ARBITRATION AGREEMENT

CASPER ORTHOPAEDIC ASSOCIATES, P.C.

ARTICLE 1 Dispute Resolution

By signing this Agreement ("Agreement") we are agreeing to resolve any Claim for medical malpractice by the dispute resolution process described in this Agreement. Under this Agreement, you can pursue your Claim and seek damages, but you are waiving your right to have it decided by a judge or jury.

ARTICLE 2 Definitions

A. The term "we," "parties," or "us" means you, (the Patient), and the provider.
B. The term "Claim" means one or more Malpractice Actions as defined under Wyoming law.
C. The term "Provider" means the physician, group or Casper Orthopaedics, and their employees, partners, associates, and agents.
D. The term "Patient" or "you" means:
   (1) you and any person who makes a Claim for care given to YOU, such as your heirs, your spouse, children, parents, or legal representatives.

ARTICLE 3 Dispute Resolution Options

A. Methods Available for Dispute Resolution. We agree to resolve any Claim by:
   (1) working directly with each other to try and find a solution that resolves the Claim, OR
   (2) using non-binding mediation (each of us will bear one-half of the costs); OR
   (3) using binding arbitration as described in this Agreement.

YOU MAY CHOOSE TO USE ANY OR ALL OF THESE METHODS TO RESOLVE YOUR CLAIM

B. Legal Counsel. Each of us may choose to be represented by legal counsel during any stage of the dispute resolution process, but each of us will pay the fees and costs of our own attorney.
C. Arbitration – Final Resolution. If working with the Provider or using nonbinding mediation does not resolve your Claim, we agree that your Claim will be resolved through binding arbitration. We both agree that the decision reached in binding arbitration will be final.

ARTICLE 4 How to Arbitrate a Claim

A. Notice. To make a Claim under this Agreement, mail a written notice to the Provider by certified mail that briefly describes the nature of your Claim (the "Notice"). If the Notice is sent to the Provider by certified mail it will suspend (toll) the applicable statute of limitations during the dispute resolution process described in this Agreement.
B. Arbitrators. Within 30 days of receiving the Notice, the Provider will contact you. If you and the Provider cannot resolve the Claim by working together or through mediation, we will start the process of choosing arbitrators. There will be three arbitrators, unless we agree that a single arbitrator may resolve the Claim.
   (1) Appointed Arbitrators. You will appoint an arbitrator of your choosing and all Providers will jointly appoint an arbitrator of their choosing.

(2) Jointly-Selected Arbitrator. You and the Provider(s) will then jointly appoint an arbitrator (the "Jointly-Selected Arbitrator"). If you and the Provider(s) cannot agree upon a Jointly-Selected Arbitrator, the arbitrators appointed by each of the parties will choose the Jointly-Selected Arbitrator from a list of individuals approved as arbitrators by the state or federal court of Wyoming. If the arbitrators cannot agree on a Jointly-Selected Arbitrator, either or both of us may request that a Wyoming court select an individual from the lists described above. Each party will pay their own fees and costs in such an action. The Jointly-Selected Arbitrator will preside over the arbitration hearing and have all other powers of an arbitrator as set forth in the Wyoming Uniform Arbitration Act.

C. Arbitration Expenses. You will pay the fees and costs of the arbitrator you appoint and the Provider(s) will pay the fees and costs of the arbitrator the Provider(s) appoints. Each of us will also pay one-half of the fees and expenses of the Jointly-Selected Arbitrator and any other expenses of the arbitration panel.

D. Final and Binding Decision. A majority of the three arbitrators will make a final decision on the Claim. The decision shall be consistent with the Wyoming Uniform Arbitration Act.

E. All Claims May Be Joined. Any person or entity that could be appropriately named in a court proceeding ("Joined Party") is entitled to participate in this arbitration as long as that person or entity agrees to be bound by the arbitration decision ("Joinder"). This includes consulting, assisting, or referral physicians utilized by Casper Orthopaedics, including, but not limited to anesthesiologists, pathologists, and other subspecialists. Joinder may also include Claims against persons or entities that provided care prior to the signing date of this Agreement. A "Joined Party" does not participate in the selection of the arbitrators but is considered a "Provider" for all other purposes of this Agreement.

ARTICLE 5 Liability and Damages May Be Arbitrated Separately

At the request of either party, the issues of liability and damages will be arbitrated separately. If the arbitration panel finds liability, the parties may agree to either continue to arbitrate damages with the initial panel or either party may cause that a second panel be selected for considering damages. However, if a second panel is selected, the Jointly Selected arbitrator will remain the same and will continue to preside over the arbitration unless the parties agree otherwise.

ARTICLE 6 Venue / Governing Law

The arbitration hearings will be held in a place agreed to by the parties. If the parties cannot agree, the hearings will be held in Casper, Wyoming. Arbitration proceedings are private and shall be kept confidential. The provisions of the Wyoming Uniform Arbitration govern this Agreement. We hereby waive the pre-litigation panel review requirements of Wyoming Statute. The arbitrators will apportion fault to all persons or entities that contributed to the injury claimed by the Patient, whether or not those persons or entities are parties to the arbitration.

ARTICLE 7 Term / Rescission / Termination

A. Term. This Agreement is binding on both of us for one year from the date you sign it unless you rescind it. If it is not rescinded, it will automatically renew every year unless either party notifies the other in writing of a decision to terminate it.

B. Rescission. You may rescind this Agreement within 3 days of signing it by sending written notice by registered or certified mail to the Provider. The effective date of the rescission notice will be the date the rescission is postmarked. If not rescinded, this Agreement will govern all medical services received by the Patient from Provider after the date of signing.

C. Termination. If the Agreement has not been rescinded, either party may still terminate it at any time, but termination will not take effect until the next anniversary of the signing of the Agreement. To terminate this Agreement, send written notice by registered or certified mail to the Provider. This Agreement applies to any Claim that arises while it is in effect, even if you file a Claim or request arbitration after the Agreement has been terminated.

ARTICLE 8 Severability

If any part of this Agreement is held to be invalid or unenforceable, the remaining provisions will remain in full force and will not be affected by the invalidity of any other provision.

ARTICLE 9 Acknowledgment of Written Explanation of Arbitration

I have received a written explanation of the terms of this Agreement. I have had the right to ask questions and have my questions answered. I understand that any Claim I might have must be resolved through the dispute resolution process in this Agreement instead of having them heard by a judge or jury. I understand the role of the arbitrators and the manner in which they are selected. I understand the responsibility for arbitration related costs I understand that I can rescind this Agreement within 3 (three) days of signing it.

I understand that I have the right to receive a copy of this Arbitration Agreement. By my signature below, I acknowledge that I have received a copy.

NOTICE

BY SIGNING THIS CONTRACT, YOU ARE AGREEING TO HAVE ANY ISSUE OF MEDICAL MALPRACTICE DECIDED BY NEUTRAL ARBITRATION AND YOU ARE GIVING UP YOUR RIGHT TO A JURY OR COURT TRIAL

By: ______________________________
Patient or Patient's Representative

____
Relationship to Patient

____
Print Patient's Name

____
Date

By: ______________________________
Physician or Authorized Representative

CASPER ORTHOPAEDIC ASSOCIATES, P.C.

Casper Orthopaedic Associates, P.C.
4140 Centennial Hills Blvd, Suite A • Casper, WY 82609 • (307) 265-7205 ID Verified ____________

Appointment Doctor ____________ Date ____________

PATIENT INFORMATION (CHILDS name if applicable):

Last ________ First ________ Middle ___

*SSN ________ Age ____ Male ☐ Female ☐

DOB ________ Marital Status ________

Street ____________

City ________ State ____ Zip ______

Mailing ____________

City ________ State ____ Zip ______

Phone (H) ______ (W) ______ (C) ______

E-Mail Address ____________

Employer ________ Work Status ______

Employer Address ____________

Employer Phone ______ Occupation ______

RESPONSIBLE PARTY / PARENT PRESENT WITH CHILD

Last ________ First ________ Middle ___

*SSN ________ Age ____ Male ☐ Female ☐

DOB ________ Marital Status ________

Street ____________

City ________ State ____ Zip ______

Mailing ____________

City ________ State ____ Zip ______

Phone (H) ______ (W) ______ (C) ______

Employer ________ Work Status ______

Employer Address ____________

Employer Phone ______ Occupation ______

SPOUSE / OTHER RESPONSIBLE PARTY

Last ________ First ________ Middle ___

*SSN ________ Age ____ Male ☐ Female ☐

DOB ________ Marital Status ________

Street ____________

City ________ State ____ Zip ______

Mailing ____________

City ________ State ____ Zip ______

Phone (H) ______ (W) ______ (C) ______

Employer ________ Work Status ______

Employer Address ____________

Employer Phone ______ Occupation ______

INSURANCE 1

Ins. Co. Name ____________

Insured Policy Holder ____________

Insured DOB ________ SSN ________

Policy ID # ________ Group ID # ______

Relationship to Patient ____________

Claims Address ____________

City ________ State ____ Zip ______

Insurance Phone # ____________

Pre Certification Phone # ____________

INSURANCE 2

Ins. Co. Name ____________

Insured Policy Holder ____________

Insured DOB ________ SSN ________

Policy ID # ________ Group ID # ______

Relationship to Patient ____________

Claims Address ____________

City ________ State ____ Zip ______

Insurance Phone # ____________

Pre Certification Phone # ____________

CURRENT INJURY INFORMATION

Type: Accident Work Auto Date ________

Place ________ Time ______

Body Part: ________ Right Left Bilateral

Description of Accident ____________

____

____

____

RELATIVE / FRIEND NOT LIVING IN HOME

Last ________ First ________

Address ____________

City ________ State ____ Zip ______

Phone ____________

Disclosure of this information is voluntary. However, failure to provide this information will result in no credit being extended and all services must be paid for at the time they are rendered.

I authorize treatment of the patient named above and agree to pay all fees and charges for such treatment. Charges shown by statements are agreed to be correct and reasonable, unless protested in writing within thirty days of the billing date. If in the event legal action should become necessary to collect an unpaid balance due for medical services rendered, I agree to pay reasonable attorney's fees or other such costs as the Court determines proper. I authorize Casper Orthopaedic Associates, P.C. to obtain credit/employment information required for collection purposes.

X-rays taken at Casper Orthopaedic Associates, P.C. will remain the property of Casper Orthopaedic Associates, P.C. Copies of x-rays can be provided for a small fee.

It may be necessary for additional tests to be ordered and performed outside of Casper Orthopaedics Associates, P.C. I authorize transfer of medical information, patient information and insurance information to the following outside sources: Wyoming Medical Center, Casper Surgical Center, Wyoming Surgical Center, Wyoming Imaging Center, Casper Medical Imaging, Diagnostic Lab, and Medical Testing Lab and/or other medical facilities if indicated. I have the right to amend, revoke and to obtain a written report annually of all disclosures of health information.

Casper Orthopaedics will routinely call the patient to remind them of an upcoming appointment. A message will be left on your voice mail or answering machine regarding the date and the time of that appointment.

It is agreed that payments will not be delayed or withheld because of any insurance coverage or the pendency of claims.

Signature of Responsible Party ______________________________ Date ____________________

I have received the Patient Information Brochure ______________________________ / ____________
Patient Signature Date

PRIVACY NOTIFICATION

By signing below, you acknowledge that you have been informed of the Notice of Information Privacy Practices ("Notice") from Casper Orthopaedic Associates, P.C. You have the right to review our Notice prior to signing this acknowledgment. The terms of the Notice may change. If the terms do change, you may obtain a revised Notice by simply contacting Casper Orthopaedic, P.C. at (307) 265-7205 and request a revised Notice. We will also post any revised Notice at 4140 Centennial Hills Boulevard. You have the right to request that we restrict our uses or disclosures of your protected health information, which we are otherwise permitted to make for treatment, payment and healthcare operations, although we are not required to agree to those restrictions.

Acknowledgment______________________________ Date____________________

INSURANCE OPTION

I hereby authorize and request payment to be made directly to Casper Orthopaedic Associates, P.C. for medical treatment provided to myself or any member of my family covered by my medical insurance program. If necessary, I authorize release of medical information relative to any claims submitted to my insurance company. I understand that any part of my bill not paid by my insurance company is my responsibility. Further, should my insurance company not honor this assignment of benefits, I will immediately forward any payment made directly to me by my insurance carrier. This authorization shall remain in effect for twelve (12) months from the date signed. I understand that I may revoke this authorization at any time by notifying the practice in writing, but if I do, it will not have any affect on any actions they took before they received the revocation.

Insurance 1____________________ Insurance 2____________________

Insured Policy Holder Name____________________ Insured Policy Holder Name____________________
(Signature) (Signature)
Date____________________ Date____________________

CASPER ORTHOPAEDIC ASSOCIATES

Please fill out these forms completely!

We Know that filling out these forms can be difficult – but please complete them carefully. Your accurate responses will give us a better understanding of your and your problems. From this information we can provide you the best care possible.

Please be careful to follow the directions in each section. Clearly mark the check boxes and fill in the blanks where indicated.

Thank you for your helping us to know you better!

Date: ______________________

Patient Name: ______________________
(Please print)

Gender: ☐ Male ☐ Female

Date of Birth: ______________________
Month/Day/Year

Current Age: ______________________

Height: ____________ Weight: ________

Referring Physician: ______________________

Primary Care Physician: ______________________

PAIN DIAGRAM

Please mark the areas where you feel the following sensations. Pay attention to right and left sides.

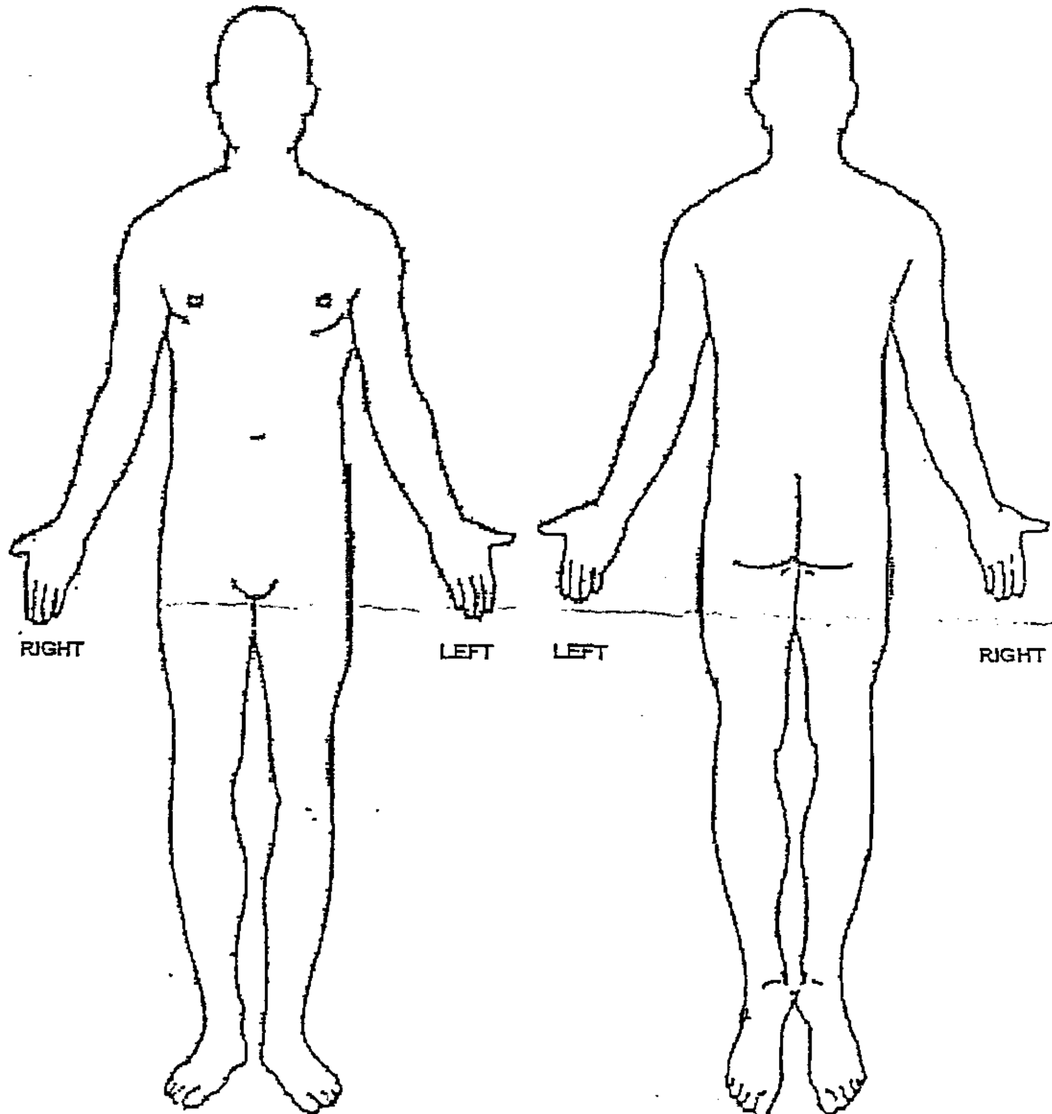
Ache
AAAAA
AAAAA
AAAAA

Numbness
NNNN
NNNN
NNNN

Pins & Needles
PPPP
PPPP
PPPP

Burning
BBBB
BBBB
BBBB

Stabbing
SSSS
SSSS
SSSS



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FACTORS OF COMPLAINT

What do you want to happen as a result of this visit?

____

____

____

How and when did your problem begin? (Please mark each answer that applies to your neck/back pain.)

- ☐ I don't know how it began.
- ☐ It comes and goes.
- ☐ I've had it a long time. (_____ years)
- ☐ Injury (date of injury_______) On the job? ☐yes ☐no
  Please explain how the injury happened.
  ____

Are you currently in litigation with regards to your back pain? ☐yes ☐no

Have you been laid off from your job? ☐yes ☐no ☐N/A

How bad is your pain? Place an "X" (—X—) on each of the lines below to indicate your pain.

How bad is your **low back** pain?

No pain ———————————————— Worst possible

How bad is your **leg** pain?

No pain ———————————————— Worst possible

How bad is your **middle back** pain?

No pain ———————————————— Worst possible

How bad is your **neck** pain?

No pain ———————————————— Worst possible

How bad is your **arm** pain?

No pain ———————————————— Worst possible

Do you have any of the following problems?
(Please check your answer.)

Is your pain worse at night? ☐yes ☐no

Does your pain awaken you from sleep? ☐yes ☐no

Does coughing affect your pain? ☐yes ☐no

Do your legs tire/hurt if you walk too far? ☐yes ☐no

If YES, how far can you walk?

☐less than 1 block ☐1-3 blocks ☐more than 3 blocks

Is this relieved by resting your legs? ☐yes ☐no

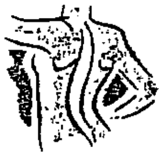
Is this relieved by bending forward? ☐yes ☐no

Bladder Control (urine):
- ☐ No problem
- ☐ Can't empty bladder
- ☐ Loss of urine (accidents)

Bowel Control:
- ☐ No problem
- ☐ Constipation
- ☐ Loss of control (accidents)

How does each of the following affect you pain? (check your answer)

Sitting	☐Better	☐Worse	☐No change	
Standing	☐Better	☐Worse	☐No change	
Walking	☐Better	☐Worse	☐No change	
Lying down	☐Better	☐Worse	☐No change	
Rising from chair	☐Better	☐Worse	☐No change	
Physical activity	☐Better	☐Worse	☐No change	
Heat	☐Better	☐Worse	☐No change	☐Don't know
Cold	☐Better	☐Worse	☐No change	☐Don't know
Massage	☐Better	☐Worse	☐No change	☐Don't know



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PREVIOUS TREATMENT

We need to know about the treatments you have already received for your current back/neck pain. If YES, did it make your condition better or worse?

Have you had:

Chiropractic care	☐ better	☐ worse
Physical therapy	☐ better	☐ worse
Injections	☐ better	☐ worse
Psychological consultation	☐ better	☐ worse
Other: ____________	☐ better	☐ worse

For your current back/neck pain, please mark the boxes for the timeframe that any tests were done.

	<6 mo	<12 mo
X-rays	☐	☐
MRI scan	☐	☐
CT scan	☐	☐
Myelogram	☐	☐
Discogram	☐	☐
EMG/NCV (nerve test)	☐	☐

Have you ever had surgery on your back or neck?

☐ yes ☐ no If YES, complete the following:

1) Type of surgery ____________
Date ____________
Surgeon ____________
Did it make your pain ☐ better or ☐ worse?

2) Type of surgery ____________
Date ____________
Surgeon ____________
Did it make your pain ☐ better or ☐ worse?

3) Type of surgery ____________
Date ____________
Surgeon ____________
Did it make your pain ☐ better or ☐ worse?

GENERAL MEDICAL HISTORY

Check all the conditions below that you have currently or have had in the past. If NONE check ☐

☐ Heart attack	☐ Colon Problems	☐ Gout	☐ Enlarged prostate	☐ ALS
☐ Heart murmur	☐ Diabetes	☐ Anxiety	☐ Menstrual problems	☐ HIV
☐ Angina	☐ Hepatitis	☐ Depression	☐ Cancer: type	☐ Tremor
☐ High blood pressure	☐ Cirrhosis	☐ Emphysema	☐ Osteoporosis	*Have you used:*
☐ Stroke	☐ Kidney stones	☐ Tuberculosis	☐ Multiple Sclerosis (MS)	☐ Immuno-suppression?
☐ Varicose veins	☐ Kidney infection	☐ Chronic bronchitis	☐ Visual Changes	
☐ Stomach ulcer	☐ Degenerative arthritis	☐ Frequent pneumonia	☐ Blood Clots	☐ Corticosteroids
☐ Duodenal problems	☐ Rheumatoid arthritis	☐ Asthma	☐ Hepatitis A, B, C	☐ Other: ________
☐ Anemia (low blood count)	☐ Bleeding tendency	☐ Sexual difficulty	☐ Dizziness	☐ Other: ________

List any major surgery you have had, other than on your back or neck.

Type of surgery	Year
1. ____________	______
2. ____________	______
3. ____________	______

Are you allergic to any medications?
☐ yes ☐ no If YES, list the medications.

____
____
____

Are you allergic to metal? ☐ yes ☐ no

Do you take any medications, including herbal, over-the-counter, and prescription?
☐ yes ☐ no If YES, list all medications you are taking.

Medication	Reason taken	How often taken	Doctor (if prescribed)

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☐I do not know the medical history of my biological parents or other family members. (Go on to next section.)	Mother: ☐ Alive age:____ ☐ Deceased at age:__ due to __________	Father: ☐ Alive age:____ ☐ Deceased at age:__ due to __________	Number of living brothers/sisters____, Number of deceased brothers/sisters____, cause(s)__________

Members of my family (parents, brothers/sisters, grandparents, aunts/uncles) suffer with the following:

Check all that apply:

☐ Stroke	☐ Heart trouble	☐ Kyphosis
☐ Diabetes	☐ Back problems	☐ Arthritis
☐ Lung disease	☐ Cancer	☐ None of these
☐ High blood pressure	☐ Osteoporosis	☐ Don't know
	☐ Scoliosis	☐ Other

SOCIAL HISTORY

Marital Status
- ☐ Married
- ☐ Separated
- ☐ Divorced
- ☐ Single
- ☐ Widow/widower

Education
Check the highest level completed:
- ☐ Grammar school
- ☐ High school
- ☐ College
- ☐ Post-graduate

Smoking
Do you now, or have you ever smoked?
☐yes ☐no

If YES, please complete the following:
I smoke ____ packs per day
and I have smoked for ____ years.
or
I did smoke ____ packs per day
for ____ years, but I quit smoking ____ years ago.

Do you use any smokeless tobacco product? ☐yes ☐no

Alcohol
Do you drink:
Beer? ☐yes ☐no
Wine? ☐yes ☐no
"Hard" drinks? ☐yes ☐no

Frequency of drinking:
☐never
☐rarely
☐socially (how often_____)
☐daily

Do you have a history of heavy drinking?
☐yes ☐no

Effect of your back/neck pain on your lifestyle.

I describe my home setting as supportive of me during this time.	☐yes	☐no
I describe my work setting as supportive of me during this time.	☐yes	☐no
My pain has affected my interaction with my family and friends.	☐yes	☐no
The changes in my lifestyle due to my problem have been difficult for me.	☐yes	☐no

What is your ability to enjoy life? ☐Excellent ☐Very good ☐Good ☐Fair ☐Poor

Please indicate your current work status.
- ☐ Working full time
- ☐ Working part time
- ☐ Seeking employment
- ☐ Not working by choice (retired, homemaker, student, etc.)
- ☐ Physically unable to work due to back/neck problem
- ☐ Physically unable to work not due to back/neck problem

Before having back or neck pain, did you normally work:
☐full time ☐part time ☐neither

What is your usual occupation?
____

Do you like your work situation?
☐yes ☐no ☐N/A

Has your pain affected your ability to do your job or any other daily activities? ☐yes ☐no
If YES, please explain ____________________

Is there anything we have failed to ask that you believe is important for us to know?
☐yes ☐no If YES, please explain: ____________________

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REVIEW OF SYSTEMS

Do you have any allergies other than to medications (such as to latex, shellfish, etc.)?
☐yes ☐no If YES, describe.______

Do you have any of the following?

General:
Recent weight loss of more than 10 pounds? ☐yes ☐no
Recent weight gain of more than 10 pounds? ☐yes ☐no
Fever? ☐yes ☐no
Chills? ☐yes ☐no
Night sweats? ☐yes ☐no

Have you seen your primary care physician in the past year? ☐yes ☐no

Cardiac:
Chest pain ☐yes ☐no
Shortness of Breath ☐yes ☐no

Respiratory:
Wheezing ☐yes ☐no
Pneumonia ☐yes ☐no
Chronic cough ☐yes ☐no

Gastrointestinal:
Abdominal pain ☐yes ☐no
Nausea ☐yes ☐no
Vomiting ☐yes ☐no
Diarrhea ☐yes ☐no
Liver problems ☐yes ☐no

Skin:
Open sores ☐yes ☐no
New moles ☐yes ☐no
Poor healing ☐yes ☐no
Skin infection ☐yes ☐no

Hematoligic/Oncologic:
Easy bruising ☐yes ☐no
Blood thinning medications ☐yes ☐no
Blood transfusion ☐yes ☐no
Organ transplant ☐yes ☐no

Bones/Joints:
Shoulder pain ☐yes ☐no
Wrist/hand pain ☐yes ☐no
Hip pain ☐yes ☐no
Knee pain ☐yes ☐no
Lupus ☐yes ☐no
Muscle weakness ☐yes ☐no
Fibromyalgia ☐yes ☐no

Genitourinary:
Abnormal kidney function ☐yes ☐no
Pain with urination ☐yes ☐no
Frequent urinary infections ☐yes ☐no

Mental Health:
Sleep disturbances ☐yes ☐no
Feeling of hopelessness ☐yes ☐no

Nervous System:
Headaches ☐yes ☐no
Tremors ☐yes ☐no
Poor speech ☐yes ☐no
Changes in vision ☐yes ☐no

Endocrine:
Thyroid problems ☐yes ☐no

 Patient's initials ______ Date ______

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BACK PAIN QUESTIONNAIRE

If you have LOW BACK pain- complete this page,
if you only have neck pain, skip this page.

Please Read: This questionnaire is designed to give us information on how your back(or leg) trouble has affected your ability to manage in everyday life. Please answer every section. Mark the one box in each section that most closely describes you 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 extra pain.
- ☐ I can look after myself normally but it is very painful.
- ☐ 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 everyday in most aspects of self care.
- ☐ I do not get dressed, wash with difficulty, an 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 – Walking
- ☐ Pain does not prevent me from walking any distance.
- ☐ Pain prevents me walking more than 1 mile.
- ☐ Pain prevents me walking more than 1/2 mile.
- ☐ Pain prevents me walking more than 100 yards.
- ☐ 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 still in any chair as long as I like.
- ☐ I can sit in my favorite chair as long as I like.
- ☐ Pain prevents me sitting more than 1 hour.
- ☐ Pain prevents me sitting more than 1/2 hour.
- ☐ Pain prevents me sitting more than 10 mins.
- ☐ Pain prevents me from sitting at all.

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 me extra pain.
- ☐ Pain prevents me from standing for more than 1 hour.
- ☐ Pain prevents me from standing more than 1/2 an hour.
- ☐ Pain prevents me from standing for more than 10 mins.
- ☐ Pain prevents me from standing at all.

Section 7 – Sleeping
- ☐ My sleep is never disturbed by pain.
- ☐ My sleep is occasionally disturbed by pain.
- ☐ Because of pain I get less than 6 hours sleep.
- ☐ Because of pain I get less than 4 hours sleep.
- ☐ Because of pain I get less than 2 hours sleep.
- ☐ Pain prevents me from sleeping at all.

Section 8 – Sex Life (if applicable)
- ☐ My sex life is normal and causes no extra pain.
- ☐ My sex life is normal but causes some extra pain.
- ☐ My sex life is nearly normal but is very painful.
- ☐ My sex life is severely restricted by pain.
- ☐ My sex life is nearly absent because of pain.
- ☐ Pain prevents any sex life at all.

Section 9 – Social Life
- ☐ My social life is normal and causes me no extra 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. sports, etc.
- ☐ Pain has restricted my social life and I do not go out as often.
- ☐ Pain has restricted my social life to my home.
- ☐ I have no social life because of pain.

Section 10 – Traveling
- ☐ I can travel anywhere without extra pain.
- ☐ I can travel anywhere but is gives me extra pain.
- ☐ Pain is bad but I can manage journeys over two hours.
- ☐ Pain restricts me to journeys of less than one hour.
- ☐ Pain restricts me to short necessary journeys under 30 minutes.
- ☐ Pain prevents me from traveling except to receive treatment.

 Patient's initials ______ Date ______

Casper Orthopaedic Associates

NECK PAIN QUESTIONNAIRE

If you have NECK pain- complete this page.

Please Read: This questionnaire has been designed to enable us to understand how much your neck pain has affected your ability to manage your everyday activities. Please just mark the one choice which most closely describes your problem right now.

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 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 everyday in most aspects of self care.
- ☐ I do not get dressed, 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, 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 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 – Headaches
- ☐ I have no headache 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 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 cannot 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 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 of my recreational activities with no neck pain at all.
- ☐ I am able to engage in all of 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 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.

 Patient's initials ______ Date ______