Personal Injury Financial Policy

1. If an attorney represent you:

   You must provide us with their name and address prior to receiving services.

   They must sign and fax a lien within 24 hours of your initial visit in our office.

   You must provide us with the following four forms of information:

   A. Personal Health Insurance
   B. Medical Pay Insurance (Your auto insurance)
   C. Liability Auto Insurance (Person who hit you)

2. If an attorney does not represent you:

   You must sign a lien assigning payments for our services directly to us from your insurance carrier(s) prior to receiving services.

   You must provide us with the following three insurances:

   A. Personal Health Insurance
   B. Medical Pay Insurance (Your auto insurance)
   C. Liability Auto Insurance (Person who hit you)

***Regardless of whether or not you have an attorney, if you do not have insurance you will be considered a cash patient and will be expected to pay for services at the time they are rendered.**

I have read and agree to the above terms.

_____ _____

Patient Signature Date

Alexander Spine Center

Motor Vehicle Accident Insurance Questionnaire

Name: _____ Accident Date: _____

State accident occurred in: _____

1. Has the accident been reported to the police? Y / N If yes, were they at the accident scene? Y / N If yes, was anyone cited? Y / N
   If yes, whom? ( ) Myself ( ) My Driver ( ) The other driver ( ) Other _____
2. Have you retained an attorney? Y / N If yes, name of your attorney: _____
   Address: _____ Suite #: _____
   City: _____ State: _____ Zip Code: _____
   Phone #: ( ) _____ Fax #: ( ) _____
3. Have you reported the accident to any insurance company? Y / N
   If yes, which one(s)? ( ) My own ( ) My driver's ( ) The owner of the vehicle I was in
   ( ) the other driver's ( ) The owner of the other driver's vehicle
4. Were you in your own vehicle at the time of the accident? Y / N If yes, skip to Box 2.

BOX 1 – Information about the vehicle you were in, if it was NOT your own.

Insured's Name: _____ Relationship to yourself: ( ) Self ( ) Spouse ( ) Child ( ) Other

Insured's address: _____

Insured's Phone#: ( ) _____ Insurance Co Phone #: ( ) _____

Ins Co for the vehicle you were in: _____ Policy #: _____

Medical Adjuster's Name: _____ Claim #: _____

Medical Adjuster's Phone #: ( ) _____ Ext.: _____

Insurance Billing Address: _____ Attn: _____

BOX 2 – Your vehicle information: (Regardless if you were in someone else's vehicle at the time)

Insured's Name: _____ Relationship to yourself: ( ) Self ( ) Spouse ( ) Child ( ) Other

Insured's address: _____

Insured's Phone#: ( ) _____ Insurance Co Phone #: ( ) _____

Ins Co for the vehicle you were in: _____ Policy #: _____

Medical Adjuster's Name: _____ Claim #: _____

Medical Adjuster's Phone #: ( ) _____ Ext.: _____

Insurance Billing Address: _____ Attn: _____

BOX 3 – Information pertaining to the person that hit you:

Insured's Name: _____ Relationship to yourself: ( ) Self ( ) Spouse ( ) Child ( ) Other

Insured's address: _____

Insured's Phone#: ( ) _____ Insurance Co Phone #: ( ) _____

Ins Co for the vehicle you were in: _____ Policy #: _____

Medical Adjuster's Name: _____ Claim #: _____

Medical Adjuster's Phone #: ( ) _____ Ext.: _____

Insurance Billing Address: _____ Attn: _____

5. Have you received the Personal Injury Protection forms from your insurance company? Y / N
   If yes, have you returned them to the insurance company? Y / N Do you have a copy? Y / N

The information given in this questionnaire is true to the best of my knowledge.

_____ _____ _____

Patient / Guardian Signature Witness Signature Today's Date

Alexander Spine Center

Personal Injury Questionnaire

Name: _____ Police notified? ( ) Yes ( ) No Date of Accident: _____

1. Were you the ( ) Driver or ( ) Passenger / ( ) Front Seat or ( ) Back Seat / hit from ( ) Behind ( ) Front ( ) L Side ( ) R Side?

2. Did you strike any part of your body? ( ) Yes ( ) No
   If yes, what part? _____

3. Were you knocked unconscious? ( ) Yes ( ) No
   If so, for how long? _____

4. Where were you taken after the accident? _____
   Were X-rays taken? ( ) Yes ( ) No

5. Have you been treated by another doctor since the accident? ( ) Yes ( ) No
   If yes, please list the doctor's name and phone number: _____

6. Please briefly describe the accident: _____
   _____
   _____

7. Please briefly describe how you felt...a) Immediately after the accident: _____
   b) Later that same day: _____
   c) The next day: _____

8. What are your PRESENT complaints and / or physical symptoms: _____
   _____

9. Do you have any previous illness or physical complaints that relate to this case? ( ) Yes ( ) No
   If yes, please explain: _____

10. Did you notice any activity restrictions as a result of this injury? ( ) Yes ( ) No
    If yes, please describe: _____

11. Have you lost time from work as a result of this accident? ( ) Yes ( ) No - If yes, last date worked: _____

12. Since the accident occurred, are your symptoms: ( ) Improving ( ) Getting Worse ( ) Same?

13. Have you ever been in a previous auto accident? ( ) Yes ( ) No If yes, when? _____

14. Were you treated for injuries as a result of your previous accident? ( ) Yes ( ) No
    If yes, what were the results of your treatment? _____

15. Do you have any continued complaints from your previous accident? ( ) Yes ( ) No
    If yes, please explain: _____

Please read *before* signing:
I agree to participate in medical and therapy treatments by this provider and accept that no guarantee of results or outcome is expressed. I hereby authorize payment for medical benefits to **Alexander Spine Center** for services rendered.

_____ _____ _____

Patient Signature | Parent / Guardian Signature | Today's Date

Alexander Spine Center

Daniel W. Alexander, D.C.

11705 Jones Bridge Road, D101
Johns Creek GA 30005

678-297-0901; (fax) 678-297-0903

ASSIGNMENT OF BENEFITS AND RIGHT TO SUE FOR PIP

To Whom It May Concern:

I hereby authorize and direct any insurance company with whom I may make a claim for PIP or Med-Expense benefits, and/or my attorney, to pay directly **Alexander Spine Center**, (hereinafter referred to as "this health provider"), any money that is owed to this health provider for services provided to me.

In the event that any insurance company that is obligated to reimburse me for charges I incur with this health provider refuses to make such payments after demand is made by either me or this health provider, I hereby assign and transfer to this health provider any and all causes of action that I have against said insurance company, including but not limited to the right to bring a lawsuit, for the failure to pay the available PIP and/or Med-Expense benefits up to the amount of this health provider's full bill.

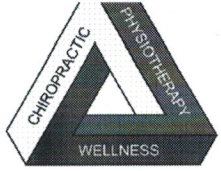
I authorize this health provider to bring any such cause of action either in my name or in this health provider's name. I further authorize this health provider to compromise, settle or otherwise resolve any such claim arising out of the insurance company's failure to pay to this health provider the full limit of available PIP or Med-Expense benefits up to the amount to its full bill.

I understand that I remain personally responsible for the total amounts due to this health provider for its services. I understand that payment is due at the time services are rendered, and that this health provider is providing a *courtesy* to me by trying to have the bill paid through alternative sources. I agree that this document does not constitute any consideration for this health provider to await payment, and that payment may be demanded from me immediately upon the rendering of services.

I authorize this health provider to release any information pertinent to my case to any insurance company or attorney to facilitate the collection of my bill. I agree that this health provider be given Power of Attorney to endorse or sign my name on any and all checks for payment of my doctor bill.

Patient: _____

Date: _____



ALEXANDER SPINE CENTER

Irrevocable Assignment, Lien and Authorization
Insurance Benefits and Attorney

TO WHOM IT MAY CONCERN:

I hereby authorize and direct you, my insurance carrier and/or attorney to pay directly to Alexander Spine Center, such sums as may be due and owing this office for services rendered me, both by reason of accident or illness and by reason of any other bills that are due this office and withhold such sums from any disability benefits, medical payment benefits, no fault benefits, health and accident, Workers' Compensation benefits, or any other insurance benefits obligated to reimburse me from any settlement, judgment or verdict on my behalf as may be necessary to adequately protect Alexander Spine Center. I hereby further give lien to said office against any and all insurance benefits named herein and any and all proceeds of any settlement, judgment or verdict which may be paid to me as a result of the injuries or illness for which I have been treated for by Alexander Spine Center. This is to act as an assignment of my rights and benefits to the extent of the office's services provided.

I understand that I remain personally responsible for the total amounts due the office for services rendered. I further understand and agree that this Assignment, Lien and Authorization does not constitute any consideration for the office to await payments, and they may demand payments from me immediately upon rendering services at their option.

I authorize the office to release any information pertinent to my case to any insurance carrier, adjuster or attorney to facilitate collection under this Assignment, Lien and Authorization.

I further understand and agree that if Alexander Spine Center must take any action to collect an outstanding balance on this account, I will be responsible for any payment of and will reimburse this office for all costs of such collection efforts, including but not limited to all court costs and all attorney fees.

Patient Signature: _____ (Seal) Date: _____

I authorize my Attorney_____ to sign this lien to pay the outstanding balance at settlement

Patient Signature: _____ (Seal) Date: _____

Please sign this Assignment, Lien and Authorization and return to Alexander Spine Center.

Attorney Signature: _____ (Seal) Date: _____

11705 Jones Bridge Road, D101, Alpharetta GA 30005
678-297-0901
www.alexanderspinecenters.com

Alexander Spine Center

Daniel W. Alexander, D.C.

11705 Jones Bridge Road, D101
Johns Creek, Ga 30005

678-297-0901; (fax) 678-297-0903

Third Party Disclaimer

I understand that according to the coordination of benefits portion of my health insurance, there will be no "provider discount" that applies when my third party liability case is processed, through my health insurance. I understand that I am ultimately responsible for all services rendered by **Alexander Spine Center**, with no regard to the practice's participation with my health insurance, in this matter.

Patient Signature	Witness Signature	Today's Date

DIAGNOSTIC IMAGING CONSULTANTS

A. Scott Thorpe, DC, DACBR, Rudy N. Heiser, DC, MS, DACBR,
Terry Sandman, DC, MPH, DACBR

ALEXANDER SPINE CENTER **STEVE GONINAN, D.C.**
11705 JONES BRIDGE RD. STE. D101 JOHNS CREEK, GA 30005
PH: (678) 297-0901 FAX: (678) 297-0903
Films/Date Exposed _____ **Medical History**_____

****Please print and complete form with patient's signature****

Patient Name _____ Date of Birth _____ Sex ___M___F
Address _____ City/State/Zip _____
Phone _____ SS# _____ Case/Acct# _____

BILL: ____ PIP ____ Health/Other Ins. __x__DR. ____Atty. ____Patient

Primary Insurance: _____ Phone _____
Adjuster_____ ID/Claim#_____
Address_____ Insured _____
City/State/Zip_____ Date of Injury____/____/____

Attorney: _____ Phone_____
Address_____City/State/Zip_____

****

ASSIGNMENT, LIEN AND AUTHORIZATION/INSURANCE BENEFITS

For and in consideration of receiving services by "Assignee" and for other good and valuable consideration, I hereby agree to the following: I authorize assignee to release any information pertinent to my case to any insurance company, adjuster, or attorney to facilitate collection under this Assignment, Lien, Reservation of Benefits and Authorization.

ASSIGNMENT OF BENEFITS, RESERVATION AND REQUEST TO ESCROW ANY DISPUTED BENEFITS:

I HEREBY ASSIGN MY insurance benefits and any and all causes of action available under my policy of automobile insurance to, DIAGNOSTIC IMAGING CONSULTANTS OF ST. PETERSBURG, PA d/b/a DIAGNOSTIC IMAGING CONSULTANTS hereinafter, collectively referred to as the Assignee. Additionally, both the assignee and the undersigned patient acknowledge they are foregoing or assuming certain rights under this agreement that they would not otherwise have under normal circumstances, and as such, agree the same serves as additional consideration for this assignment of benefits to the provider/assignees. In the event my insurance company, obligated to make payments to me upon charges made by assignee for services, refuses to make or reduces such payments and in order to maximize the benefits available under my policy coverage, I hereby request the insurance company (assuming there is coverage remaining at the time the company receives the Assignees' bill and if the company fails to pay Assignee the full amount of the bill(s) submitted), to avoid exhaustion of coverage while Assignee pursues its rights under this Agreement, both parties to this agreement (the Assignee and I) further authorize, direct, notice and request the Insurance Company to set aside and place in escrow an amount equal to the full amount of any such denial or reduction, and to hold that amount in escrow until the dispute is resolved in the appropriate forum.

IN THE EVENT MY insurance company obligated to make payments to me upon the charges made by Assignee for their services refused to make such payments, upon demand by me or Assignee, I hereby assign and transfer to Assignee any and all causes of action that I might have or that might exist in my favor against such company and authorize Assignee to prosecute said cause of action either in my name or in Assignee name and further I authorize Assignee to compromise, settle or otherwise resolve said claim or cause of action as they see fit.

I AUTHORIZE ASSIGNEE to release any information pertinent to my case to any insurance company, adjuster or attorney to facilitate collection under this Assignment, Lien and Authorization. I agree that the above mentioned Assignee be given Special Power of Attorney to endorse/sign my name on any and all checks and claim forms for payment of my bill.

I UNDERSTAND THAT I remain personally responsible for the total amounts due the Assignee for their services as insurance coverage may only pay a certain percentage of the bill; as, I may have an insurance deductible or my insurance benefits may exhaust or otherwise be limited. I further understand and agree that this Assignment, Lien and Authorization does not require Assignee to await payments and they may demand payments from me immediately upon rendering services at their option, although the Assignee agrees to first demand immediate payment from the insurance company as their first means of pursuing payment for services rendered. Also, I understand that if this account is assigned to an attorney for collection and/or suit, the assignee shall be entitled to reasonable attorney fees and costs of collection. I also understand that, if any bad check is written, I agree to pay for those added costs.

Dated this _____ day of _____, 20 ___.

Patient Signature_____**Printed Name**_____**Witness: Deidra James**

5136 Central Ave., St. Petersburg, FL 33707
Phone: 727-579-2500 Toll Free: 877-579-8800 Fax 727-579-1060

Patient's Name_____ Number_____ Date_____

LOW BACK DISABILITY QUESTIONNAIRE (REVISED OSWESTRY)

This questionnaire has been designed to give the doctor information as to how your back pain has affected your ability to manage in everyday life. **Please answer every section and mark in each section only ONE box** which applies to you. We realize you may consider that two of the statements in any one section relate to you, but **please just mark the box which MOST CLOSELY describes your problem.**

Section 1 - Pain Intensity

- ☐ I can tolerate the pain without having to use painkillers.
- ☐ The pain is bad but I can manage without taking painkillers.
- ☐ Painkillers give complete relief from pain.
- ☐ Painkillers give moderate relief from pain.
- ☐ Painkillers give very little relief from pain.
- ☐ Painkillers have no effect on the pain and I do not use them.

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 every day in most aspects of self care.
- ☐ I do not get dressed, I wash with difficulty and stay in bed.

Section 3 – Lifting

- ☐ I can lift heavy weights without extra pain.
- ☐ I can lift heavy weights but it 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 from walking more than one mile.
- ☐ Pain prevents me from walking more than one-half mile.
- ☐ Pain prevents me from walking more than one-quarter mile
- ☐ 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 in any chair as long as I like
- ☐ I can only sit in my favorite chair as long as I like
- ☐ Pain prevents me from sitting more than one hour.
- ☐ Pain prevents me from sitting more than 30 minutes.
- ☐ Pain prevents me from sitting more than 10 minutes.
- ☐ Pain prevents me from sitting almost all the time.

Scoring: Questions are scored on a vertical scale of 0-5. Total scores and multiply by 2. Divide by number of sections answered multiplied by 10. A score of 22% or more is considered significant activities of daily living disability.
(Score___ x 2) / (____Sections x 10) = _____ %ADL

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 extra pain.
- ☐ Pain prevents me from standing more than 1 hour.
- ☐ Pain prevents me from standing more than 30 minutes.
- ☐ Pain prevents me from standing more than 10 minutes.
- ☐ Pain prevents me from standing at all.

Section 7 -- Sleeping

- ☐ Pain does not prevent me from sleeping well.
- ☐ I can sleep well only by using tablets.
- ☐ Even when I take tablets I have less than 6 hours sleep.
- ☐ Even when I take tablets I have less than 4 hours sleep.
- ☐ Even when I take tablets I have less than 2 hours sleep.
- ☐ Pain prevents me from sleeping at all.

Section 8 – Social Life

- ☐ My social life is normal and gives 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. dancing.
- ☐ 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 9 – Traveling

- ☐ I can travel anywhere without extra pain.
- ☐ I can travel anywhere but it gives me extra pain.
- ☐ Pain is bad but I manage journeys over 2 hours.
- ☐ Pain is bad but I manage journeys less than 1 hour.
- ☐ Pain restricts me to short necessary journeys under 30 minutes.
- ☐ Pain prevents me from traveling except to the doctor or hospital.

Section 10 – Changing Degree of Pain

- ☐ My pain is rapidly getting better.
- ☐ My pain fluctuates but overall is definitely getting better.
- ☐ My pain seems to be getting better but improvement is slow at the present.
- ☐ My pain is neither getting better nor worse.
- ☐ My pain is gradually worsening.
- ☐ My pain is rapidly worsening.

Comments_____

Reference: Fairbank, Physiotherapy 1981; 66(8): 271-3, Hudson-Cook. In Roland, Jenner (eds.), Back Pain New Approaches To Rehabilitation & Education. Manchester Univ Press, Manchester 1989: 187-204

Patient's Name_____ Number_____ Date_____

NECK DISABILITY INDEX

This questionnaire has been designed to give the doctor information as to how your neck pain has affected your ability to manage in everyday life. **Please answer every section and mark in each section only ONE box** which applies to you. We realize you may consider that two of the statements in any one section relate to you, but **please just mark the box which MOST CLOSELY describes your problem.**

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 every day in most aspects of self care.
☐ I do not get dressed, I wash with difficulty and stay in bed.

Section 3 – Lifting

☐ I can lift heavy weights without extra pain.
☐ I can lift heavy weights but it 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.
☐ I can't read as much as I want because of moderate pain in my neck.
☐ I can hardly read at all because of severe pain in my neck.
☐ I cannot read at all.

Section 5-Headaches

☐ I have no headaches at all.
☐ I have slight headaches which come infrequently.
☐ I have slight headaches which come frequently.
☐ I have moderate headaches which come infrequently.
☐ I have severe headaches which come frequently.
☐ I have headaches almost all the time.

Scoring: Questions are scored on a vertical scale of 0-5. Total scores and multiply by 2. Divide by number of sections answered multiplied by 10. A score of 22% or more is considered a significant activities of daily living disability.
(Score___ x 2) / (____Sections x 10) = _____ %ADL_____

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 can't do any work at all.

Section 8 – Driving

☐ I 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 can't drive my car as long as I want because of moderate pain in my neck.
☐ I can hardly drive my car at all because of severe pain in my neck.
☐ I can't drive my car at all.

Section 9 – Sleeping

☐ I have no trouble sleeping.
☐ My sleep is slightly disturbed (less than 1 hr. sleepless).
☐ My sleep is moderately disturbed (1-2 hrs. sleepless).
☐ My sleep is moderately disturbed (2-3 hrs. sleepless).
☐ My sleep is greatly disturbed (3-4 hrs. sleepless).
☐ My sleep is completely disturbed (5-7 hrs. sleepless).

Section 10 – Recreation

☐ I am able to engage in all my recreation activities with no neck pain at all.
☐ I am able to engage in all my recreation activities, with some pain in my neck.
☐ I am able to engage in most, but not all of my usual recreation activities because of pain in my neck.
☐ I am able to engage in a few of my usual recreation activities because of pain in my neck.
☐ I can hardly do any recreation activities because of pain in my neck.
☐ I can't do any recreation activities at all.

Comments_____
%ADL

Reference: Vernon, Mior. JMPT 1991; 14(7): 409-15

HEADACHE DISABILITY INDEX

NAME: _____ DATE: _____ AGE: ____ SCORES TOTAL: ____; E____; F____
(100) (52) (48)

INSTRUCTIONS: Please CIRCLE the correct response:

1. I have headache: [1] 1 per month [2] more than 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 item as it pertains to your headache only.

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

Reference: Jacobson Gary P., Ramadan NM, et al., The Henry Ford Hospital Headache Disability Inventory (HDI). Neurology 1994; 44:837-842