your ability to manage in everyday life. **Please answer every section and mark in each section only ONE box which applies to you.** We realize you may consider that two of the statements in any one section relate to you, but please just mark the box which MOST CLOSELY describes your problem.

SECTION 1 - PAIN INTENSITY

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

SECTION 2 - PERSONAL CARE

- ❑ 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.
- ❑ 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 - WALKING

- ❑ Pain does not prevent me from walking any distance.
- ❑ Pain prevents me from walking more than one mile.
- ❑ Pain prevents me from walking more than one-half mile.
- ❑ Pain prevents me from walking more than one-quarter 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.

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 30 minutes.
- ❑ Pain prevents me from sitting more than 10 minutes.
- ❑ Pain prevents me from sitting almost all the time.

SECTION 6 - STANDING

- ❑ I can stand as long as I want without extra pain.
- ❑ I can stand as long as I want but it gives extra pain.
- ❑ Pain prevents me from standing more than 1 hour.
- ❑ Pain prevents me from standing more than 30 minutes.
- ❑ Pain prevents me from standing more than 10 minutes.
- ❑ Pain prevents me from standing at all.

SECTION 7 - SLEEPING

- ❑ Pain does not prevent me from sleeping well.
- ❑ I can sleep well only using sleeping tablets.
- ❑ Even when I take tablets I have less than 6 hrs sleep.
- ❑ Even when I take tablets I have less than 4 hrs sleep.
- ❑ Even when I take tablets I have less than 2 hrs sleep.
- ❑ Pain prevents me from sleeping at all.

SECTION 8 - SOCIAL LIFE

- ❑ My social life is normal and gives me no extra pain.
- ❑ My social life is normal but increases the degre of pain.
- ❑ Pain has no significant effect on my social life apart from limiting my more energetic interests (eg. dancing).
- ❑ Pain has restricted my social life and I do not got out as often.
- ❑ Pain has restricted my social life at my home.
- ❑ I have no social life because of pain.

SECTION 9 - TRAVELING

- ❑ 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 is bad but I manage journeys 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.

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.

Questionnaire completed by person signing below:

Patient's Printed Name:_____

Patient's Signature:_____

Date Completed:_____

RIVERMEAD POST CONCUSSION SYMPTOMS QUESTIONNAIRE

INSTRUCTIONS: (Please read carefully): After a head injury or accident some people experience symptoms that can cause worry or nuisance. We would like to know if you now suffer any of the symptoms given below. Because many of these symptoms occur normally, we would like you to compare yourself now with before the accident. For each symptom listed below please CHECK the number that most closely represents your answer.

Compared with **BEFORE** the accident, do you **NOW** suffer from:

	not experienced	**no more of a problem**	**mild problem**	**moderate problem**	**severe problem**
Headaches	❑0	❑1	❑2	❑3	❑4
Feelings of dizziness	❑0	❑1	❑2	❑3	❑4
Nausea and/or vomiting	❑0	❑1	❑2	❑3	❑4
Noise sensitivity (easily upset by loud noise)	❑0	❑1	❑2	❑3	❑4
Sleep disturbance	❑0	❑1	❑2	❑3	❑4
Fatigue, tiring more easily	❑0	❑1	❑2	❑3	❑4
Being irritable, easily angered	❑0	❑1	❑2	❑3	❑4
Feeling depressed or tearful	❑0	❑1	❑2	❑3	❑4
Feeling frustrated or impatient	❑0	❑1	❑2	❑3	❑4
Forgetfulness, poor memory	❑0	❑1	❑2	❑3	❑4
Poor concentration	❑0	❑1	❑2	❑3	❑4
Taking longer to think	❑0	❑1	❑2	❑3	❑4
Blurred vision	❑0	❑1	❑2	❑3	❑4
Light sensitivity (easily upset by bright light)	❑0	❑1	❑2	❑3	❑4
Double vision	❑0	❑1	❑2	❑3	❑4
Restlessness	❑0	❑1	❑2	❑3	❑4

Are you experiencing any other difficulties? Please specify, and rate as above.

1._____	❑0	❑1	❑2	❑3	❑4
2._____	❑0	❑1	❑2	❑3	❑4

Questionnaire completed by person signing below:

Patient's Printed Name:_____

Patient's Signature:_____

Date Completed:_____

Administration only:

RPQ-3 (total for first 3 items): _____

RPQ-13 (total for next 13 items): _____

King, NS, et al (1995). The Rivermead Post Concussion Symptoms Questionnaire: a measure of symptoms commonly experienced after head injury and its reliability. Journal of Neurology, 242: 587-592.