NORTHWEST SPORTS PERFORMANCE & WELLNESS

NEW PATIENT PACKAGE
Please complete the following pages in their entirety.

GENERAL INFORMATION

NAME: DATE OF BIRTH: AGE: GENDER:

HOME ADDRESS: CITY: STATE: ZIP:

MAILING ADDRESS (If Different from Above):

HOME PHONE: CELL PHONE: WORK PHONE: (EXT)

EMAIL ADDRESS: ______________________ PREFERRED METHOD OF CONTACT: ☐ HOME ☐ WORK ☐ CELL ☐ EMAIL

EMAIL FOR APPOINTMENT REMINDERS: (☐ SAME AS ABOVE) ______________________

MARITAL STATUS: ☐ SINGLE ☐ MARRIED ☐ SEPARATED ☐ DIVORCED ☐ WIDOWED
SPOUSE/PARTNER NAME / OCCUPATION: ______________________
CHILDREN & AGES: ______________________

OCCUPATION: ______________________ EMPLOYER: ______________________
☐ SELF-EMPLOYED ☐ UNEMPLOYED ☐ STUDENT ☐ RETIRED ☐ DISABLED

EMERGENCY CONTACT: PHONE: RELATIONSHIP:

HOW DID YOU HEAR ABOUT US: ☐ FAMILY ☐ FRIEND ☐ CHIRO ☐ PT ☐ LMP ☐ TRAINER
OTHER: ______________________

PRIMARY CARE PHYSICIAN: NAME/CLINIC: PHONE: CITY:

MEDICAL RECORDS RELEASE AUTHORIZATION

I (Print Name), ______________________, AUTHORIZE THIS OFFICE (NORTHWEST SPORTS PERFORMANCE / GOLFLETICA) TO RELEASE INFORMATION TO MY INSURANCE COMPANY, REFERRING & CONSULTING PHYSICIANS, OR OTHER HEALTH CARE PROFESSIONALS AS DEEMED APPROPRIATE.

______________________ ______________________
PATIENT / PARENT - GUARDIAN FOR MINOR SIGNATURE DATE

GOLFLETICA®
The Art of Golf Performance & Wellness

HEALTH INSURANCE FORMATION

DO YOU HAVE HEALTH INSURANCE: ☐ NO ☐ YES: PLEASE COMPLETE THE FOLLOWING

*PLEASE PROVIDE A COPY OF YOUR INSURANCE CARD AT CHECK-IN.

PRIMARY INSURANCE:	SUBSCRIBER'S NAME:	YOUR DATE OF BIRTH:
ID #:	GROUP # / SUBSCRIBER #:	CLAIMS ADDRESS:
SECONDARY INSURANCE:	SUBSCRIBER'S NAME:	YOUR DATE OF BIRTH:
ID #:	GROUP # / SUBSCRIBER #:	CLAIMS ADDRESS:

MOTOR VEHICLE ACCIDENT - PIP / L & I - WORK ACCIDENT ☐ NOT APPLICABLE

PLEASE COMPLETE THIS SECTION IF YOUR VISIT IS RELATED TO A CAR/WORK/PIP CLAIM.

TYPE: ☐ MOTOR VEHICLE ACCIDENT - PIP ☐ WORK-RELATED: WA STATE L & I ☐ SELF-INSURED L & I

DATE OF INJURY: TIME OF INJURY: CLAIM #: POLICY #:

INSURANCE COMPANY NAME: ____________________

INSURANCE COMPANY ADDRESS: CITY: STATE: ZIP: PHONE:

ADJUSTER'S NAME: PHONE NUMBER: EMAIL: FAX:

PLEASE DESCRIBE HOW, WHEN, & WHERE THE INJURY OCCURRED: ____________________

BY SIGNING BELOW, I AGREE TO THE FOLLOWING:

- The information I have provided is accurate to the best of my knowledge and I will inform the office of any changes.
- I authorize my insurance benefits be paid directly to Sese Sports Performance Group, PS / Northwest Sports Performance & Wellness, and other official DBA's and to act as my agent in obtaining payment from insurance.
- I understand I am financially responsible for all copays, deductibles, co-insurance, and other services not paid for by my insurance company.
- I understand there is a $35 fee for each returned check as per RCW 62A.3-515 plus the amount of the check.
- I agree to not withhold or delay payment if my insurance denies payment of any of my submitted charges.
- I understand that if a collection agency service should become necessary for any unpaid balances, I agree that I am fully responsible for the unpaid balance including interest and collection fees.
- I understand there is a 24-Hour Cancellation Policy and a fee for any late cancellation or missed appointment.
- I understand if legal action must be taken for unpaid balances, I am fully responsible for all fees incurred by the office.

____________________ ____________________

PATIENT / PARENT - GUARDIAN FOR MINOR SIGNATURE DATE

APPOINTMENT CANCELLATION POLICY

Our goal is to provide the best care possible to all of our patients so they can live a long and active lifestyle as healthy as possible. To help us achieve our goal and to provide you with the appropriate care you require, please inform us at least 24-hours in advance if you cannot keep your scheduled appointment. We value your time and commitment as we do ours and your fellow patients. Therefore we have an Appointment Cancellation Policy.

Our office requires at least 24-hours notice in the event you need to reschedule or cancel your appointment. This allows us to reschedule your appointment effectively and allows another patient in need to take your spot.

If you miss your appointment or "no show" or do not contact our office 24-hours in advance, then this will be considered a missed appointment and will be addressed in the following manner:

New Patients:

- You will receive an email and/or phone call about your missed appointment.
- You will incur at $50.00 no show fee.
- Your appointment will be rescheduled at the physician's discretion AFTER the no show fee has been paid.

Established Patients:

- You will receive an email and/or phone call about your missed appointment and have the opportunity to reschedule.
- You will incur a $35.00 no show fee.
- Two or more late arrivals may result in dismissal from our practice.

Late Patients:

- Established patients are normally slotted for a 15 minute appointment. This does not necessarily mean 15 minutes of treatment as it includes check-in, rescheduling, collection of fees, and any other administrative procedures. If you arrive late to your scheduled appointment, you will only receive the remainder of your allotted time slot.

Appointment Reminders:

- Reminders for upcoming appointments are normally sent 24 to 48 hours in advance. If you need to reschedule your appointment, you can reply to that email directly or call the office during regular business hours. Please ensure you have provided us with your preferred email address for appointment reminders.

This policy has been placed in effect to help us provide you with the best care possible. If you have any questions or concerns regarding this policy, please let us know and we will be happy to assist you.
I have read and understand the Appointment Cancellation Policy of this offie and agree to the terms stated above. I also understand that this office reserves the right to update this policy at any time or make any amendments as necessary.

______________________________	______________________________	__________________
PRINT PATIENT NAME	PATIENT/GUARDIAN SIGNATURE	DATE

HEALTH INFORMATION PATIENT PRIVACY ACT (A HIPPA COMPLIANT OFFICE)

In the course of your care as a patient of this Clinic, we may use or disclose personal and health related information about you in the following ways:

- Your protected health information, including your clinical records, may be disclosed to another health care provider or hospital if it is necessary to refer you for further diagnosis, assessment or treatment.
- Your health care records as well as your billing records may be disclosed to another party, such as an insurance carrier, an HMO, a PPO, or your employer, if they are or may be responsible for the payment of services provided to you.
- Your name, email address, mailing address, phone number and your health care records may be used to contact you regarding appointment reminders, information about alternatives to your present care, or other health related information that may be of interest to you.

You have a right to request restrictions on our use of your protected health information for treatment, payment and operations purposes. Such requests are not automatic and require the agreement of this office. If you are not home to receive an appointment reminder or other related information, a message may be left on your answering machine or with a person in your household. You have a right to confidential communications and to request restrictions relative to such contacts. You also have the right to be contacted by alternative means or at alternative locations.

We are permitted and may be required to use or disclose your health information without your authorization in these following circumstances:

- If we provide health care services to you in an emergency.
- If we are required by law to provide care to you and we are unable to obtain your consent after attempting to do so.
- If there are substantial barriers to communicating with you, but in our professional judgment we believe that you intend for us to provide care.
- If we are ordered by the courts or another appropriate agency.

You have the right to receive an accounting of any such disclosures made by this office. Any use or disclosure of your protected health information, other than as outlined above, will only be made upon your written authorization. If you provide an authorization for release of information you have the right to revoke that authorization at a later date. Information that we use or disclose based on this privacy notice may be subject to re-disclosure by the person to whom we provide the information and may no longer be protected by the federal privacy rules.

We normally provide information about your health to you in person at the time you receive chiropractic care from us. We may also mail/email information to you regarding your health care or about the status of your account. If you would like to receive this information at an address other than your home, or if you would like the information in a specific form, please advise us in writing as to your preferences. You have the right to inspect and/or copy your health information for as long as the information remains in our files. In addition you have the right to request an amendment to your health information. Requests to inspect, copy or amend your health related information should be provided to us in writing.

We are required by state and federal law to maintain the privacy of your patient file and the health protected information therein. We are also required to provide you with this notice of our privacy practices with respect to your health information. We are further required by law to abide by the terms of this notice while it is in effect.

We reserve the right to alter or amend the terms of this privacy notice. If changes are made to our privacy notice we will notify you in writing as soon as possible following the changes. Any change in our privacy notice will apply for all of your health information in our files. If you have a complaint regarding our privacy notice, our privacy practices, or any aspect of our privacy activities, you may direct your complaint to the Clinic Director, Dr. Harry G. Sese, DC.

If you would like further information about our privacy policies and practices, please contact the Clinic Director, Dr. Harry G. Sese, DC. You also have the right to lodge a complaint with the Secretary of the Department of Health and Human Services. If you choose to lodge a complaint with this office or with the Secretary, your care will continue and you will not be disadvantaged by this office or our staff in any manner whatsoever.

This notice is effective as of date signed below. This notice, and any alterations or amendments made hereto, will expire seven years after the date upon which the record was created. My signature acknowledges that I have received a copy of this notice.

______________________________	______________________	________________
PRINT PATIENT / REPRESENTATIVE NAME	SIGNATURE	DATE

____

DESCRIPTION OF AUTHORITY TO ACT ON BEHALF OF PATIENT

GOLFLETICA®
The Art of Golf Performance & Wellness

NEW PATIENT MEDICAL HISTORY FORM

NAME: ______________________ DATE OF BIRTH: ____________ GENDER: ____________

HEIGHT: ____ FT ____ INCHES WEIGHT: ________ LBS DOMINANT HAND: ____________________

EXERCISE HISTORY:

WHAT IS YOUR MAIN FORM OF EXERCISE? ____

HOW OFTEN DO YOU EXERCISE IN A WEEK? ____________ DAYS ________ MINUTES PER SESSION

WHAT IS YOUR AVERAGE INTENSITY? □ LOW IMPACT □ MODERATE □ LHIGH INTENSITY

WHAT DO YOU NORMALLY DO? □ AEROBIC CARDIO □ STRENGTH/WEIGHTS □ BODY WEIGHT □ STRETCHING □ INTERVAL □ CROSSFIT □ PERSONAL TRAINER

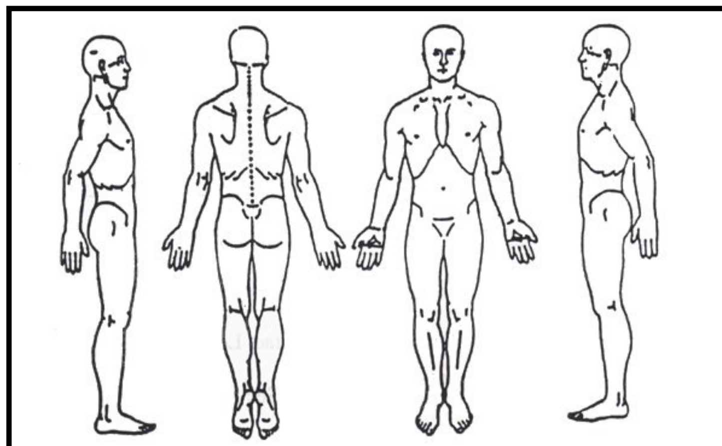
MEDICAL HISTORY:

PLEASE CHECK ANY CONDITIONS THAT YOU CURRENTLY EXPERIENCE OR HAVE HAD IN THE PAST:

□ Anemia
□ Arthritis
□ Asthma
□ Bleeding Disorder
□ Blood Clots
□ COPD
□ Cancer
□ Crohn's Disease
□ Diabetes
□ Depression
□ Fibromyalgia
□ Gout
□ HIV / AIDS
□ Hearing Loss
□ Heart Attack
□ Hepatitis
□ Hernia
□ Herniated Disc
□ High Blood Pressure
□ High Cholesterol
□ Hyperthyroidism
□ Hypothyroidism
□ Kidney Disease
□ Liver Disease
□ Lung Disease
□ Migraines
□ Osteoporosis
□ Pacemaker
□ Psoriasis
□ Rheumatoid Arthritis
□ Seizures
□ Stroke
□ Tendonitis
□ Ulcers
□ Vision Loss
□ Vertigo
□ Other: ____

REASON FOR VISIT:

REASON FOR SEEKING CARE: ____
GOALS FOR TODAY'S VISIT: ____
MARK ALL THE AREAS ON YOUR BODY WHERE YOU ARE EXPERIENCING PAIN AND/OR DISCOMFORT:



SYMPTOMS HISTORY:

HOW LONG HAVE YOU BEEN HAVING THESE SYMPTOMS?	DATE OF ONSET: ______________________ □ _____ DAYS □ _____ WEEKS □ _____ MONTHS □ _____ YEARS
HOW IS IT PROGRESSING?	□ IMPROVING □ GETTING WORSE □ STAYING THE SAME
WHAT IS THIS DUE TO?	□ CAR ACCIDENT □ WORK INJURY □ SPORT INJURY □ TRAUMA □ LIFTING □ TWISTING □ BENDING □ FALL □ ASSAULT □ UNKNOWN □ OTHER: ______________________
IF YOU ARE HAVING **NECK** OR **BACK** PAIN, DOES IT RADIATE INTO YOUR ARMS OR LEGS?	□ NO □ YES: DESCRIBE: ______________________ DO YOU HAVE ANY: □ NUMBNESS □ TINGLING □ WEAKNESS
ARE YOUR SYMPTOMS?	□ CONSTANT □ INTERMITTENT □ ONLY WITH ACTIVITY
WHEN IS IT WORSE?	□ MORNING □ AFTERNOON □ EVENING □ BEDTIME □ VARIES
HOW WOULD YOU DESCRIBE YOUR SYMPTOMS?	□ ACHING □ SHARP □ DULL □ THROBBING □ DEEP □ BURNING □ CATCHING □ PINS & NEEDLES □ OTHER: ______________________
WHAT IS YOUR CURRENT LEVEL OF PAIN /DISCOMFORT?	NO PAIN □ 0 □ 1 □ 2 □ 3 □ 4 □ 5 □ 6 □ 7 □ 8 □ 9 □ 10 WORST PAIN
ARE ANY OF YOUR REGULAR DAILY ACTIVITIES AFFECTED?	______________________ ______________________
WHAT MAKES YOUR SYMPTOMS WORSE?	______________________ ______________________
WHAT MAKES YOUR SYMPTOMS BETTER?	______________________ ______________________
DO YOU HAVE ANY OF THESE ASSOCIATED SYMPTOMS?	□ SWELLING □ POPPING / CLICKING □ FEVER □ ANXIETY □ BRUISING □ CATCHING / LOCKING □ CHILLS □ STRESS □ REDNESS □ INSTABILITY □ OTHER: ______________ □ CHANGES IN BOWEL / BLADDER CONTROL □ LOSS OF SLEEP

CURRENT MEDICATIONS:

ARE YOU TAKING ANY PRESCRIBED MEDICATION:	□ NO □ IF YES: (LIST NAME & PURPOSE) ______________ ______________________ ______________________
DO YOU HAVE ANY ALLERGIES? (DRUG OR OTHER)	□ NO □ IF YES: (PLEASE SPECIFY) ______________ ______________________ ______________________

TREATMENT HISTORY:

HAVE YOU HAD TREATMENT FROM ANY OF THE FOLLOWING FOR THIS CONDITION? (WHO & WHEN)

- □ CHIROPRACTOR: ______
- □ PHYSICAL THERAPY: ______
- □ MASSAGE THERAPY: ______
- □ ACUPUNCTURE: ______
- □ FAMILY MD: ______

HAVE YOU HAD ANY SURGERIES IN THE PAST?

□ NO □ YES: ______

______

HAVE YOU HAD ANY IMAGING STUDIES IN THE PAST? (LIST BODY PART, DATE OF STUDY & FACILITY)

- □ X-RAY: ______
- □ MRI: ______
- □ CT: ______
- □ BONE SCAN: ______

HAVE YOU BROKEN ANY BONES IN THE PAST?

□ NO □ IF YES: (LIST BODY PART, WHEN, & TREATMENT RECEIVED)

______

REVIEW OF SYSTEMS:

PLEASE CHECK ANY CONDITIONS THAT YOU CURRENTLY EXPERIENCE OR HAVE HAD IN THE PAST:

GENERAL
- □ Convulsions
- □ Dizziness
- □ Fainting
- □ Headache
- □ Nervousness

MUSCLES & JOINTS
- □ Low Back Problems
- □ Pain between Shoulders
- □ Neck Problems
- □ Arm Problems
- □ Leg Problems
- □ Swollen Joints
- □ Painful Joints
- □ Stiff Joints
- □ Sore Muscles
- □ Weak Muscles
- □ Walking Problems

RESPIRATORY
- □ Chronic Cough
- □ Difficulty Breathing
- □ Coughing Blood
- □ Coughing Phlegm
- □ Wheezing

CARDIO-VASCULAR
- □ Palpitations
- □ Chest Pain
- □ Poor Circulation
- □ Rapid/Slow Heart Rate
- □ Swollen Ankles
- □ Varicose Veins

EAR/NOSE/THROAT
- □ Ear Ache
- □ Ringing in Ear
- □ Nasal Blockage
- □ Nose Bleeds
- □ Poor Vision
- □ Sinus Problems
- □ Sore Throats

GASTRO-INTESTINAL
- □ Belching / Gas
- □ Digestive Issues
- □ Constipation
- □ Diarrhea
- □ Always Hungry/Thirsty
- □ Hemorrhoids
- □ Abdominal Pain
- □ Poor Appetite
- □ Vomiting
- □ Black/Bloody Stool

GENITO-URINARY
- □ Blood in Urine
- □ Frequent Urination
- □ Difficulty to Urinate
- □ Prostate Problems
- □ Loss of Bladder Control

SKIN OR ALLERGIES
- □ Boils / Acne
- □ Dry Skin
- □ Rash / Dermatitis
- □ Hives
- □ Sensitive Skin

FOR WOMEN ONLY
- □ Birth Control
- □ Hormone Replacement
- □ Cramps / Backaches
- □ Excessive Flow
- □ Hot Flashes
- □ Irregular Cycle
- □ Vaginal Discharge
- □ Breast Tenderness / Pain
- □ **Currently Pregnant?** Circle: YES NO

FAMILY HISTORY:

PLEASE LIST ANY HEALTH ISSUES WITHIN YOUR IMMEDIATE FAMILY: (E.G. DIABETES, HIGH BLOOD PRESSURE, HEART DISEASE, CANCER, ETC)

MOTHER: ______
FATHER: ______
SIBLINGS: ______
GRANDPARENTS: ______

SOCIAL HISTORY:

ARE YOU CURRENTLY WORKING?	□ NO □ YES:	LAST JOB & WHEN: ____ □ FULL-TIME □ PART-TIME □ MODIFIED DUTY
WHAT IS YOUR JOB TITLE?	____	
ARE YOU SATISFIED WITH YOUR JOB?	NOT SATISFIED □ 0 □ 1 □ 2 □ 3 □ 4 □ 5 □ 6 □ 7 □ 8 □ 9 □ 10 COMPLETELY SATISFIED	
WHAT IS YOUR HIGHEST LEVEL OF EDUCATION?	□ HIGH SCHOOL □ GED □ VOCATIONAL □ SOME COLLEGE □ COLLEGE DEGREE □ GRADUATE DEGREE	
DO YOU USE TOBACCO?	□ CIGARETTE: ____ PACKS/DAY □ CHEW: ____ /DAY □ CIGARS	
DO YOU USE ALCOHOL?	□ NEVER □ SOCIALLY □ REGULARLY: ____ DRINKS/DAY ____	
DO YOU USE MARIJUANA?	□ NEVER □ RECREATIONAL USE □ MEDICAL USE □ FOR PAIN	
DO YOU DRINK CAFFEINE?	□ NEVER □ YES: TYPE: ____ AMOUNT/DAY: ____	

CERTIFICATION:

I hereby certify that the statements and answers given on these forms are accurate to the best of my knowledge and understand it is my responsibility to inform this office of any changes in my health. I agree to allow this office to examine me for further evaluation.

PATIENT SIGNATURE ____ DATE ____

CONSENT TO EXAMINATIO OF A MINOR / CHILD:

I hereby authorize **Dr. H. Sese, DC & Associates** to perform further evaluation as deemed necessary to my son/daughter:

PRINT NAME OF CHILD / MINOR ____

SIGNATURE OF PARENT / GUARDIAN ____ DATE ____

BACK PAIN and Disability Questionnaire (revised Oswestry)

PLEASE COMPLETE THIS FORM IF YOU ARE HAVING BACK PAIN.

Name: ________________________________ Date: ________________________________

This questionnaire has been designed to give the health care provider 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. 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 today.

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 does not vary much.

SECTION 2 – PERSONAL CARE

□ I would not have to change my way of washing or dressing in order to avoid pain.
□ I do not normally change my way of washing and dressing even though it causes some pain.
□ Washing and dressing increase the pain but I manage not to change my way of doing it.
□ Washing and dressing increase the pain and I find it necessary to change my way of doing it.
□ Because of the pain I am unable to do some washing and dressing.
□ Because of the pain I am unable to do any washing and dressing without help.

SECTION 3 – LIFTING

□ I can lift heavy weights without extra pain.
□ I can lift heavy weights but it causes extra pain.
□ Pain prevents me from lifting heavy weights off the floor.
□ Pain prevents me from lifting heavy weights off the floor, but I manage if they are conveniently positioned (e.g. on a table).
□ Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
□ I can only lift very light weights at the most.

SECTION 4 – WALKING

□ I have no pain on walking.
□ I have some pain on walking but it does not increase with distance.
□ I cannot walk more than one mile without increasing pain.
□ I cannot walk more than ½ mile without increasing pain.
□ I cannot walk more than ¼ mile without increasing pain.
□ I cannot walk at all without increasing pain.

SECTION 5 – SITTING

□ I can sit in any chair as long as I like.
□ I can 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.
□ I avoid sitting because it increases my pain straight away.

SECTION 6 – S TANDING

□ 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 ½ hour without increasing pain.
□ I cannot 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 does not prevent me from sleeping well.
□ Because of pain my normal night's sleep is reduced by less than ¼.
□ Because of pain my normal night's sleep is reduced by less than ½.
□ Because of pain my normal night's sleep is reduced by less than ¾.
□ Pain prevents me from sleeping at all.

SECTION 8 – SOCIAL LIFE

□ My social life is normal and gives me no pain.
□ My social life in normal but increases the degree of pain.
□ Pain has no significant effect on my social life apart from limiting 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 9 – 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.
□ Pain restricts all forms of travel.
□ Pain prevents all forms of travel except that done lying down.

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 at present.
□ My pain is neither getting better or worse.
□ My pain is gradually worsening.
□ My pain is rapidly worsening

Score: ________________%____________________________

NECK PAIN and Disability Index (Vernon-Minor)

PLEASE COMPLETE THIS FORM IF YOU ARE HAVING NECK PAIN.

Name: ____ Date: ________________________________

This Questionnaire has been designed to give the health care provider information as to how your **NECK** 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. 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 today.

SECTION 1 – PAIN INTENSITY
- □ I have no pain at the moment.
- □ The pain is very mild at the moment.
- □ The pain is moderate at the moment.
- □ The pain is fairly severe at the moment.
- □ The pain is very severe at the moment.
- □ The pain is the worst imaginable at the moment.

SECTION 2 – PERSONAL CARE (washing, dressing, etc.)
- □ I can look after myself normally without causing 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 I 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, for example on a table.
- □ Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
- □ I can lift very light weights.
- □ I cannot lift or carry anything at all.

SECTION 4 – READING
- □ I can read as much as I want to with no pain in my neck.
- □ I can read as much as I want to with slight pain in my neck.
- □ I can read as much as I want to with moderate pain in my neck
- □ I can hardly read at all because of severe pain in my neck.
- □ I cannot read at all.

SECTION 5 – HEADACHES
- □ I have no headaches at all.
- □ I have slight headaches which come infrequently.
- □ I have moderate headaches which come infrequently.
- □ I have moderate headaches which come frequently.
- □ I have severe headaches which come frequently.
- □ I have headaches almost all of 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 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 can drive my car without any neck pain.
- □ I can drive my car as long as I want with slight pain in my neck.
- □ I can drive my car as long as I want with moderate neck pain.
- □ I can't drive my car as long as I want because of moderate pain in my neck.
- □ I can hardly drive at all because of severe pain in my neck.
- □ I can't drive my car at all.

SECTION 9 – SLEEPING
- □ I have no trouble sleeping.
- □ My sleep is slightly disturbed (less than one hour sleepless).
- □ My sleep is mildly disturbed (1-2 hours sleepless).
- □ My sleep is moderately disturbed (2-3 hours sleepless).
- □ My sleep is greatly disturbed (3-5 hours sleepless).
- □ My sleep is completely disturbed (5-7 hours sleepless).

SECTION 10 – RECREATION
- □ I am able to engage in all my recreation activities with no neck pain at all.
- □ I am able to engage in all my recreation activities, with some pain in my neck.
- □ I am able to engage in most, but not all of my usual recreation activities because of pain in my neck.
- □ I am able to engage in a few of my usual recreation activities because of pain in my neck.
- □ I hardly do any recreation activities because of pain in my neck.
- □ I can't do recreation activities at all.

Score: __________________%______________

DIRECTIONS TO CLINIC: 1823 115TH AVE NE, BELLEVUE, WA, 98004
IF LOST, CALL: 425-221-7253

DIRECTIONS FROM I-405 NORTH

1. Take EXIT 13A-B for NE 8th EAST.
2. Turn LEFT on 116th Ave NE and Continue North.
3. Pass Group Health / Overlake Hospital. (On Your Left).
4. Cross NE 12th St Intersection.
5. Pass Seattle Children's Hospital. (On Your Right).
6. Turn LEFT on NE 19th St at Top of Hill. (Dead End Sign)
7. Take first LEFT on 115th Ave NE. (Cul-De-Sac)
8. FOURTH House on the RIGHT.
9. Parking in Front or on Street.

DIRECTIONS FROM I-405 SOUTH

1. Follow Signs for "HOSPITAL" / NE 4th St Exit.
2. Turn RIGHT at Off Ramp.
3. Turn LEFT on 116th Ave NE and Continue North.
4. Pass Group Health / Overlake Hospital. (On Your Left).
5. Cross NE 12th St Intersection.
6. Pass Seattle Children's Hospital. (On Your Right).
7. Turn LEFT on NE 19th St at Top of Hill. (Dead End Sign)
8. Take first LEFT on 115th Ave NE. (Cul-De-Sac)
9. FOURTH House on the RIGHT.
10. Parking in Front or on Street.

DIRECTIONS COMING FROM SEATTLE VIA 520 BRIDGE

1. Take WA-520 EAST towards Northup Way in Bellevue.
2. Take EXIT towards 124th Ave NE.
3. Turn RIGHT onto Northup Way.
4. Turn LEFT onto 116th Ave NE.
5. Turn RIGHT onto NE 19th St at Top of Hill. (Dead End Sign)
6. Take first LEFT on 115th Ave NE. (Cul-De-Sac)
7. FOURTH House on the RIGHT.
8. Parking in Front or on Street.

DIRECTIONS FROM NE 8TH STREET

1. Head NORTH on 116th Ave NE.
2. Pass Group Health / Overlake Hospital. (On Your Left).
3. Cross NE 12th St Intersection.
4. Pass Seattle Children's Hospital. (On Your Right).
5. Turn LEFT on NE 19th St at Top of Hill. (Dead End Sign)
6. Take first LEFT on 115th Ave NE. (Cul-De-Sac)
7. FOURTH House on the RIGHT.

Parking in Front or on Street.