

OUTTEN CHIROPRACTIC
401 High House Rd., Suite 110
Cary, NC 27513

Neck Index

Please complete this form as accurately as possible. Your answers will help us to determine whether chiropractic can help you. If you do not sincerely believe your condition can respond satisfactorily, we will not accept your case. Thank you for your cooperation.

Name: _____

Date: _____

Pain Intensity (please circle one)

I have no pain at this moment
The pain is mild at this moment
The pain comes and goes and is moderate
The pain is fairly severe at this moment
The pain is severe at this moment
The pain is the worst imaginable right now

Personal Care (please circle one)

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 & careful
I need some help but I manage most of my care
I need help everyday in most aspects of self-care
I don't dress, I wash with difficulty and stay in bed

Recreation (please circle one)

I am able to engage in all my recreational activities without pain
I am able to engage in all my usual activities with some pain
I am able to engage in most but not all of my usual activities
I am only able to engage in a few of my usual activities
I can hardly do any recreational activities because of back pain
I cannot do any recreational activities at all

Lifting (please circle one)

I can lift heavy weights without extra pain
I can lift heavy weights but it causes extra pain
Pain prevents me from lifting heavy objects, but I can manage
Pain prevents me from lifting heavy objects, only lightly weighted
I can only lift very light weights
I cannot lift or carry anything at all

Reading (please circle one)

I can read as much as I want with no pain
I can read as much as I want with slight pain
I can read as much as I want with moderate pain
I cannot read as much as I want because of moderate pain
I can hardly read at all because of severe pain
I cannot read at all because of pain

Driving (please circle one)

I can drive my car without any pain
I can drive my car as long as I want with slight pain
I can drive my car as long as I want with moderate pain
I cannot drive my car as long as I want because of moderate pain
I can hardly drive at all because of pain
I cannot drive at all because of pain

Concentration (please circle one)

I can concentrate fully when I want with no difficulty
I can concentrate fully when I want with slight difficulty
I have a fair degree of difficulty concentrating when I want
I have a lot of difficulty concentrating when I want
I have a great deal of difficulty concentrating when I want
I cannot concentrate at all

Sleeping (please circle one)

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

Work (please circle one)

I can do as much work as I want
I can only do my usual work but no more
I can only do most of my usual work, but no more
I cannot do my usual work
I can hardly do any work
I cannot do any work at all

Headaches (please circle one)

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

How bad is your ache or pain? Please circle a number: 0 (no Pain) 1 2 3 4 5 6 7 8 9 10 (unbearable)
To the best of my knowledge the preceding answers to the questions on this form are the complete truth regarding my current health complaints.

Print Name: _____

Signature: _____

Date: _____