Welcome

We are pleased to welcome you to our practice. Please take a few minutes to fill out this form as completely as you can. If you have questions we'll be glad to help you. We look forward to working with you in maintaining your health.

Patient Information

Name _____ Soc. Sec. # _____
Last Name *First Name* *Initial*

Address _____

City _____ State _____ Zip _____ Home Phone _____

Cell Phone _____ Email _____

Sex ☐ M ☐ F Age _____ Birthdate _____ ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

Patient Employed by _____ Occupation _____

Business Address _____ Business Phone _____

Business Email _____

Whom may we thank for referring you? _____

Notify in case of emergency _____ Home Phone _____

Cell Phone _____ Business Phone _____

Email _____

Primary Insurance

Person Responsible for Account _____
Last Name *First Name* *Initial*

Relation to Patient _____ Birthdate _____ Soc. Sec. # _____

Address *(if different from patient)* _____ City _____

State _____ Zip _____ Home Phone _____

Cell Phone _____ Email _____

Person Responsible Employed by _____ Occupation _____

Business Address _____ Business Phone _____

Business Email _____

Insurance Company _____ Phone _____

Insurance Email _____

Contract # _____ Group # _____ Subscriber # _____

Name of other dependents under this plan _____

Reason for Visit

Have you ever seen a chiropractor? ☐ Yes ☐ No If yes, when and why? _____

Your reason for *this* visit: _____

Please describe your pain and its location: _____

When did symptoms begin (date)? _____ Have you had similar conditions in the past? _____

Is pain getting: ☐ Worse ☐ Better ☐ Same ☐ Comes and goes How often do you have this pain? _____

Have you been treated by a medical physician for this condition? _____

If so, when and where? _____

Activities or movements that are difficult/painful to perform: ☐ Sitting ☐ Walking ☐ Bending ☐ Lying down ☐ Lifting

Type of pain: ☐ Sharp ☐ Dull ☐ Throbbing ☐ Aching ☐ Burning ☐ Tingling ☐ Numbness ☐ Cramping
☐ Stiffness ☐ Swelling ☐ Other _____

Is pain interfering with: ☐ Work ☐ Sleep ☐ Daily Routine ☐ Recreation

Please complete both sides.

Health History

Please list any medication (including pain killers) you are taking: _____

_____

Please list any serious injuries you have had in the last 10 years:

	Description	Date
Falls		
Head Injuries		
Broken Bones		
Dislocations		
Surgeries		
Other Serious Injuries		

Women: Are you pregnant? ☐ Y ☐ N If so, how far along? _____ Nursing ☐ Y ☐ N

Medical Conditions

Check (✓) yes or no whether you have had or currently have any of the following medical conditions?

☐ Y ☐ N Heart Attack/Stroke
☐ Y ☐ N Congenital Heart Defect
☐ Y ☐ N Alcohol/Drug Abuse
☐ Y ☐ N Fainting/ Seizures/Epilepsy
☐ Y ☐ N Shingles
☐ Y ☐ N Psychiatric Problems
☐ Y ☐ N Difficulty Breathing
☐ Y ☐ N Hepatitis
☐ Y ☐ N Anemia

☐ Y ☐ N Arthritis
☐ Y ☐ N Frequent Neck Pain
☐ Y ☐ N Jaw Pain
☐ Y ☐ N Wrist Pain
☐ Y ☐ N Shoulder Pain
☐ Y ☐ N Arm Pain
☐ Y ☐ N Leg Pain
☐ Y ☐ N Lower Back Problems
☐ Y ☐ N Severe/ Frequent Earaches

☐ Y ☐ N Ringing in Ears
☐ Y ☐ N Severe/ Frequent Headaches
☐ Y ☐ N Diabetes/Tuberculosis
☐ Y ☐ N Dizziness
☐ Y ☐ N Emphysema/Glaucoma
☐ Y ☐ N Kidney Problems
☐ Y ☐ N Artificial Bones/Joints
☐ Y ☐ N Cancer
☐ Y ☐ N HIV Positive/AIDS

☐ Y ☐ N Ulcer/Colitis
☐ Y ☐ N Gout
☐ Y ☐ N Numbness, where?
_____
☐ Y ☐ N Tingling, where?
_____
☐ Y ☐ N Muscle Spasms, where? _____

Personal Habits

	Heavy	Moderate	Light	None
Alcohol	☐	☐	☐	☐
Coffee	☐	☐	☐	☐
Tobacco	☐	☐	☐	☐
Drugs	☐	☐	☐	☐
Exercise	☐	☐	☐	☐
Sleep	☐	☐	☐	☐
Appetite	☐	☐	☐	☐

Authorization

I have reviewed the information on this questionnaire and it is accurate to the best of my knowledge. I understand that this information will be used by the chiropractor to help determine appropriate and healthful chiropractic treatment. If there is any change in my medical status, I will inform the chiropractor.

I authorize my insurance company to pay to the chiropractor or chiropractic group all insurance benefits otherwise payable to me for services rendered. I authorize the use of this signature on all insurance submissions.

I authorize the chiropractor to release all information necessary to secure the payment of benefits. I understand that I am financially responsible for all charges whether or not paid by insurance.

Signature _____ Date _____

Payment is due in full at time of treatment, unless prior arrangements have been approved.

Patient Consent Authorization

CONSENT FOR TREATMENT:
I voluntarily consent to the rendering of care, including treatment and performance of diagnostic procedures. I understand that I am under the care and supervision of the attending physician/ health care provider and it is the responsibility of the staff to carry out the instructions of such physician.

ASSIGNMENT OF BENEFITS: I hereby assign payment directly to the physician accepting this assignment of medical benefits applicable and otherwise payable to me but not to exceed the physician's regular charges. I understand that I am financially responsible for charges not covered by this assignment or for any and all charges that the insurance carrier declines to pay. It is further agreed that any credit or balance resulting from payment of insurance or other sources may be applied to any other accounts owed to said physician/ health care provider by the insured or his/her family.

RELEASE OF INFORMATION: The physician may disclose all or part of the patients information to any person or corporation which is or may be liable under contract to the provider or to the patient or to a family member or employer of the patient for all part or part of the providers charges, including but not limited to, insurance companies, workers compensation carrier, welfare funds or the patients employer.

H.M.O. DISCLAIMER: I certify that I am not presently enrolled in any HMO. Subsequent rejection of a claim as a result of this admission, due to current enrollment in an HMO plan will constitute responsibility for payment of claim on my part.

MEDICARE PATIENT CERTIFICATION –AUTHORIZATION TO RELEASE INFORMATION AND PAYMENT REQUEST: I certify that the information given by me in applying for payment under Title XVIII and / or Title XI of the Social Security Act, is correct. I authorize any holder of medical or other information about me, to release to the Social Security Administration or its intermediary carriers, any information needed for this or related Medicare claim. I request that payment of authorized benefits be made on my behalf. I assign the benefits payable for physician's services. I understand that I am responsible for my health insurance deductibles and coinsurance.

_____ X _____

Print patients name Patient signature

For Women Only
By my signature on this form I do hereby state that to the best ok my knowledge, I am not pregnant, nor is pregnancy suspected or confirmed at this particular time.

Signed _____

Patient Payment Arrangements

Patient Name: _____ Date: _____

Treating Specialist:

____ **Walter Tonyes, DC**
Scotchtown Chiropractic
633 Route 211 East, Middletown, NY 10941

____ **Bryan Weslowski, MA PT**
Scotchtown Physical Therapy
633 Route 211 East, Middletown, NY 10941

Primary Insurance Company: _____

*** **Please Be Advised:** **Your insurance company may deny payment for your care.** This also applies to insurances that require authorization or prior approval for your treatment. There is NO GUARANTEE OF PAYMENT. The insurance company will make the final determination on your case when the bill is received and reviewed by them. *****

Payment Arrangements For Services Rendered

Co-payments	Daily	_____	
Deductible	Daily	_____	Weekly _____
Cash (no insurance)	Daily	_____	
Pre-Paid Cash Plan	Monthly	_____	

** Upon completion of the recommended treatment plan, any unpaid balance will be billed to you on monthly invoices. You agree to make regular/consecutive payments. (For any remaining balance up to $100, a minimum of $25 per month will be due. For balances greater than $100 a minimum of $50 per month will be due to pay off your bill.) Any account that is sent to collections will be subject to that agencies fees.

Financial Arrangements & Hardship Documentation

Comments:

_____

_____

_____

_____

Patient Signature: _____

Consulting Employee: _____

WORKER COMPENSATION INFORMATION

Date_____

PATIENT INFORMATION

Name_____ Birthdate_____ Soc. Sec. #_____

Address_____

_____

Telephone_____ Occupation_____

EMPLOYER

Employer Name_____

Employer Address_____

_____

Employer Telephone_____ Injury Verified By (For Office Use)_____

Contact Person_____

WORKER COMPENSATION CARRIER (FOR OFFICE USE)

Worker Compensation Carrier_____

Carrier Address_____

_____

Carrier Phone Number_____ Coverage Verified by_____

Adjuster's Name_____ Claim Number_____

INJURY INFORMATION

Date of Injury_____ Time_____ ☐ AM ☐ PM

Place of Injury_____

Accident reported to employer? ☐ Yes ☐ No Name of person you reported accident to_____

Give full description of how accident happened_____

_____

_____

_____

_____

Have you lost time from work? ☐ Yes ☐ No How much?_____

Other doctors seen for this condition:

Doctor's Name_____ Diagnosis_____

Were X-Rays taken? ☐ Yes ☐ No Other Tests? ☐ Yes ☐ No

If yes, by whom? Please list test(s) and result(s)_____

_____

_____

_____

Any previous Worker Compensation injuries? ☐ Yes ☐ No Date(s) of previous injuries_____

Describe previous Worker Compensation injuries_____

AUTHORIZATION

I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment in the event that my claim for Workers Compensation benefits is denied.

Patient's Signature_____ Date_____

ALIGNIS Clinical Records System

Patient Health Assessment

Please PRINT or WRITE Clearly

General Information

Patient Name:_____ Date:_____

Provider Name: Walter E Tonyes, DC

Primary Care Physician's Name:_____

Patient Sex: M_____ F_____ Date of Birth:_____ Social Security #:_____

Patient Address:_____

Home Phone:_____ Work Phone:_____

Patient Employer:_____ Patient Occupation:_____

Subscriber Name:_____ Relation to Patient:_____

Subscriber Employer:_____ Subscriber Social Security #:_____

Referred for Treatment by:_____

Health Insurance Plan:_____ Group #:_____ Member #:_____

Complaint History

1. Describe your current complaint and how the problem began: _____

How long have you had this condition?_____ **Date of onset:**_____

2. How would you describe pain?

❒ Sharp ❒ Soreness ❒ Throbbing ❒ Tingling ❒ Dull ❒ Stiffness
❒ Spasm ❒ Burning ❒ Ache ❒ Weakness ❒ Numbness ❒ Shooting

3. How would you rate the intensity of your pain? *(Circle the appropriate number)*

0 1 2 3 4 5 6 7 8 9 10

(no pain) *(moderate pain)* *(terrible/unbearable pain)*

4. How often is the pain present?

❒ Constant (81-100%) ❒ Frequent (51-80%) ❒ Occasional (26-50%) ❒ Intermittent (25% or less)

5. Since your problem began is the pain:

❒ Getting worse ❒ Getting better ❒ Staying the same

6. How did your problem begin? **Explain:** _____

❒ An auto accident ❒ Work related accident ❒ Other type of accident
❒ Gradual ❒ Sudden ❒ No specific reason

7. What makes your problem better?

❒ Nothing ❒ Walking ❒ Standing ❒ Sitting ❒ Moving around/exercise ❒ Lying down ❒ Inactivity

8. What makes your problem worse?

❒ Nothing ❒ Walking ❒ Standing ❒ Sitting ❒ Moving around/exercise ❒ Lying down ❒ Inactivity

9. Are you currently taking any medications? ❒ Yes ❒ No

If yes, please describe _____

10. Were you previously treated for an earlier occurrence of this *same* condition? ❒ Yes ❒ No

If yes, by whom? ❒ MD ❒ Chiropractor ❒ Physical therapist ❒ Other_____

What were the approximate dates, type of treatment and the results? _____

11. What is your physical activity at work?

❒ Mostly sitting ❒ Light manual labor ❒ Moderate manual labor ❒ Heavy manual labor

Chiropractic Patient Information Form Form 1B

Landmark Healthcare, Inc, 1750 Howe Ave., Suite 300
Sacramento, CA 95825

Landmark healthcare
Marking a Turning Point in Healthcare Options

Practitioner last name	First name	M.I.	License #	Phone #	Fax #
TONYES	WALTER	E	X-007654	(845) 692 3224	(845) 692 3426

Patient to complete the following sections:

Patient last name	First name	M.I.	Daytime phone ( )	Social security number - -

Please list your reason(s) for this visit or your condition(s) in order of importance:	Date you first noticed:	Using a scale in which "0" is none (no pain or symptoms) and "10" is severe pain or symptom(s), **circle** the number that best reflects your condition: ↓ none . . . . . to . . . . . severe ↓	Please check the box below that best represents how much of the time you feel pain or your symptom(s) for the listed reason:
1 _____	_____	0 1 2 3 4 5 6 7 8 9 10	❑0-25% ❑26-50% ❑51-75% ❑76-100%
2 _____	_____	0 1 2 3 4 5 6 7 8 9 10	❑0-25% ❑26-50% ❑51-75% ❑76-100%
3 _____	_____	0 1 2 3 4 5 6 7 8 9 10	❑0-25% ❑26-50% ❑51-75% ❑76-100%
4 _____	_____	0 1 2 3 4 5 6 7 8 9 10	❑0-25% ❑26-50% ❑51-75% ❑76-100%

For each of the reasons or conditions listed above, please mark how it happened:

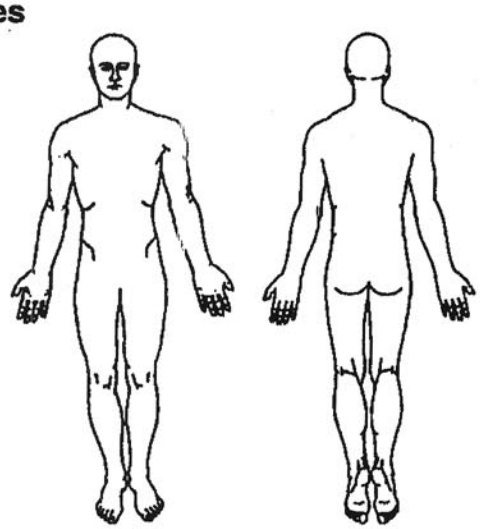
1. ❑Developed over time ❑Illness ❑Injury ❑Auto accident ❑Other _____ ❑ I don't know
2. ❑Developed over time ❑Illness ❑Injury ❑Auto accident ❑Other _____ ❑ I don't know
3. ❑Developed over time ❑Illness ❑Injury ❑Auto accident ❑Other _____ ❑ I don't know
4. ❑Developed over time ❑Illness ❑Injury ❑Auto accident ❑Other _____ ❑ I don't know

For each reason listed above, please check if it is better or worse with any of the following:

	HEAT		COLD		REST		ACTIVITY		OTHER (please describe on line below)	
	better	worse	better	worse	better	worse	better	worse	better	worse
Reason 1	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑ _____
Reason 2	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑ _____
Reason 3	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑ _____
Reason 4	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑ _____

Please mark the areas of discomfort or pain on the figures to the right using the symbol that best describes the feeling:

+++ Sharp or stabbing
ooo Pins and needles
vvv Dull or aching
/// Numbness



Please check the box that best describes whether your pain or symptom(s) limit normal activities:

Activity	normal	somewhat limited	Severely limited
Lifting	❑	❑	❑
Bending	❑	❑	❑
Standing	❑	❑	❑
Walking	❑	❑	❑
Sitting	❑	❑	❑
Climbing stairs	❑	❑	❑
Running	❑	❑	❑
Resting in bed	❑	❑	❑
Intercourse	❑	❑	❑
Computer work/typing	❑	❑	❑
Normal work	❑	❑	❑
Household activities	❑	❑	❑
Recreational activities	❑	❑	❑
Other (list below)	❑	❑	❑

_____

a. During what time of the day do you feel worse? _____

b. Do you sleep well? ❑ Yes ❑No What are your normal sleeping hours? _____ to _____

-Please Continue on Page 2-

Please continue ...

c. Are you currently under the care of a medical doctor or other type of health care provider for any condition?
❑ No ❑ Yes → For what condition? _____

Name of doctor/provider _____ Phone number _____

d. Have you ever had an overnight stay in a hospital or a surgical procedure of any kind?
❑ No ❑ Yes If yes, please describe each event below:

Event _____ Year _____

Event _____ Year _____

e. Do you exercise? ❑ Yes ❑ No If yes, please describe activity _____

How many days a week? _____ How many minutes per session? _____

Personal history

The following lists a variety of conditions that patients may experience. Please read through the list and check the box next to each condition that applies to you.

Pain in body

- ❑ Neck pain with difficulty swallowing
- ❑ Extreme neck stiffness with pain or electric shocks in arms or legs when moving neck
- ❑ Leg pain that worsens with exercise but is relieved by resting
- ❑ Loss of feeling in inner thighs
- ❑ Back pain with urinary problems

Types of pain

- ❑ Severe pain interrupts sleep
- ❑ Constant pain that doesn't improve by changing positions or lying down

Current conditions

- ❑ Unable to balance when walking
- ❑ Recent unexplained weight loss
- ❑ Recent progressive muscle weakness or shaking
- ❑ Recent or current fever over 102°F
- ❑ Loss of bowel or bladder control
- ❑ Blurred or double vision, dizziness, nausea or faintness when neck is in certain positions
- ❑ Recent major accident such as a fall from height, whiplash or blow to the head
- ❑ Memory loss after injury

Previously diagnosed condition/ medical history

- ❑ Congenital bone or joint disorder
- ❑ Rheumatoid arthritis
- ❑ Severe degenerative arthritis
- ❑ History of compression fracture
- ❑ History of heart attack
- ❑ History of stroke or aneurysm
- ❑ Past history of cancer or currently diagnosed with cancer
- ❑ Diabetes with cold, burning or numb feet
- ❑ Gout
- ❑ Lupus
- ❑ Ankylosing spondylitis
- ❑ Immune suppression such as from chemotherapy, organ transplant, etc.
- ❑ 3 or more months use of steroid medications or intravenous drugs (past or recent)

Family history

- ❑ Autoimmune disorders
- ❑ Arthritis
- ❑ Cancer
- ❑ Diabetes
- ❑ Heart disease
- ❑ Kidney disease
- ❑ Mental illness
- ❑ Seizure disorder

I certify that the above information is true and correct to the best of my knowledge and I hereby consent to the release of my confidential medical and patient information in the possession of the practitioner named above to other health professionals to whom I am referred and to the insurance company or other entity responsible for payment, utilization and/or quality review for all or a portion of my care.

Signature _____ Today's date: ____/____/____

If patient required assistance to complete, sign name and state relationship (i.e., parent, translator) below:

Name _____ Relationship _____ Today's date: ____/____/____

KAM020299

Patient Health Questionnaire - PHQ

ACN Group, Inc. - Form PHQ-2002

ACN Group Use Only rev 9/11/2002

Patient Name _____ **Date** _____

1. Describe your symptoms _____

_____

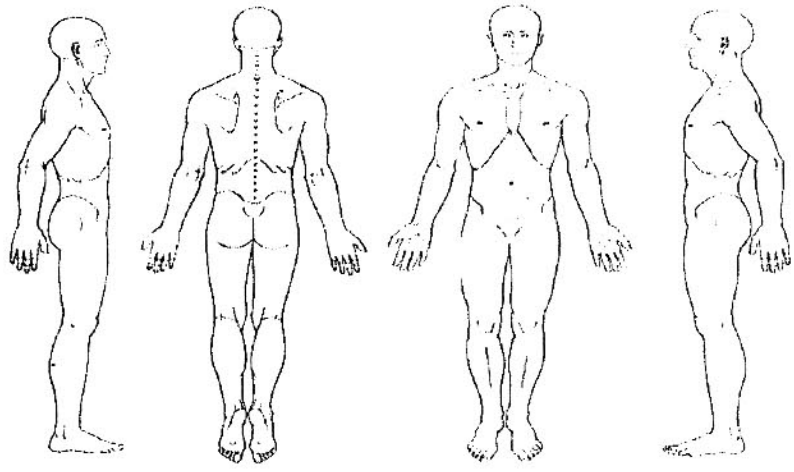
a. When did your symptoms start? _____

b. How did your symptoms begin? _____

2. How often do you experience your symptoms?

① Constantly (76-100% of the day)
② Frequently (51-75% of the day)
③ Occasionally (26-50% of the day)
④ Intermittently (0-25% of the day)

Indicate where you have pain or other symptoms



3. What describes the nature of your symptoms?

① Sharp ④ Shooting
② Dull ache ⑤ Burning
③ Numb ⑥ Tingling

4. How are your symptoms changing?

① Getting Better
② Not Changing
③ Getting Worse

5. During the <u>past 4 weeks</u>:

a. Indicate the average intensity of your symptoms

None ⓪ ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩ Unbearable

b. How much has pain interfered with your normal work (including both work outside the home, and housework)

① Not at all ② A little bit ③ Moderately ④ Quite a bit ⑤ Extremely

6. During the <u>past 4 weeks</u> how much of the time has your condition interfered with your social activities?
(like visiting with friends, relatives, etc)

① All of the time ② Most of the time ③ Some of the time ④ A little of the time ⑤ None of the time

7. In general would you say your overall health right now is...

① Excellent ② Very Good ③ Good ④ Fair ⑤ Poor

8. Who have you seen for your symptoms?

① No One
② Other Chiropractor
③ Medical Doctor
④ Physical Therapist
⑤ Other

a. What treatment did you receive and when? _____

b. What tests have you had for your symptoms and when were they performed?

① Xrays *date:* _____ ③ CT Scar *date:* _____
② MRI *date:* _____ ④ Other *date:* _____

9. Have you had similar symptoms in the past? ① Yes ② No

a. If you have received treatment in the past for the same or similar symptoms, who did you see?

① This Office
② Other Chiropractor
③ Medical Doctor
④ Physical Therapist
⑤ Other

10. What is your occupation?

① Professional/Executive
② White Collar/Secretarial
③ Tradesperson
④ Laborer
⑤ Homemaker
⑥ FT Student
⑦ Retired
⑧ Other

_____

a. If you are not retired, a homemaker, or a student, what is your current work status?

① Full-time
② Part-time
③ Self-employed
④ Unemployed
⑤ Off work
⑥ Other

Patient Signature _____ **Date** _____

ACN

Patient Health Questionnaire - page 2

American Chiropractic Network

ACN Use Only rev 4/23/99

Patient Name _____ **Date** _____

What type of regular exercise do you perform? ① None ② Light ③ Moderate ④ Strenuous

What is your height and weight? Height ___ ___ ___ (Feet / Inches) Weight ___ ___ ___ lbs.

For each of the conditions listed below, place a check in the Past column if you have had the condition in the past. If you presently have a condition listed below, place a check in the Present column.

Past	Present		Past	Present		Past	Present	
○	○	Headaches	○	○	High Blood Pressure	○	○	Diabetes
○	○	Neck Pain	○	○	Heart Attack	○	○	Excessive Thirst
○	○	Upper Back Pain	○	○	Chest Pains	○	○	Frequent Urination
○	○	Mid Back Pain	○	○	Stroke			
○	○	Low Back Pain	○	○	Angina	○	○	Smoking/Use Tobacco Products
						○	○	Drug/Alcohol Dependence
○	○	Shoulder Pain	○	○	Kidney Stones			
○	○	Elbow/Upper Arm Pain	○	○	Kidney Disorders	○	○	Allergies
○	○	Wrist Pain	○	○	Bladder Infection	○	○	Depression
○	○	Hand Pain	○	○	Painful Urination	○	○	Systemic Lupus
			○	○	Loss of Bladder Control	○	○	Epilepsy
○	○	Hip/Upper Leg Pain	○	○	Prostate Problems	○	○	Dermatitis/Eczema/Rash
○	○	Knee/Lower Leg Pain				○	○	HIV/AIDS
○	○	Ankle/Foot Pain	○	○	Abnormal Weight Gain/Loss			
			○	○	Loss of Appetite	***Females Only***		
○	○	Jaw Pain	○	○	Abdominal Pain	○	○	Birth Control Pills
						○	○	Hormonal Replacement
○	○	Joint Swelling/Stiffness	○	○	Ulcer	○	○	Pregnancy
○	○	Arthritis	○	○	Hepatitis	○	○	
○	○	Rheumatoid Arthritis	○	○	Liver/Gall Bladder Disorder			
						Other Health Problems/Issues		
○	○	General Fatigue	○	○	Cancer	○	○	
○	○	Muscular Incoordination	○	○	Tumor	○	○	
○	○	Visual Disturbances	○	○	Asthma	○	○	
○	○	Dizziness	○	○	Chronic Sinusitis			

Indicate if an immediate family member has had any of the following:

○ Rheumatoid Arthritis ○ Heart Problems ○ Diabetes ○ Cancer ○ Lupus ○ _____

List all prescription and over-the-counter medications, and nutritional/herbal supplements you are taking:

_____

_____

List all the surgical procedures you have had and times you have been hospitalized:

_____

_____

Patient Signature _____ ***Date*** _____

Doctor's Additional Comments

_____

_____

_____

Doctors Signature _____ ***Date*** _____

Back Index

ACN Group, Inc. - Form BI-100

ACN Group, Inc. Use Only rev 11/13/02

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

⓪ 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

⓪ 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

⓪ 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

⓪ 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

⓪ 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

⓪ 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

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.
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

⓪ 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

⓪ 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

⓪ 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.

Back Index Score _____

Neck Index

ACN Group, Inc. - Form NI-100

ACN Group, Inc Use Only rev 11/13/02

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.

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).

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.

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.

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.

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.

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.

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 care 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.

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.

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 Index Score _____

SF-12™ Health Survey

ACN Group, Inc. Use Only rev 11/13/02

Patient Name _____ **Date** _____

Please answer every question. Some questions may look like others, but each one is different. Please take the time to read and answer each question carefully by filling in the bubble that best represents your response.

1. *In general, would you say your health is:* ① Excellent ② Very Good ③ Good ④ Fair ⑤ Poor

2. *The following items are about activities you might do during a typical day. Does your health now limit you in these activities? If so, how much?*

	Yes, limited a lot	Yes, limited a little	No, not limited at all
a. **Moderate activites**, such as moving a table, pushing a vacuum cleaner, bowling, or playing golf?	①	②	③
b. Climbing **several** flights of stairs?	①	②	③

3. *During the **past 4 weeks**, have you had any of the following problems with your work or other regular daily activities **as a result of your physical health**?*

	Yes	No
a. **Accomplished less** than you would like	①	②
b. Were limited in the **kind** of work or other activities	①	②

4. *During the **past 4 weeks**, have you had any of the following problems with your work or other regular daily activities **as a result of any emotional problems** (such as feeling depressed or anxious)?*

	Yes	No
a. **Accomplished less** than you would like	①	②
b. Didn't do work or other activities as carefully as usual	①	②

5. *During the **past 4 weeks**, how much did **pain** interfere with your normal work (including both work outside the home, and housework)?*

① Not at all ② A little bit ③ Moderately ④ Quite a bit ⑤ Extremely

6. *These questions are about how you feel and how things have been with you during the **past 4 weeks**. For each question, please give the one answer that comes closest to the way you have been feeling. How much of the time during the **past 4 weeks**....*

	All of the time	Most of the time	A good bit of the time	Some of the time	A little of the time	None of the time
a. Have you felt calm and peaceful?	①	②	③	④	⑤	⑥
b. Did you have a lot of energy?	①	②	③	④	⑤	⑥
c. Have you felt downhearted and blue?	①	②	③	④	⑤	⑥

7. *During the **past 4 weeks**, how much of the time has your physical health or emotional problems interfered with your social activities (like visiting with friends, relatives, etc.)?*

① All of the time ② Most of the time ③ Some of the time ④ A little of the time ⑤ None of the time

MANAGED PHYSICAL NETWORK, INC.
ELIGIBILITY GUARANTEE/ASSIGNMENT OF BENEFITS FORM

Walter E Tonyes, DC — MPN Provider

633 Route 211 East, Middletown, NY 10941 — Provider's Address

ELIGIBILITY GUARANTEE:

I, _____ hereby certify that I am eligible for
(Name of Patient/Member/Guardian)

health care benefits offered by _____ through my employer,
(Name of Health Plan)

_____ as of _____
(Name of Employer Group) (Month) (Date) (Year)

I understand that if the above is not true, or if I am not eligible under the terms of my employer's Medical and Hospital /Subscriber Agreement, or Insurance Policy, I am liable for all charges for services rendered. Also, if the above is not true, I agree to pay in full for all services received within thirty (30) days of receiving a bill from the above Provider or Health Plan.

ASSIGNMENT OF BENEFITS:

I authorize the release of any health information necessary to process this claim. A photocopy of this authorization shall be as effective and valid as the original.

I authorize payment of medical benefits to the Provider listed above who accepts assignment through his/her contract with MPN and/or MPN's Health Plans.

I understand that the MPN Provider will not bill me any charges over and above the insurance payment, other than the applicable co-payments, co-insurance or deductibles, since the MPN Provider has agreed in his/her contract with MPN and/or MPN's Health Plans to waive all unpaid fees.

I understand that I may be responsible for non-covered services and/or unauthorized services as long as the MPN Provider notifies me in writing prior to the delivery of services of my responsibility to pay for such services and I have agreed in writing to pay for such services.

_____ _____
(Date) (Signature of Patient/Subscriber)

Patient Health Questionnaire

American Chiropractic Network

ACN Use Only rev 4/23/99

Patient Name _____ **Date** _____

1. When did your symptoms start: _____ **Describe your symptoms and how they began:**

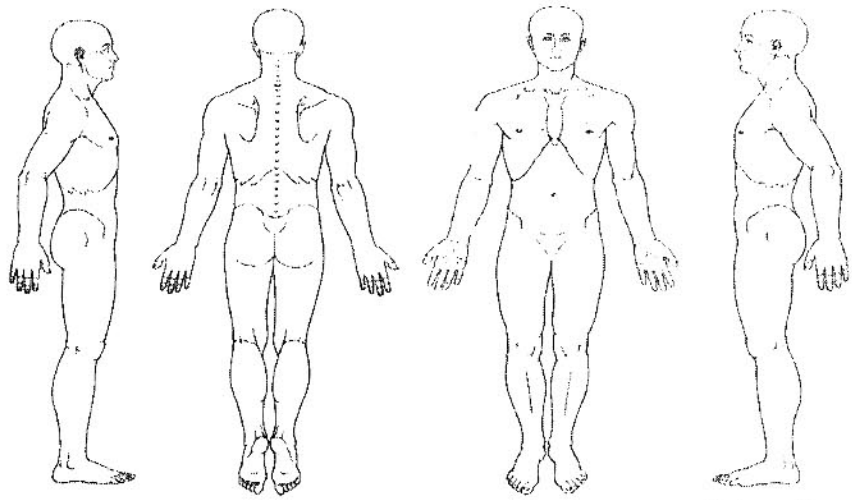
_____

_____

2. How often do you experience your symptoms?

① Constantly (76-100% of the day)
② Frequently (51-75% of the day)
③ Occasionally (26-50% of the day)
④ Intermittently (0-25% of the day)

Indicate where you have pain or other symptoms



3. What describes the nature of your symptoms?

① Sharp ④ Shooting
② Dull ache ⑤ Burning
③ Numb ⑥ Tingling

4. How are your symptoms changing?

① Getting Better
② Not Changing
③ Getting Worse

5. How bad are your symptoms at their:

	None										Unbearable
a. worst:	⓪	①	②	③	④	⑤	⑥	⑦	⑧	⑨	⑩
b. best:	⓪	①	②	③	④	⑤	⑥	⑦	⑧	⑨	⑩

6. How do your symptoms affect your ability to perform daily activities?

⓪	①	②	③	④	⑤	⑥	⑦	⑧	⑨	⑩
No complaints		*Mild, forgotten with activity*		*Moderate, interferes with activity*		*Limiting, prevents full activity*		*Intense, preoccupied with seeking relief*		*Severe, no activity possible*

7. What activities make your symptoms worse: _____

8. What activities make your symptoms better: _____

9. Who have you seen for your symptoms?

① No One
② Other Chiropractor
③ Medical Doctor
④ Physical Therapist
⑤ Other

a. When and what treatment? _____

b. What tests have you had for your symptoms and when were they performed?

① Xrays *date:* _____ ③ CT Scan *date:* _____
② MRI *date:* _____ ④ Other *date:* _____

10. Have you had similar symptoms in the past? ① Yes ② No

a. If you have received treatment in the past for the same or similar symptoms, who did you see?

① This Office
② Other Chiropractor
③ Medical Doctor
④ Physical Therapist
⑤ Other

11. What is your occupation?

_____

① Professional/Executive
② White Collar/Secretarial
③ Tradesperson
④ Laborer
⑤ Homemaker
⑥ FT Student
⑦ Retired
⑧ Other

a. If you are not retired, a homemaker, or a student, what is your current work status?

① Full-time
② Part-time
③ Self-employed
④ Unemployed
⑤ Off work
⑥ Other

12. What do you hope to get from your visit/treatment *(select all that apply):*

① Reduce symptoms
② Resume/increase activity
③ Explanation of condition/treatment
④ Learn how to take care of this on my own
⑤ How to prevent this from occurring again
⑥

Patient Signature _____ **Date** _____

Patient Health Questionnaire - page 2

American Chiropractic Network

ACN Use Only rev 4/23/99

Patient Name _____ **Date** _____

What type of regular exercise do you perform? ① None ② Light ③ Moderate ④ Strenuous

What is your height and weight? Height [ ][ ][ ] (Feet / Inches) Weight [ ][ ][ ] lbs.

For each of the conditions listed below, place a check in the Past column if you have had the condition in the past. If you presently have a condition listed below, place a check in the Present column.

Past	Present	
○	○	Headaches
○	○	Neck Pain
○	○	Upper Back Pain
○	○	Mid Back Pain
○	○	Low Back Pain
○	○	Shoulder Pain
○	○	Elbow/Upper Arm Pain
○	○	Wrist Pain
○	○	Hand Pain
○	○	Hip/Upper Leg Pain
○	○	Knee/Lower Leg Pain
○	○	Ankle/Foot Pain
○	○	Jaw Pain
○	○	Joint Swelling/Stiffness
○	○	Arthritis
○	○	Rheumatoid Arthritis
○	○	General Fatigue
○	○	Muscular Incoordination
○	○	Visual Disturbances
○	○	Dizziness

Past	Present	
○	○	High Blood Pressure
○	○	Heart Attack
○	○	Chest Pains
○	○	Stroke
○	○	Angina
○	○	Kidney Stones
○	○	Kidney Disorders
○	○	Bladder Infection
○	○	Painful Urination
○	○	Loss of Bladder Control
○	○	Prostate Problems
○	○	Abnormal Weight Gain/Loss
○	○	Loss of Appetite
○	○	Abdominal Pain
○	○	Ulcer
○	○	Hepatitis
○	○	Liver/Gall Bladder Disorder
○	○	Cancer
○	○	Tumor
○	○	Asthma
○	○	Chronic Sinusitis

Past	Present	
○	○	Diabetes
○	○	Excessive Thirst
○	○	Frequent Urination
○	○	Smoking/Use Tobacco Products
○	○	Drug/Alcohol Dependence
○	○	Allergies
○	○	Depression
○	○	Systemic Lupus
○	○	Epilepsy
○	○	Dermatitis/Eczema/Rash
○	○	HIV/AIDS

Females Only

○	○	Birth Control Pills
○	○	Hormonal Replacement
○	○	Pregnancy
○	○	

Other Health Problems/Issues

○	○
○	○
○	○

Indicate if an immediate family member has had any of the following:

○ Rheumatoid Arthritis ○ Heart Problems ○ Diabetes ○ Cancer ○ Lupus ○ _____

List all prescription and over-the-counter medications, and nutritional/herbal supplements you are taking:

_____ _____ _____

_____ _____ _____

List all the surgical procedures you have had and times you have been hospitalized:

_____ _____ _____

_____ _____ _____

Patient Signature _____ **Date** _____

Doctor's Additional Comments

_____

_____

_____

Doctors Signature _____ **Date** _____

Back Index

American Chiropractic Network

ACN Use Only rev 4/23/99

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

⓪ 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

⓪ 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

⓪ 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

⓪ 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

⓪ 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

⓪ 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

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.
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

⓪ 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

⓪ 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

⓪ 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.

Back Index Score _____

Neck Index

American Chiropractic Network

ACN Use Only rev 4/23/99

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.

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).

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.

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.

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.

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 I stay in bed.

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.

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 care 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.

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.

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 Index Score

SF-12™ Health Survey

ACN Use Only rev 4/23/99

Patient Name _____ **Date** _____

Please answer every question. Some questions may look like others, but each one is different. Please take the time to read and answer each question carefully by filling in the bubble that best represents your response.

1. *In general, would you say your health is:* ① Excellent ② Very Good ③ Good ④ Fair ⑤ Poor

2. *The following items are about activities you might do during a typical day. Does your health now limit you in these activities? If so, how much?*

	Yes, limited a lot	Yes, limited a little	No, not limited at all
a. ***Moderate activites**, such as moving a table, pushing a vacuum cleaner, bowling, or playing golf?*	①	②	③
b. *Climbing **several** flights of stairs?*	①	②	③

3. *During the **past 4 weeks**, have you had any of the following problems with your work or other regular daily activities **as a result of your physical health**?*

	Yes	No
a. ***Accomplished less** than you would like*	①	②
b. *Were limited in the **kind** of work or other activities*	①	②

4. *During the **past 4 weeks**, have you had any of the following problems with your work or other regular daily activities **as a result of any emotional problems** (such as feeling depressed or anxious)?*

	Yes	No
a. ***Accomplished less** than you would like*	①	②
b. *Didn't do work or other activities as carefully as usual*	①	②

5. *During the **past 4 weeks**, how much did **pain** interfere with your normal work (including both work outside the home, and housework)?*

① Not at all ② A little bit ③ Moderately ④ Quite a bit ⑤ Extremely

6. *These questions are about how you feel and how things have been with you during the **past 4 weeks**. For each question, please give the one answer that comes closest to the way you have been feeling. How much of the time during the **past 4 weeks**....*

	All of the time	Most of the time	A good bit of the time	Some of the time	A little of the time	None of the time
a. *Have you felt calm and peaceful?*	①	②	③	④	⑤	⑥
b. *Did you have a lot of energy?*	①	②	③	④	⑤	⑥
c. *Have you felt downhearted and blue?*	①	②	③	④	⑤	⑥

7. *During the **past 4 weeks**, how much of the time has your physical health or emotional problems interfered with your social activities (like visiting with friends, relatives, etc.)?*

① All of the time ② Most of the time ③ Some of the time ④ A little of the time ⑤ None of the time