NECK PAIN DISABILITY INDEX QUESTIONNAIRE

PLEASE READ: This questionnaire is designed to enable us to understand how much your neck pain has affected your ability to manage your everyday activities. Please answer each section by circling the ONE CHOICE that most applies to you. We realize that you may feel that more than one statement may relate to you, but *PLEASE JUST CIRCLE THE ONE. CHOICE WHICH MOST CLOSELY DESCRIBES YOUR PROBLEM RIGHT NOW.*

SECTION 1 - Pain Intensity

A I have no pain at the moment.
B The pain is very mild at the moment.
C The pain is moderate at the moment.
D The pain is fairly severe at the moment.
E The pain is very severe at the moment.
F The pain is the worst imaginable at the moment.

SECTION 2 -Personal Care (Washing, Dressing, etc.)

A I can look after myself normally without causing extra pain.
B I can look after myself normally, but it causes extra pain.
C It is painful to look after myself and I am slow and careful.
D I need some help, but manage most of my personal care.
E I need help every day in most aspects of self care.
F I do not get dressed, I wash with difficulty and stay in bed.

SECTION 3 - Lifting

A I can lift heavy weights without extra pain.
B I can lift heavy weights, but it gives extra pain.
C Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned, for example, on a table.
D Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
E I can lift very light weights.
F I cannot lift or carry anything at all.

SECTION 4 - Reading

A I can read as much as I want to with no pain in my neck.
B I can read as much as I want to with slight pain in my neck.
C I can read as much as I want to with moderate pain in my neck.
D I cannot read as much as I want because of moderate pain in my neck.
E I cannot read as much as I want because of severe pain in my neck.
F I cannot read at all.

SECTION 5 - Headaches

A I have no headaches at all.
B I have slight headaches which come infrequently.
C I have moderate headaches which come infrequently.
D I have moderate headaches which come frequently.
E I have severe headaches which come frequently.
F I have headaches almost all the time.

SECTION 6 - Concentration

A I can concentrate fully when I want to with no difficulty.
B I can concentrate fully when I want to with slight difficulty.
C I have a fair degree of difficulty in concentrating when I want to.
D I have a lot of difficulty in concentrating when I want to.
E I have a great deal of difficulty in concentrating when I want to.
F I cannot concentrate at all.

SECTION 7 - Work

A I can do as much work as I want to.
B I can only do my usual work, but no more.
C I can do most of my usual work, but no more.
D I cannot do my usual work.
E I can hardly do any work at all.
F I cannot do any work at all.

SECTION 8 - Driving

A I can drive my car without any neck pain.
B I can drive my car as long as I want with slight pain in my neck.
C I can drive my car as long as I want with moderate pain in my neck.
D I cannot drive my car as long as I want because of moderate pain in my neck.
E I can hardly drive at all because of severe pain in my neck.
F I cannot drive my car at all.

SECTION 9 - Sleeping

A I have no trouble sleeping.
B My sleep is slightly disturbed (less than 1 hour sleepless).
C My sleep is mildly disturbed (1-2 hours sleepless).
D My sleep is moderately disturbed (2-3 hours sleepless).
E My sleep is greatly disturbed (3-5 hours sleepless).
F My sleep is completely disturbed (5-7 hours)

SECTION 10 - Recreation

A I am able to engage in all of my recreational activities with no neck pain at all.
B I am able to engage in all of my recreational activities with some pain in my neck.
C I am able to engage in most, but not all of my recreational activities because of pain in my neck.
D I am able to engage in a few of my recreational activities because of pain in my neck.
E I can hardly do any recreational activities because of pain in my neck.
F I cannot do any recreational activities at all.

COMMENTS: _____

_____

_____

NAME: _____ **DATE:** _____ **SCORE:** _____

Oswestry Low Back Pain Scale

Please rate the severity of your pain by circling a number below:

No pain 0 1 2 3 4 5 6 7 8 9 10 *Unbearable pain*

Name _____ Date _____

Instructions: Please circle the **ONE NUMBER** in each section which most closely describes your problem.

Section 1 – 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 severe.
5. The pain is severe and does not vary much.

Section 2 – Personal Care (Washing, Dressing, etc.)
0. I would 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 increase the pain but I manage not to change my way of doing it.
3. Washing and dressing increase 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.

Section 3 – Lifting
0. I can lift heavy weights without extra pain.
1. I can lift heavy weights but it gives extra pain.
2. Pain prevents me lifting heavy weights off the floor.
3. Pain prevents me lifting heavy weights off the floor, but I can manage if they are conveniently positioned, e.g., on a table.
4. Pain prevents me lifting heavy weights but I can manage light to medium weights if they are conveniently positioned.
5. I can only lift very light weights at most.

Section 4 – Walking
0. I have no pain on walking.
1. I have some pain on walking but it does not increase with distance.
2. I cannot walk more than 1 mile without increasing pain.
3. I cannot walk more than ½ mile without increasing pain.
4. I cannot walk more than ¼ mile without increasing pain.
5. I cannot walk at all without increasing pain.

Section 5 – Sitting
0. I can sit in any chair as long as I like.
1. I can sit only 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 ½ hour.
4. Pain prevents me from sitting more than 10 minutes.
5. I avoid sitting because it increases pain immediately.

Section 6 – Standing
0. I can stand as long as I want without pain.
1. I have some pain on 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 ½ hour without increasing pain.
4. I cannot stand for longer than 10 minutes without increasing pain.
5. I avoid standing because it increases the pain immediately.

Section 7 – 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 nights sleep is reduced by less than one-quarter.
3. Because of pain my normal nights sleep is reduced by less than one-half.
4. Because of pain my normal nights sleep is reduced by less than three-quarters.
5. Pain prevents me from sleeping at all.

Section 8 – Social Life
0. My social life is normal and gives me no pain.
1. My social life is normal but it increases the degree of pain.
2. Pain has no significant effect 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.

Section 9 – Traveling
0. I get no pain when traveling.
1. I get some pain when traveling but none of my usual forms of travel make it any worse.
2. I get extra pain while traveling but it does not compel me to seek alternate forms of travel.
3. I get extra pain while traveling which compels to seek alternative forms of travel.
4. Pain restricts me to short necessary journeys under ½ hour.
5. Pain restricts all forms of travel.

Section 10 – Changing Degree of Pain
0. My pain is rapidly getting better.
1. My pain fluctuates but 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.

TOTAL _____

Lower Extremity Functional Scale

We are interested in knowing whether you are having any difficulty at all with the activities listed below because of your lower limb problem for which you are currently seeking attention. Please check (√) an answer for **each** activity.

Today, do you or would you have any difficulty at all with:

Activities	Extreme Difficulty Or Unable to Perform Activity	Quite a Bit of Difficulty	Moderate Difficulty	A Little Bit of Difficulty	No Difficulty
Any of your usual work, household, or school activities					
Your usual hobbies, recreational or sporting activities					
Getting into or out of the bath					
Walking between rooms					
Putting on your shoes or socks					
Squatting					
Lifting an object, like a bag of groceries from the floor					
Performing light activities around your Home					
Performing heavy activities around your Home					
Getting into or out of a car					
Walking 2 blocks					
Walking a mile					
Going up or down 10 stairs (about 1 flight of stairs)					
Standing for 1 hour					
Sitting for 1 hour					
Running on even ground					
Running on uneven ground					
Making sharp turns while running fast					
Hopping					
Rolling over in bed					

Binkley JM, Stratford POW, Lott SA, Riddle DL. The lower extremity functional scale (LEFS): Scale development, measurement properties, and clinical application. Physical Therapy 1999;79:371-383.

Patient name: _____ Signature: _____ Date: _____

Score _____/80 MDC (minimum detectable change) = 9 pts Error +/- 5 scale points

Upper Extremity Functional Scale

We are interested in knowing whether you are having any difficulty at all with the activities listed below because of your upper limb problem for which you are currently seeking attention. Please check (√) an answer for **each** activity.

Today, do you or would you have any difficulty at all with:

Activities	Extreme Difficulty Or Unable to Perform Activity	Quite a Bit of Difficulty	Moderate Difficulty	A Little Bit of Difficulty	No Difficulty
Any of your usual work, household, or school activities					
Your usual hobbies, recreational or sporting activities					
Lifting a bag of groceries to waist level					
Lifting a bag of groceries above your head					
Grooming your hair					
Pushing up on your hands (e.g., from bathtub or chair)					
Preparing food (e.g., peeling, cutting)					
Driving					
Vacuuming, sweeping, or raking					
Dressing					
Doing up buttons					
Using tools or appliances					
Opening doors					
Cleaning					
Tying or lacing shoes					
Sleeping					
Laundering clothes (e.g., washing, ironing, folding)					
Opening a jar					
Throwing a ball					
Carrying a small suitcase with your affected limb)					

Stratford P, Binkley JM, Stratford POW. Development and initial validation of the upper extremity functional index. Physiotherapy Canada Fall 2001;259-266, 281.

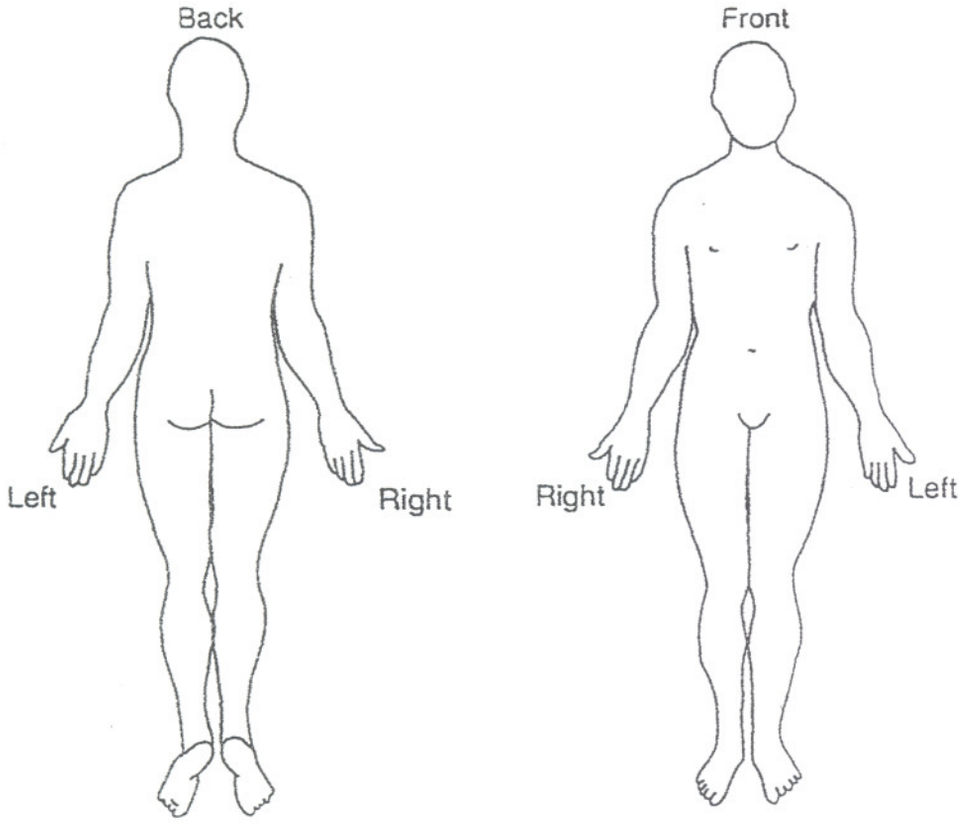
Patient name: _____ Signature: _____ Date: _____

Score _____/80 MDC (minimum detectable change) = 9 pts Error +/- 5 scale points

Date: _____ Name: _____

Draw location of your pain on body outlines

Ache	Burning	Numbness	Pins and Needles	Stabbing	Other
MMM	= = = =	0000	. . . . .	//////////	XXXXX
M	= = = =	00	. . . .	////	XXX



What is your TYPICAL or AVERAGE pain?

0	0	0	0	0	0	0	0	0	0	0
0	1	2	3	4	5	6	7	8	9	10

No Pain **Unbearable Pain**

NAME _____ **Primary complaint -** _____

1. Please indicate your usual level of pain during **the past week**:

No pain 0 1 2 3 4 5 6 7 8 9 10 **Worst possible pain**

2. Does pain, numbness, tingling or weakness extend into your leg (from the low back) &/or arm (from the neck)?

None of the time 0 1 2 3 4 5 6 7 8 9 10 **All of the time**

3. How would you **rate your general health**? (10-x)

Poor 0 1 2 3 4 5 6 7 8 9 10 **Excellent**

4. If you had to spend the rest of your life with your condition as it is right now, how would you feel about it?

Delighted 0 1 2 3 4 5 6 7 8 9 10 **Terrible**

5. How anxious (eg. tense, uptight, irritable, fearful, difficulty in concentrating / relaxing) you have been feeling during **the past week:**

Not at all 0 1 2 3 4 5 6 7 8 9 10 **Extremely anxious**

6. How much you have been able to control (i.e., reduce/help) your pain/complaint on your own during **the past week:**

I can reduce it 0 1 2 3 4 5 6 7 8 9 10 **I can't reduce it at all**

7. Please indicate how depressed (eg. Down-in-the-dumps, sad, downhearted, in low spirits, pessimistic, feelings of hopelessness) you have been feeling in **the past week:**

Not depressed at all 0 1 2 3 4 5 6 7 8 9 10 **Extremely depressed**

8. On a scale of 0 to 10, how certain are you that you will be doing normal activities or working in **six months**?

Very certain 0 1 2 3 4 5 6 7 8 9 10 **Not certain at all**

9. I can do light work for an hour?

Completely agree 0 1 2 3 4 5 6 7 8 9 10 **Completely disagree**

10. I can sleep at night

Completely agree 0 1 2 3 4 5 6 7 8 9 10 **Completely disagree**

11. An increase in pain is an indication that I should stop what I am doing until the pain decreases.

Completely disagree 0 1 2 3 4 5 6 7 8 9 10 **Completely agree**

12. Physical activity makes my pain worse?

Completely disagree 0 1 2 3 4 5 6 7 8 9 10 **Completely agree**

13. I should not do my normal activities including work with my present pain.

Completely disagree 0 1 2 3 4 5 6 7 8 9 10 **Completely agree**

Please sign your name _____ **Date** _____

PRIVACY PRACTICES ACKNOWLEDGEMENT

PATIENT ACKNOWLEDGEMENT FORM

I have received the Notice of Privacy Practices and I have been provided an opportunity to review it.

Name_____Birthdate_____

Signature_____

Date_____

INFORMED CONSENT

I understand that payment is required at time of service. Most medical insurances and credit cards are accepted. I understand and agree that health accident insurance policies are an agreement between an insurance carrier and myself. Furthermore, I understand that this chiropractic office will prepare any necessary reports and forms to assist me in making collections from the insurance company and that any amount authorized to be paid directly to this chiropractic office will be credited to my account. However, I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered me will be immediately due and payable. I further agree to pay all collection agency fees, attorney fees, court fees and other related costs incurred in the collection of my account.

I understand that, like in all health care procedures, risk is involved. The risks including, but not limited to, sprains, fractures, dislocations, disk injury, stroke, other injuries, however remote are possible after receiving care from any chiropractor. I have been given the chance to question my doctor on theses risks, and understanding risks are possible, I consent to treatment.

I authorize the release of medical records to the physician or physicians to who I may be referred. I authorize the release of any medical information necessary to process insurance claims.

I authorize and assign payment of medical benefits for **Thomas E. Smith, DC**.

Patient
Signature_____Date_____

Guardian or Spouse's Signature Authorizing Care_____Date_____

Taken By _____Date_____