MASSAGE SOLUTIONS of Bend
...you deserve to feel this good

ASSIGNMENT OF BENEFITS AND FINANCIAL RESPONSIBILITY

Patient/Client Name: _____ Date of Birth: _____

Address: _____ Telephone: _____

Your signature serves as acknowledgement that you understand and agree to the following:

1. I am financially responsible for all services rendered by Massage Solutions of Bend, LLC.
2. I authorize the release of information, relating to any claim for services provided, to insurance carrier(s) or other parties responsible for payment of such claims.
3. I assign, and direct the insurance carrier(s) to make insurance payments directly to Massage Solutions of Bend, LLC.
4. If payment of service rendered is delinquent and the account is referred to an attorney or collection agency, I agree to pay the costs of collecting the unpaid charges, including, but not limited to, reasonable attorney fees and costs of suit.
5. Massage Solutions of Bend, LLC agrees to bill the insurance carrier(s) as a courtesy of the patient/client.
6. The patient/client agrees to furnish all information concerning patient's medical conditions to Massage Solutions of Bend, LLC.
7. The patient/client agrees to pay the co-payment obligation for each treatment.
8. The patient/client has the right to pay for each treatment, be given a receipt, and self-bill the insurance company.
9. The patient/client has the right to discontinue treatments at any time with prior notice of cancellation within a 24-hour time period.
10. The patient/client understands our 24-hour cancellation policy and will be responsible for payment for their service should they fail to keep or cancel all set appointments**.**
    Please provide credit card for billing. **Initial _____
11. The provider has the right to refuse service to anyone at any time.
12. I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and me. Furthermore, I understand that the Massage Solutions of Bend, LLC will prepare any necessary reports and forms to assist me in making collections from the insurance company and that any amount authorized to be paid directly to the Massage Solutions of Bend, LLC be credited to my account on receipt. However, I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend and terminate my care and treatment, any fees for professional services rendered me will be immediately due and payable.

Patient/Client Signature: _____ Date: _____

UNDER 18 YEARS OLD? Sign Here

You signature below acknowledges that you understand the above and are declining Massage Solutions of Bend, LLC to bill your insurance carrier(s) for a period of no less than six months for the signed date below and agree that all charges are due immediately at the time of service.

Patient/Client Signature: _____ Date: _____

If under18 yrs. Guardian: _____ Date: _____

MASSAGE SOLUTIONS
of Bend

HIPPA & Medical Release Form

Name _____ Date of Birth _____/_____/_____

RELEASE INFORMATION

I authorize the release of information including the diagnosis, records; examination rendered to me and claims information. This information may be released to:

- ☐ Spouse _____
- ☐ Child(ren) _____
- ☐ Other _____

☐ Information is not to be released to anyone.

MESSAGES

Please call: ☐ cell phone ☐ work or ☐ home phone _____
If unable to reach me:

- ☐ you may leave a detailed message
- ☐ please leave message asking me to return your call
- ☐ The best time to reach me is [day] _____ between (time) _____

AUTHORIZATION TO DISCLOSE MEDICAL RECORDS

I _____ authorize Massage Solutions of Bend, LLC to release a copy of the medical information for my treatments to _____ .

This information will be used on my behalf for medical treatment and billing information only.

Date: _____ Signature: _____

MASSAGE SOLUTIONS of Bend

. . . you deserve to feel this good

PLEASE READ & INITIAL

When billing insurance, the fee rates are set by CMS Industry & are Federally Mandated by the Federal Government & Oregon Workman's Comp and Medicare/caid Fee Schedule. Massage Solutions of Bend DOES NOT SET THESE FEES.

In addition, Massage Solutions of Bend, LLC will keep on file a current debit/credit card (American Express not accepted) should you fail to keep or cancel 24 hours in advance of your appointment reserved for your care. Massage Solutions of Bend cannot bill your insurance company for any missed appointments, as this is the patient's responsibility.

Patient's Initials _____

Just as a point of reference, your fees can be between the following rates, these are averages, and not set fees. The actual fee will be determined by your insurance benefits. These fees are not subject to cash pay, membership or discounted fees.

New Patient Office Visit	$86 - $214 first visit
Follow Up Established Office Visit	$39 - $212 per visit

Massages are billed in 15-minute increments, with a fee of $41 per 15 minutes.

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

If you have questions about this notice, please contact the designated privacy officer of our office at:
541-317-4826. 1289 NE 2nd Street, Suite 3, Bend, OR 97701

We take our responsibility to safeguard your protected health information very seriously. We value your trust as an important part of our ability to provide you with the best possible care. We are dedicated to defending your right to a confidential relationship with your provider.

This notice is intended to inform you of how we protect, use and disclose your information, as well as to explain your right to control these disclosures.

Your Health Information
We may use and disclose health information about you without your permission for the following purposes:

1. We may disclose your information for treatment purposes and to coordinate your medical care.

2. We may disclose your information internally to ensure that you receive insurance benefits.

3. We may disclose your information internally to enhance the operation of our practice. This includes our commitment to reviewing the quality of care we provide.

4. We may disclose your information to comply with a limited number of legal requirements, as outlined in this notice.

Additional information regarding each of these disclosures is provided in this notice. In any case, we will only disclose the minimum amount of information necessary for the purpose it was requested. Effective Date: July 10, 2016

Our Duties
We are required by federal and state law to keep your health information private. We must also provide you with this Notice and abide by its terms. We may need to revise our privacy practices from time to time. We expressly reserve the right to change the terms of our Notice of Privacy Practices and to make the new terms effective for all information covered by our Notice. If such changes occur, we will let you know about the new terms by providing a copy of the changes.

Your Privacy Rights
Please note that you're entitled to very specific rights regarding the use and disclosure of your information. We have listed your rights below:

Right to Inspect and Copy
You have the right to inspect and copy your health information, such as medical and billing records, that we use to make decisions about your care. You must submit a written request to our designated contact in order to inspect and/or copy your information. If you request a copy of your information, we may charge a fee for the costs of copying, mailing or other associated supplies. You may also choose to receive a copy of your health information in electronic form.

We may deny your request to inspect and/or copy information in certain circumstances. If you are denied access to your health information, you can ask that the denial be reviewed. If the law requires such a review, we will select a licensed health care professional to review your request and our denial. The person conducting the review will not be the person who denied your request and we will comply with the outcome of the review.

Right to Amend
If you believe our records contain errors, you may make a written request that they be amended. We reserve the right to review your request and can decline to amend the record. We are required to place a copy of your proposed amendment in the record, even when we do not agree to amend the record itself.

We may deny your request for an amendment if we did not create the information, unless the person or entity that created the information, unless the person or entity that created the information is no longer available to make the amendment.

Right to Request Restrictions
You have the right to request restrictions on the use and disclosure of your information. We are not required to agree to your request. If we do agree, we will comply to the best of our ability unless the information is needed to provide you with emergency treatment. To request restrictions, you may complete and submit the Request for Restriction on Use/Disclosure of Medical Information to our designated Privacy Office/Contact. If your restriction invalidates your insurance coverage, we may require you to execute a waiver of insurance benefits and a payment agreement.

Right to Request Confidential Communications
You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you at work or by mail.

To request confidential communications, you may complete and submit the form Request for Restriction on Use/Disclosure of Medical Information to our designated Privacy Officer/Contact. We will not ask you the reason for your request. We will accommodate all reasonable requests. Your request must specify how or where you wish to be contacted.

Right to a Paper Copy of This Notice
You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time. Even if you have agreed to receive it electronically, you are still entitled to a paper copy. To obtain such a copy, contact our designated Privacy Office/Contact.

Right to an Accounting Disclosure
You have the right to request an "accounting of disclosures." This is a list of the disclosures we made of medical information about you for purposes other than treatment, payment and health care operations.

To obtain this list, you must submit your request in writing to our designated Privacy Officer/Contact. It must state a time period, which may not be longer than six years and may not include dates before April 14, 2003. Your request should indicated in what format you want the list (for example, on paper or electronically).

The first list you request within a 12-month period will be free. For additional lists, we may charge you for the costs of providing the list. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.

Complaints and Investigations
We have developed procedures for investigating any complaints or concerns you may have regarding our use and disclosure of your information or any other complaint you may have regarding our services. The law allows you to contact the Secretary of the Department of Health and Human Services with complaints about our use and disclosure information.

You may also contact our on-site Privacy Office/Contact, who is dedicated to investigating complaints regarding the use and disclosure of information in our care. We will not, and legally cannot, retaliate against you for any complaint.

Types of Use and Disclosure of Your Protected Health Information
We may disclose your information for the following purposes without your consent:

For Treatment Purposes
We may disclose information needed for the provision, coordinated or management of health care and related services, including the coordination between our office and a third party, such as a consultation between medical providers or a referral from our office to another provider. Personnel in our office may share information about you and disclose information to people who do not work in our office in order to coordinate your care, such as phoning prescriptions to your pharmacy, scheduling lab work and ordering X-rays. Family members and other healthcare providers may be part of your medical care outside this office and may require information about you that we have.

For Payment
To obtain reimbursement from your insurer, we may be required to disclose your information. This may be necessary for determining your eligibility for coverage and adjudication of claims, billing, claims management and collections activities. We may also be required to disclose your information to your insurer for review of the medical necessity, coverage, appropriateness or justification of our charges.

For example, we may need to give your health plan information about a service you received here so your health plan will pay us or reimburse you for the service. We may also tell your health plan about a treatment you are going to receive to obtain prior approval, or to determine whether your plan will cover the treatment. You have the right to restrict disclosures of your PHI to a health plan if you have paid out-of-pocket in full for the treatment.

For Health Care Operations
We may use and disclose health information about you in order to run the

office and make sure that you and our other patients receive quality care. Healthcare operations may include:

- Quality assessment and improvement activities
- Reviewing the competence or qualifications of our healthcare professionals or evaluating practitioner and provider performance
- Conducting training programs, accreditation, certification, licensing or credentialing activities
- Arranging for or conducting medical review, legal services or auditing functions, including fraud and abuse detection and compliance programs
- Managing and operating our practice, including activities such as customer service and complaint resolution

Business Associates

We may disclose Protected Health Information to our business associates who perform functions on our behalf or provide us with services if the Protected Health Information is necessary for those functions or services. For example, we may use another company to do our billing, or to provide transcription or consulting services for us. All of our business associates are obligated, under contract with us, to protect the privacy and ensure the security of our Protected Health Information.

Appointment Reminders

We may contact you (via voicemail messages, email postcards or letters) as a reminder that you have an appointment for your treatment or medical care at our office.

Treatment Alternatives

We may tell you about or recommend possible treatment options or alternatives that may be of interest to you. We also may tell you about health-related products or services that may be of interest to you.

Marketing Health-Related Services

We will not use your health information for marketing communications without your written, prior authorization. We will not sell your PHI to another organization for marketing or any other purposes.

Special Situations

We may use or disclose health information about you without your permission for the following purposes, subject to all applicable legal requirements and limitations:

1. To Avert a Serious Threat to Health or Safety. We may use and disclose health information about you when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person.

2. Required by Law. We will disclose health information about you when required to do so by federal, state or local law.

3. Research. We may use and disclose health information about you for research projects that are subject to a special approval process. We will ask you for your permission if the researcher will have access to your name, address or other information that reveals who you are, or will be involved in your care at the office.

4. Organ and Tissue Donation. If you are an organ donor, we may release health information to organizations that handle organ procurement or organ, eye or tissue transplantation or to an organ donation bank, as necessary to facilitate such donation and transplantation.

5. Military, Veterans, National Security and Intelligence. If you are or were a member of the armed forces, or part of the national security or intelligence communities, we may be required by military command or other government authorities to release health information about you. We may also release information about foreign military personnel to the appropriate foreign military authority.

6. Workers' Compensation. We may release health information about you for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illness.

7. Public Health Risks. We may disclose health information about you for public health reason in order to prevent or control disease, injury or disability; or report births, deaths, suspected abuse or neglect, non-accidental physical injuries, reactions to medications or problems with products.

8. Health Oversight Activities. We may disclose health information to a health oversight agency for audits, investigations, inspections, or licensing purposes. These disclosures may be necessary for certain state and federal agencies to monitor the health care system, government programs, and compliance with civil rights laws.

9. Lawsuits and Disputes. If you are involved in a lawsuit or dispute, we may disclose health information about you in response to a court or administrative order. Subject to all applicable legal requirements, we may also disclose health information about you in response to a subpoena.

10. Law Enforcement. We may release health information if asked to do so by a law enforcement official in response to a court order, subpoena, warrant, summons or similar process, subject to all applicable legal requirements.

11. Coroners, Medical Examiners and Funeral Directors. We may release health information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or to determine the cause of death.

12. Information Not Personally Identifiable. We may use or disclose health information about you in a way that does not personally identify you or reveal who you are.

13. Family and Friends. We may disclose health information about you to your family members or friends if we obtain your verbal agreement to do so or if we give you an opportunity to object to such a disclosure and you do not raise an objection. We may also disclose health information to your family or friends if we can infer from the circumstances, based on our professional judgment, that you would not object.

14. Minors. We may disclose the Protected Health Information of minor children to their parents or guardians unless such disclosure is otherwise prohibited by law.

15. Deceased Person's PHI may be disclosed by our practice to family or others involved in the person's care or payment for care, unless our practice knows the deceased preferred that certain people not receive the PHI. Disclosures are limited to the PHI directly relevant to the person's involvement.

For example, we may assume you agree to our disclosure of your personal health information to your spouse when you bring your spouse with you into the exam room during treatment or while treatment is discussed.

In situations where you are not capable of giving consent (because you are not present or due to your incapacity or medical emergency), we may, using our professional judgment, determine that a disclosure to your family member or friend is in your best interest. In that situation, we will disclose only health information relevant to the person's involvement in your care.

Other Uses and Disclosures of Health Information

We will not use or disclose your health information for any purpose other than those identified in the previous sections without your specific, written Authorization. We must obtain your Authorization separate from any Consent we may have obtained from you.

If you give us Authorization to use or disclose health information about you, you may revoke that Authorization, in writing, at any time.

If you revoke your Authorization, we will no longer use or disclose information about you for the reasons covered by your written Authorization. However, we cannot take back any uses or disclosures already made with your permission.

You have the right to be notified following a breach of your PHI by our practice.

Complaints

If you believe your privacy rights have been violated, you may file a complaint with our office or with the Secretary of the Department of Health and Human Services. To file a complaint with our office, contact:

Massage Solutions of Bend, LLC

1289 NE 2nd Street, Suite 3 – Bend, OR 97701

541-317-4826

You will not be penalized for filing a complaint.

MEDICAL INTAKE

MASSAGE SOLUTIONS of Bend

Date: _____

Patient/Client Name: _____

Date of Birth: _____ Date of Injury: _____

Mailing Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____

Email: _____

For Insurance Use Only:

Primary Care Doctor: _____ Do you have a prescription or referral: Y N

Primary Insurance: _____ Referring Doctor: _____

Policy#: _____ Member ID: _____ Group #: _____

Claim #: _____ Insurance Contact: _____ Phone #: _____

Fax #: _____

Secondary Insurance Company: _____

Emergency Contact: _____ Relationship: _____

Emergency Contact Phone: _____

1. Please list any physical discomforts, injuries and/or concerns for your session today:

Pain at LOWEST: Rate your lowest pain level in past 24 hrs. 0 being No pain, 10 being worst pain imaginable: #_____

Describe: _____

_____

Pain Currently: Rate your current pain level at this time. 0 being No pain, 10 being worst pain imaginable: #_____

Describe: _____

_____

Pain at WORST: Rate your worst pain level in past 24 hrs. 0 being No pain, 10 being worst pain imaginable: #_____

Describe: _____

_____

2. List one important activity you are unable or have difficulty performing as a result of your pain/symptoms *(stairs, reaching overhead, etc)*:

_____

Rate your level of pain while trying to perform this task. 0 being No pain, 10 being worst pain imaginable: #_____

3. What is your goal for therapy at this time? _____

_____

4. Are you presently receiving medical care, or taking medications? If yes, please describe:

_____

5. Have you suffered any serious illness, injuries, trauma, been hospitalized or had surgery in the past 3 years?

_____

6. Do you exercise regularly? If yes, describe types & frequency: _____

_____

7. Have you ever had professional bodywork; massage, chiropractic, or acupuncture? If yes, describe types & frequency: _____

_____

8. Please mark the location of your pain on the figure to the right.

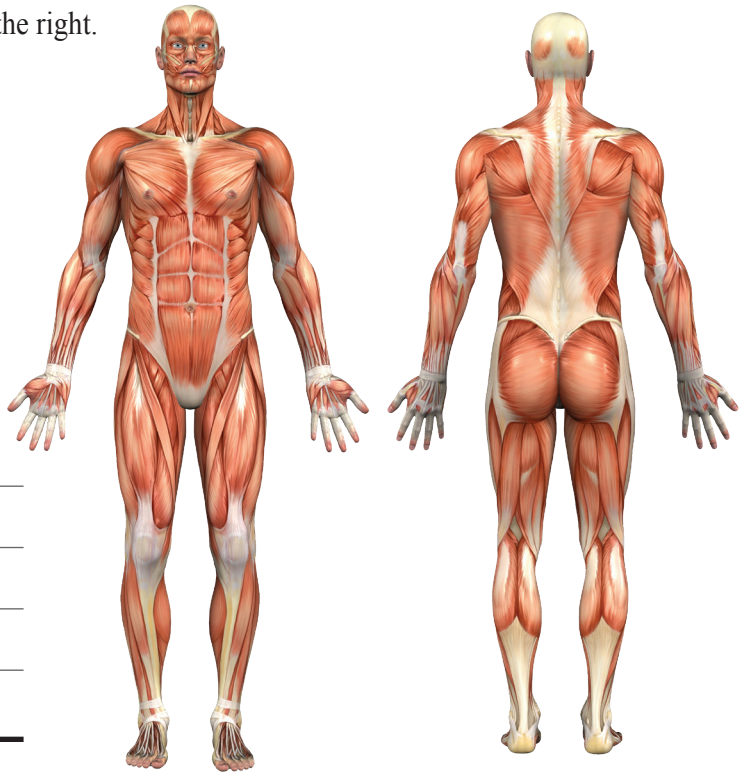
X sharp stabbing pain

0 dull achy pain

+ numb/tingling sensation

// throbbing

= = burning pain



9. Additional Comments or information:

_____

_____

_____

_____

_____

I would like to be informed of the money saving Membership Program Y N

I would like to be informed of the Referral Reward Program Y N

Consent for Care:

It is my choice to receive therapeutic massage or bodywork, and hereby consent. I further understand that massage or bodywork is not a substitute for medical care, medical examination, or diagnosis. I have stated all medical conditions that I am aware of and will inform my practitioner of any changes in my health status.

Signature X _____

The Revised Oswestry Disability Index (for low back pain/dysfunction)

Patient Name: _____ File #: _____ Date: _____

This questionnaire has been designed to give the doctor 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 ONE box that applies to you. We realize that you may consider that two of the statements in any one section relate to you, but please just mark the one box that most closely describes your problem.

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 or dressing even though it causes some pain
- ☐ Washing and dressing increases the pain, but I manage not to change my way of doing it.
- ☐ Washing and dressing increases 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 without help.
- ☐ Because of the pain, I am unable to do any washing or 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, but I can 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 lift only very light weights.
- ☐ I cannot lift or carry anything at all.

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 1/2 mile without increasing pain.
- ☐ I cannot walk more than 1/4 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 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 1/2 hour.
- ☐ Pain prevents me from sitting more than 10 minutes.
- ☐ I avoid sitting because it increases pain right away

Section 6 - Standing

- ☐ 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 1/2 hour without increasing pain.
- ☐ I cannot stand for longer than 10 minutes without increasing pain.
- ☐ I avoid standing because it increases the pain right 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 1/4.
- ☐ Because of pain, my normal night's sleep is reduced by less than 1/2.
- ☐ Because of pain, my normal night's sleep is reduced by less than 3/4.
- ☐ Pain prevents me from sleeping at all.

Section 8 - Social Life

- ☐ My social life is normal and gives me no 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, 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 makes it any worse.
- ☐ I get extra pain while traveling, but it does not compel me to seek alternative forms of travel.
- ☐ 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 is definitely getting better.
- ☐ My pain seems to be getting better, but improvement is slow at present.
- ☐ My pain is neither getting better nor worse.
- ☐ My pain is gradually worsening.
- ☐ My pain is rapidly worsening.

PDR Oswestry Neck Pain Questionnaire

This questionnaire is designed to enable us to understand how much your nect pain has affected your ability to manage everyday activities. Please answer each Section by circling the ONE CHOICE that most applies to you. We realize that you may feel that more than one statement may relate to you, but Please circle the one choice which closely describes your problem right now.

Section 1 - Pain Intensity

- ☐ I have no pain at the moment.
- ☐ The pain is mild at the moment.
- ☐ The pain comes and goes and is moderate.
- ☐ The pain is moderate and does not vary much.
- ☐ The pain is severe, but comes and goes.
- ☐ The pain is severe and does not vary much.

Section 2 - Personal Care

- ☐ I can look after myself 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 undressed, 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 causes extra pain.
- ☐ Pain prevents me from lifting heavy weights off the floor, but I can 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 lift only very light weights.
- ☐ I cannot lift or carry anything at all.

Section 4 - Reading

- ☐ I can read as much as I want with no pain in my neck.
- ☐ I can read as much as I want with slight pain in my neck.
- ☐ I can read as much as I want with moderate pain in my neck.
- ☐ I cannot read as much as I want because of moderate pain in my neck.
- ☐ I cannot read as much as I want because of severe pain in my neck.
- ☐ I cannot read at all.

Section 5 - Headache

- ☐ I have no headaches at all.
- ☐ I have slight headaches that come infrequently.
- ☐ I have moderate headaches that come infrequently.
- ☐ I have moderate headaches that come frequently.
- ☐ I have severe headaches that 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 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 cannot do any work at all.

Section 8 - Driving

- ☐ I can drive my car without 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 cannot 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 cannot drive my car at all.

Section 9 - Sleeping

- ☐ I have no trouble sleeping.
- ☐ My sleep is slightly disturbed (less than 1 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 recreational activities, with no neck pain at all.
- ☐ I am able to engage in all my recreational activities, with some pain in my neck.
- ☐ I am able to engage in most, but not all of my usual recreational activities because of pain in my neck.
- ☐ I am able to engage in only a few of my usual recreational activities because of pain in my neck.
- ☐ I can hardly do any recreational activities because of pain in my neck.
- ☐ I cannot do any recreational activities at all.

Section 11 - Numeric Rating Scale (NRS)

Try and assign a number from 0 to 10 to your current pain level. If you have no pain use a 0.
As the numbers get higher, they stand for pain that is getting worse.
A 10 means that the pain is as bad as it can be.

0	1	2	3	4	5	6	7	8	9	10
No pain		Mild		Moderate		Severe			Worst Possible	

OSW-SCORE: %

P-SCORE: