

1
one

WELCOME

ABOUT YOU

Today's Date: ____ / ____ / ____ File #: _____

Patient Name: _____
 LAST FIRST MI

What You Prefer To Be Called: _____ Male Female

Birthdate: ____ / ____ / ____ Age: ____ SS#: _____

Mailing Address: _____

 CITY STATE ZIP

Home Phone #: _____

Work Phone #: _____ Ext: _____

Other Phone #s: _____

E-Mail Address: _____

Referred By: _____

Employer: _____ How Long? _____

Employer's Address: _____

 CITY STATE ZIP

Occupation: _____

Status: Minor Single Married Divorced Separated Widowed

Spouse's Name: _____

Do you have children? Yes No How many? _____

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two

INSURANCE INFO

Co. Name: _____

Address: _____

Phone #: _____

Insured's SS#: _____

Group # (Plan, Local, or Policy #): _____

Insured's Name: _____

Relation: _____ Date of Birth: ____ / ____ / ____

Insured's Employer: _____

Please inform front desk of 2nd. Insurance source.

REASON FOR VISIT

The reason for this visit is a result of (*Please circle*): work, sports, auto, trauma or chronic.
 (*Explain what happened*): _____

Please describe the pain & its location: _____

When did condition begin? ____ / ____ / ____

Is this condition getting worse? Yes No Constant Comes and goes

Is this condition interfering with your (*Please Circle*): work, sleep, or daily routine.

If so, please explain: _____

Have you had this or similar conditions in the past? Yes No

If so, please explain: _____

Have you been treated by a Medical Physician for this condition? Yes No

If so, where? _____

Have you ever been treated by a Chiropractor before? Yes No

If so, whom? _____ Phone#: _____

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PLEASE CONTINUE ON BACK

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IN EVENT OF EMERGENCY

Who should we contact? _____
 Relation: _____
 Home Phone #: _____ Work Phone #: _____
 Who is your Medical Doctor? _____ Phone #: _____

HEALTH HISTORY

Are you taking any of the following medications?

Nerve pills Pain killers (including aspirin) Muscle relaxers Stimulants
 Blood Thinners Tranquilizers Insulin Other(s) _____

Do you have or ever had any of the following diseases or conditions?

Y N Heart Attack / Stroke Y N Heart Surg./Pacemaker Y N Heart Murmur
 Y N Congenital Heart Defect Y N Mitral Valve Prolapse Y N Artificial Valves
 Y N Alcohol / Drug Abuse Y N Venereal Disease Y N Hepatitis
 Y N HIV+ / Aids Y N Shingles Y N Cancer
 Y N Frequent Neck Pain Y N Emphysema / Glaucoma Y N Anemia
 Y N High/Low Blood Pressure Y N Psychiatric Problems Y N Rheumatic Fever
 Y N Severe/Frequent Headaches Y N Kidney Problems Y N Ulcers / Colitis
 Y N Fainting/Seizures/Epilepsy Y N Sinus Problems Y N Asthma
 Y N Diabetes / Tuberculosis Y N Difficulty Breathing Y N Chemotherapy
 Y N Lower Back Problems Y N Artificial Bones / Joints Y N Arthritis

Please list any other serious medical condition(s) you have or ever had:

Please list anything that you may be allergic to: _____

List previous surgeries/treatments with dates: _____

List any **past** serious accidents with dates: _____

Family Health History: _____

Do you: Take Supplements or Vitamins? Yes No / Exercise? Yes No

Are you on a special diet: Yes No / Since: ____/____/____

Do you smoke? No Yes / How Much? _____ How Long? _____

Are you wearing: Heel Lifts Sole lifts Inner soles Arch supports

What is the age of your mattress? ____ Is it comfortable? Yes No

For women: Are you taking Birth Control? Yes No

Are you Pregnant? No Yes/How long? ____ Nursing? Yes No

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ACCOUNT INFO

Person ultimately responsible for account

Name: _____

Relation: _____

Billing Address: _____

CITY _____ STATE _____ ZIP _____

SSN: _____

D.L.#: _____

Work Phone#: _____

Payment method: CASH Check

Credit Card - Enter card # above (if accepted)

I hereby authorize assignment of my insurance rights and benefits directly to the provider for services rendered. I fully understand I am solely responsible for any balance not paid for by my insurance company (if offered at this office).



PLEASE RECYCLE SO THAT WE MAY PRESERVE THE HEALTH OF OUR PLANET

- We invite you to discuss with us any questions regarding our services. The best health services are based on a friendly, mutual understanding between provider and patient.
- Our policy requires payment in full for all services rendered at the time of visit, unless other arrangements have been made with the business manager. If account is not paid within 90 days of the date of service and no financial arrangements have been made, you will be responsible for legal fees, collection agency fees, and any other expenses incurred in collecting your account.
- I authorize the staff to perform any necessary services needed during diagnosis and treatment. I also authorize the provider and or managed care organization, to release any information required to process insurance claims.
- I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes to the information I have provided.

Signature _____ Date ____/____/____
┆ Adult Patient ┆ Parent or Guardian ┆ Spouse

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one

AUTO / WORK RELATED ACCIDENT

2
two a

ABOUT YOU

Today's Date: / / File #: _____

Name: _____

2b
two b

WORK RELATED ACCIDENT

Date & Time of Accident: _____ a.m. p.m.

Was your accident directly related to your work?
 Yes No

Briefly describe the events that occurred just before and during your accident: _____

Give the address where accident occurred: (if other than employer's address) _____

Was anyone else present during your accident?
 Yes No

Did you report your accident to your employer?
 Yes No

What recommendations did your employer make just after your accident? _____

Has this type of accident happened to you before?
 Yes No

To the best of your knowledge, has this accident occurred in your workplace before? _____ Yes No
In general:

Is your job physically stressful? _____ Yes No

Is your job mentally stressful? _____ Yes No

Is your workplace noisy? _____ Yes No

Have you changed jobs in the last year? Yes No

AUTO RELATED ACCIDENT

Date & Time of Accident: _____ a.m. p.m.

Were you the: Driver Front Passenger Rear Passenger

If a traffic violation was issued, to whom was it issued?

Number of people in accident vehicle? _____

Did the police come to the accident site? .. Yes No

Was a police report filed? Yes No

Were there any witnesses? Yes No

Were you wearing your seat belt? Yes No

Was this vehicle equipped with airbags? .. Yes No

If yes, did it/they inflate? Yes No

In relation to the base of your skull, where was the headrest? Above Below At base of skull

What did your vehicle impact? Another vehicle Other

If other, explain: _____

Did any part of your body strike anything in the vehicle? Yes No

If yes, please describe: _____

Make & model of the vehicle you were occupying?

Name of the location/street on which you were traveling?

In which direction were you headed? N S E W

What was the approx. speed of your vehicle? _____

Did the impact to your vehicle come from the:

Front Rear Right Side Left Side Other

During impact, were you facing: Right Left Forward

Were you aware or surprised by the impact?

If accident vehicle made impact with another vehicle...

Make and model of that other vehicle? _____

Direction other vehicle was headed? N S E W

Speed of the other vehicle? _____

In your words, please describe the accident: _____

PLEASE CONTINUE ON BACK

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AFTER INJURY

Did accident render you unconscious? Yes No

If yes, for how long? _____

Please describe how you felt immediately after the accident:

Have you gone to a Hospital or seen any other Doctor? Yes No

When did you go? Just after accident The next day 2 days plus

How did you get there? Ambulance or Private transportation

Name of Hospital and/or Attending doctor: _____

Was he/she a: D.C. M.D. D.O. D.D.S.

Describe any treatment you received: _____

Were X-rays taken? Yes No

Was medication prescribed? Yes No

Have you been able to work since this injury? Yes No

Are your work activities restricted as a result of this injury?

Yes No

Indicate the symptoms that are a result of this accident:

- Dizziness
- Difficulty sleeping
- Jaw problems
- Nausea
- Memory loss
- Irritability
- Arms/Shoulder pain
- Back pain
- Headache(s)
- Fatigue
- Numb Hands/Fingers
- Lower back pain
- Blurred vision
- Tension
- Chest pain
- Back stiffness
- Buzzing in ear
- Neck pain
- Shortness of breath
- Leg pain
- Ears ringing
- Neck stiff
- Stomach upset
- Numb Feet/Toes
- Other _____

Is your condition getting worse?

Yes No Constant Comes & goes

Indicate your degree of comfort while performing the following activities:

	Comfortable	Uncomfortable <small>even if only sometimes</small>	Painful
Lying on back	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lying on side	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lying on stomach	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sitting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Standing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Stretching	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lovemaking	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Walking	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Running	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sports	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Working	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lifting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bending	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Kneeling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Pulling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Reaching	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Have you retained an attorney: Yes No

If yes, whom: _____

His/Her Phone #: _____

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RECOVERY

To evaluate the effect that continuing work will have on your recovery please complete the following:

How many hours are in your normal work day? _____

Please indicate your daily job duties and any activities which you are occasionally asked to perform.

- Standing
- Driving
- Operating equipment
- Sitting
- Twisting
- Work with arms above head
- Walking
- Crawling
- Typing
- Lifting
- Bending
- Stooping

Other _____

What positions can you work in with minimum physical effort and for how long? _____ N/A

Prior to the injury were you capable of working on an equal basis with others your age? . . Yes No N/A

Do you work with others who can help you with any heavy lifting? Yes No N/A

While in recovery, is there any light duty work you could request? Yes No N/A

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ADDITIONAL INSURANCE

2nd Insurance Source or Auto Insurance

Type of Insurance: _____

Co. Name: _____

Address: _____

Phone #: _____

Insured's Name: _____

Policy #: _____ Claim #: _____

Insured's SS #: _____ D.O.B. / /

Insured's Employer: _____

Agent's Name: _____

If any of your medical or account information has changed, please inform our front desk personnel. Please remember you are ultimately responsible for your account.

_____/_____/_____
SIGNATURE DATE

OFFICE USE ONLY OFFICE USE ONLY OFFICE USE ONLY OFFICE USE ONLY OFFICE USE ONLY



PLEASE RECYCLE SO THAT WE MAY PRESERVE THE HEALTH OF OUR PLANET

PAIN CHART

ABOUT YOU

Name: _____ File #: _____

What is your current weight: _____ lbs., and height, _____ Ft. _____ In..

Please describe your condition:

Signature: _____ Date: ____ / ____ / ____

SHOW US WHERE IT HURTS

Please mark **area(s)** of injury or discomfort as shown in the example below. Mark all areas with the appropriate symbols and indicate the degree of pain using a scale from 1 (discomfort) to 10 (extreme pain).

Description → Numbness
Symbol → NNNN

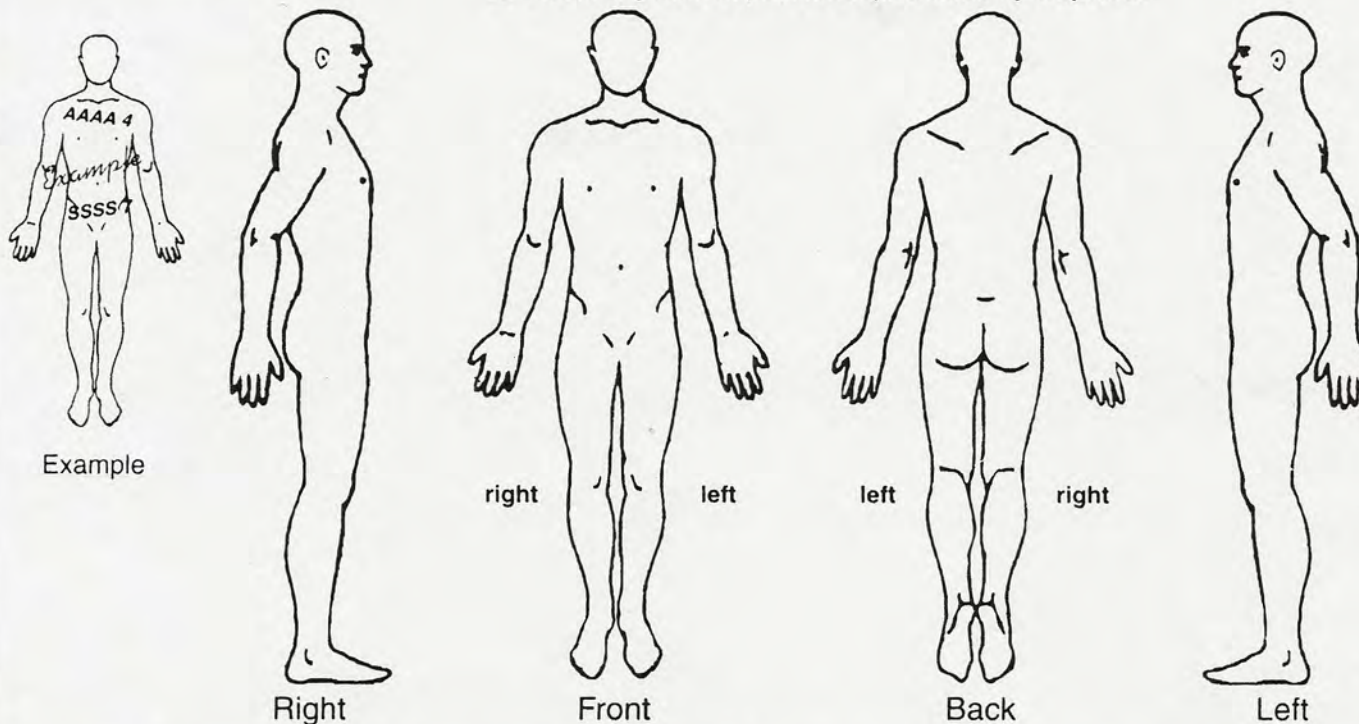
Pins & Needles
PPPP

Burning
BBBB


Aching
AAAA

Stabbing
SSSS

○ Circle any area of pain not represented by a symbol.



DOCTOR'S NOTES

PLEASE RECYCLE SO THAT WE MAY PRESERVE THE HEALTH OF OUR PLANET 

Activities Discomfort Scale

For each of the following activities, please place a check in the one column that best describes how much pain the activity presently causes, on the average (does not include unusual or prolonged activity).

Activity	Doesn't Hurt At All	Hurts A Little	Hurts Very Much	Almost Unbearable	Unbearable Pain Prevents Activity
1. Walking					
2. Sitting					
3. Bending					
4. Standing					
5. Sleeping					
6. Lifting					
7. Running or jogging					
8. Climbing Stairs					
9. Carrying					
10. Pushing or Pulling					
11. Driving					
12. Dressing					
13. Reading					
14. Watching TV					
15. Household Chores					
16. Gardening					
17. Sports					
18. Employment					

ADDITIONAL COMMENTS:

PATIENT NAME _____ PATIENT SIGNATURE _____

EXAMINER _____ DATE _____ Score _____ [72]

Turner JA, Robinson J, McCreary CP. Chronic low back pain: Predicting response to nonsurgical treatment. *Arch Phys Med Rehabilitation* 1983; 64: 560-563

NAME: _____ DATE: _____ AGE: _____ Scores Total: _____; E _____; F _____
 (100) (52) (48)

HEADACHE DISABILITY INDEX

INSTRUCTIONS: Please CIRCLE the correct response:

1. I have headache: [1] 1 per month [2] more than 1 but less than 4 per month [3] more than one per week
 2. My headache is: [1] mild [2] moderate [3] severe

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

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

Back Index

Patient Name _____ Date _____

This questionnaire will give your provider information about how your back condition affects your everyday life. Please answer every section by marking the one statement that applies to you. If two or more statements in one section apply, please mark the one statement that most closely describes your problem.

Pain Intensity

- Ⓐ The pain comes and goes and is very mild.
- ① The pain is mild and does not vary much.
- ② The pain comes and goes and is moderate.
- ③ The pain is moderate and does not vary much.
- ④ The pain comes and goes and is very severe.
- ⑤ The pain is very severe and does not vary much.

Sleeping

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

Sitting

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

Standing

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

Walking

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

Personal Care

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

Lifting

- Ⓐ I can lift heavy weights without extra pain.
- ① I can lift heavy weights but it causes extra pain.
- ② Pain prevents me from lifting heavy weights off the floor.
- ③ Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned (e.g., on a table).
- ④ Pain prevents me from lifting heavy weights off the floor, but I can manage light to medium weights if they are conveniently positioned.
- ⑤ I can only lift very light weights.

Traveling

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

Social Life

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

Changing degree of pain

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

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Score

Neck Index

Back Index

Patient Name _____ Date _____

This questionnaire will give your provider information about how your neck condition affects your everyday life. Please answer every section by marking the one statement that applies to you. If two or more statements in one section apply, please mark the one statement that most closely describes your problem.

Pain Intensity

- ⓪ I have no pain at the moment.
- ① The pain is very mild at the moment.
- ② The pain comes and goes and is moderate.
- ③ The pain is fairly severe at the moment.
- ④ The pain is very severe at the moment.
- ⑤ The pain is the worst imaginable at the moment.

Personal Care

- ⓪ I can look after myself normally without causing extra pain.
- ① I can look after myself normally but it causes extra pain.
- ② It is painful to look after myself and I am slow and careful.
- ③ I need some help but I manage most of my personal care.
- ④ I need help every day in most aspects of self care.
- ⑤ I do not get dressed, I wash with difficulty and stay in bed.

Sleeping

- ⓪ I have no trouble sleeping.
- ① My sleep is slightly disturbed (less than 1 hour sleepless).
- ② My sleep is mildly disturbed (1-2 hours sleepless).
- ③ My sleep is moderately disturbed (2-3 hours sleepless).
- ④ My sleep is greatly disturbed (3-5 hours sleepless).
- ⑤ My sleep is completely disturbed (5-7 hours sleepless).

Lifting

- ⓪ I can lift heavy weights without extra pain.
- ① I can lift heavy weights but it causes extra pain.
- ② Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned (e.g., on a table).
- ③ Pain prevents me from lifting heavy weights off the floor, but I can manage light to medium weights if they are conveniently positioned.
- ④ I can only lift very light weights.
- ⑤ I cannot lift or carry anything at all.

Reading

- ⓪ I can read as much as I want with no neck pain.
- ① I can read as much as I want with slight neck pain.
- ② I can read as much as I want with moderate neck pain.
- ③ I cannot read as much as I want because of moderate neck pain.
- ④ I can hardly read at all because of severe neck pain.
- ⑤ I cannot read at all because of neck pain.

Driving

- ⓪ I can drive my car without any neck pain.
- ① I can drive my car as long as I want with slight neck pain.
- ② I can drive my car as long as I want with moderate neck pain.
- ③ I cannot drive my car as long as I want because of moderate neck pain.
- ④ I can hardly drive at all because of severe neck pain.
- ⑤ I cannot drive my car at all because of neck pain.

Concentration

- ⓪ I can concentrate fully when I want with no difficulty.
- ① I can concentrate fully when I want with slight difficulty.
- ② I have a fair degree of difficulty concentrating when I want.
- ③ I have a lot of difficulty concentrating when I want.
- ④ I have a great deal of difficulty concentrating when I want.
- ⑤ I cannot concentrate at all.

Recreation

- ⓪ I am able to engage in all my recreation activities without neck pain.
- ① I am able to engage in all my usual recreation activities with some neck pain.
- ② I am able to engage in most but not all my usual recreation activities because of neck pain.
- ③ I am only able to engage in a few of my usual recreation activities because of neck pain.
- ④ I can hardly do any recreation activities because of neck pain.
- ⑤ I cannot do any recreation activities at all.

Work

- ⓪ I can do as much work as I want.
- ① I can only do my usual work but no more.
- ② I can only do most of my usual work but no more.
- ③ I cannot do my usual work.
- ④ I can hardly do any work at all.
- ⑤ I cannot do any work at all.

Headaches

- ⓪ I have no headaches at all.
- ① I have slight headaches which come infrequently.
- ② I have moderate headaches which come infrequently.
- ③ I have moderate headaches which come frequently.
- ④ I have severe headaches which come frequently.
- ⑤ I have headaches almost all the time.

Neck
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