Patient Name: _____ DATE:_____

NECK PAIN AND DISABILITY INDEX

Please read instructions carefully.
This questionnaire has been designed to give the therapist information as to how your neck pain has affected your ability to manage everyday life. Please read all statements in each section and mark **one** box which most accurately 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 worse than imaginable at the moment.

SECTION 2: PERSONAL CARE

- ☐ 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 on my own. I wash with difficulty and stay in bed.

SECTION 3: LIFTING

- ☐ I can lift heavy objects without any extra pain.
- ☐ I can lift heavy objects, but it gives extra pain.
- ☐ Pain prevents me from lifting heavy objects off the floor but I can manage if they are conveniently positioned on a table.
- ☐ Pain prevents me from lifting heavy objects but I can manage light to medium objects.
- ☐ I can only lift very light objects at the most.
- ☐ 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 light pain in my neck.
- ☐ I can read as much as I want to with moderate pain in my neck.
- ☐ I can't read as much as I want to 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 moderate headaches which come infrequently.
- ☐ I have moderate headaches which come frequently.
- ☐ I have severe headaches which come frequently.
- ☐ I have headaches almost all the time.

SECTION 6: CONCENTRATION

- ☐ I can concentrate fully when I want to with no difficulty.
- ☐ I can concentrate fully when I want to with slight difficulty.
- ☐ I have a fair degree of difficulty in concentrating when I want to.
- ☐ I have a lot of difficulty in concentrating when I want to.
- ☐ I have a great deal of difficulty in concentrating when I want to.
- ☐ I cannot concentrate at all.

SECTION 7: WORK

- ☐ I can do as much work as I want.
- ☐ 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 work at all.
- ☐ I cannot do any work at all.

SECTION 8: DRIVING

- ☐ I can drive without any neck pain.
- ☐ I can drive as long as I want with slight neck pain.
- ☐ I can drive as long as I want with moderate neck pain.
- ☐ I cannot drive as long as I want with moderate neck pain.
- ☐ I can hardly drive at all because of severe neck pain.
- ☐ I cannot drive at all.

SECTION 9: SLEEPING

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

SECTION 10: RECREATION

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

NECK PAIN SCALE

Rate the severity of your **Neck Pain** by indicating on the following scale.

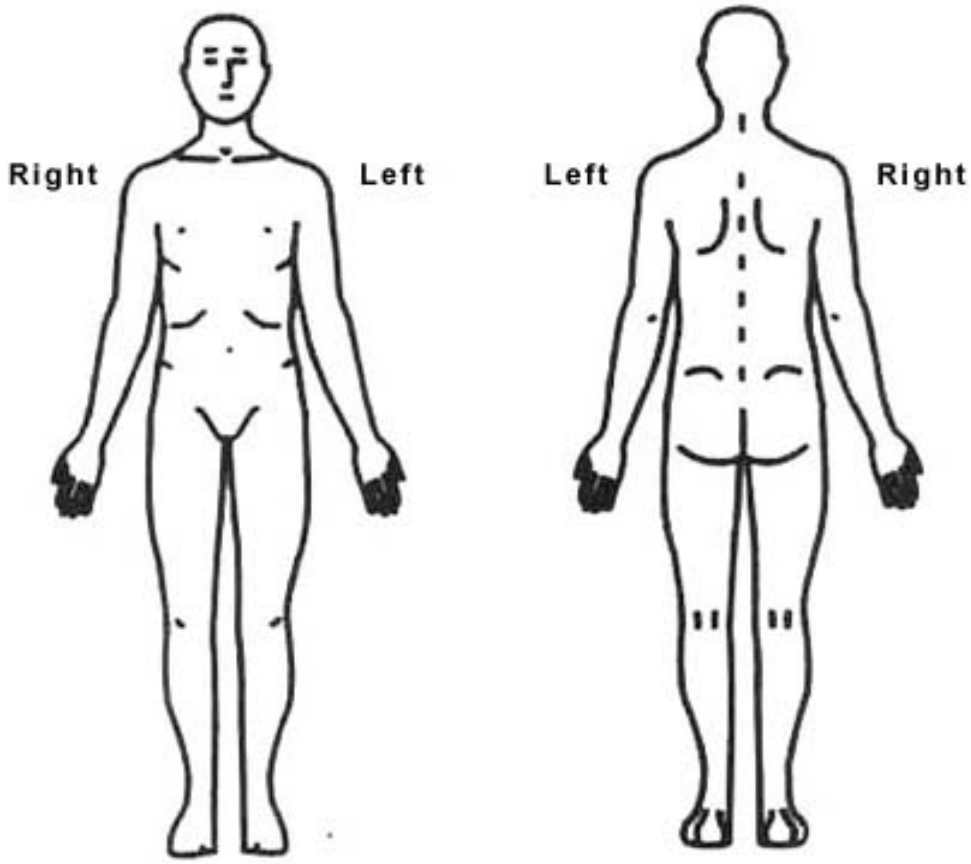
None I----------I Extreme

Total Score: _____

Pain Levels

10 Pain so intense you will go unconscious shortly.
9 Pain so intense you cannot tolerate it and demand pain killers or surgery.
8 Pain so intense you can no longer think clearly at all.
7 Intense pain causing you to think unclearly about half the time.
6 Piercing pain that causes you to think somewhat unclearly.
5 Strong deep pain that makes you pre-occupied with trying to manage it. Your normal lifestyle is curtailed.
4 Strong pain like an average toothache.
3 Very noticeable pain, like an accidental cut or blow to the nose.
2 Minor pain like lightly pinching the fold of skin between the fingers.
1 Very light barely noticeable pain.
0 No pain.

Please **mark** area of pain with an X and **label** with numbers.



Prior Therapy Form

Patient Name: _____

Date: _____

Are you currently a resident of a skilled nursing home? ☐ Yes ☐ No

Are you currently receiving home health care? ☐ Yes ☐ No

Please indicate if you have had any prior physical therapy or chiropractic care:

(Please include both inpatient and outpatient therapy)

Dates	Locations

Patient Signature: _____