



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 CHECK THE ONE CHOICE THAT MOST CLOSELY DESCRIBES YOUR PROBLEM RIGHT NOW.**

Section 1 – Pain Intensity <input type="checkbox"/> 0. I have no pain at the moment. <input type="checkbox"/> 1. The pain is very mild at the moment <input type="checkbox"/> 2. The pain is very moderate at the moment. <input type="checkbox"/> 3. The pain is fairly severe at the moment. <input type="checkbox"/> 4. The pain is very severe at the moment <input type="checkbox"/> 5. The pain is the worst imaginable at the moment.	Section 6 – Concentration <input type="checkbox"/> 0. I can concentrate when I want to with no difficulty <input type="checkbox"/> 1. I can concentrate fully when I want to with slight difficulty. <input type="checkbox"/> 2. I have a fair degree of difficulty in concentrating when I want. <input type="checkbox"/> 3. I have a lot of difficulty in concentrating when I want to. <input type="checkbox"/> 4. I have a great deal of difficulty in concentrating when I want to. <input type="checkbox"/> 5. I cannot concentrate at all.
Section 2 – Personal Care (Washing, Dressing, etc.) <input type="checkbox"/> 0. I can look after myself normally without causing extra pain. <input type="checkbox"/> 1. I can look after myself normally, but it causes extra pain. <input type="checkbox"/> 2. It is painful to look after myself and I am slow and careful. <input type="checkbox"/> 3. I need some help, but manage most of my personal care. <input type="checkbox"/> 4. I need help every day in most aspects of self care. <input type="checkbox"/> 5. I do not get dressed; I wash with difficulty and stay in bed.	Section 7 – Work <input type="checkbox"/> 0. I can do as much work as I want to. <input type="checkbox"/> 1. I can only do my usual work, but no more. <input type="checkbox"/> 2. I can do most of my usual work, but no more. <input type="checkbox"/> 3. I cannot do my usual work. <input type="checkbox"/> 4. I can hardly do any work at all. <input type="checkbox"/> 5. I cannot do any work at all.
Section 3 – Lifting <input type="checkbox"/> 0. I can lift heavy weights without extra pain. <input type="checkbox"/> 1. I can lift heavy weights, but it gives extra pain. <input type="checkbox"/> 2. Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned, for example, on a table. <input type="checkbox"/> 3. Pain prevents me from lifting heavy weights, but I can manage light to medium weight if they are conveniently positioned. <input type="checkbox"/> 4. I can lift very light weights. <input type="checkbox"/> 5. I cannot lift or carry anything at all.	Section 8 – Driving <input type="checkbox"/> 0. I can drive my car without any neck pain. <input type="checkbox"/> 1. I can drive my car as long as I want with slight pain in my neck. <input type="checkbox"/> 2. I can drive my car as long as I want with moderate pain in my neck. <input type="checkbox"/> 3. I cannot drive my car as long as I want because of moderate pain in my neck. <input type="checkbox"/> 4. I can hardly drive at all because of severe pain in my neck. <input type="checkbox"/> 5. I cannot drive my car at all.
Section 4 – Reading <input type="checkbox"/> 0. I can read as much as I want to with no pain in my neck. <input type="checkbox"/> 1. I can read as much as I want to with slight pain in my neck. <input type="checkbox"/> 2. I can read as much as I want to with moderate pain in my neck. <input type="checkbox"/> 3. I cannot read as much as I want because of moderate pain in my neck. <input type="checkbox"/> 4. I cannot read as much as I want to because of severe pain in my neck. <input type="checkbox"/> 5. I cannot read at all.	Section 9 – Sleeping <input type="checkbox"/> 0. I have no trouble sleeping <input type="checkbox"/> 1. My sleep is slightly disturbed (less than 1 hour sleepless) <input type="checkbox"/> 2. My sleep is mildly disturbed (1-2 hours sleepless) <input type="checkbox"/> 3. My sleep is moderately disturbed (2-3 hours sleepless) <input type="checkbox"/> 4. My sleep is greatly disturbed (3-5 hours sleepless) <input type="checkbox"/> 5. My sleep is completely disturbed (5-7 hours)
Section 5 – Headaches <input type="checkbox"/> 0. I have no headaches at all <input type="checkbox"/> 1. I have slight headaches with come infrequently. <input type="checkbox"/> 2. I have moderate headaches which come infrequently. <input type="checkbox"/> 3. I have moderate headaches which come frequently. <input type="checkbox"/> 4. I have severe headaches which come frequently. <input type="checkbox"/> 5. I have headaches almost all the time.	Section 10 – Recreation <input type="checkbox"/> 0. I am able to engage in all of my recreational activities with no neck pain at all. <input type="checkbox"/> 1. I am able to engage in all of my recreational activities with some pain in my neck. <input type="checkbox"/> 2. I am able to engage in most, but not all of my recreational activities because of pain in my neck. <input type="checkbox"/> 3. I am able to engage in a few of my recreational activities because of pain in my neck. <input type="checkbox"/> 4. I can hardly do any recreational activities because of pain in my neck. <input type="checkbox"/> 5. I cannot do any recreational activities at all.

Comments: _____



Please Read: Could you please complete this questionnaire. It is designed to give us information as to how your back (or leg) trouble has affected you ability to manage in everyday life. Please answer every section. Mark **one box only** in each section that most closely describes you **today**.

Section 1 – Pain Intensity <input type="checkbox"/> 0. I have no pain at the moment. <input type="checkbox"/> 1. The pain is very mild at the moment <input type="checkbox"/> 2. The pain is moderate at the moment. <input type="checkbox"/> 3. The pain is fairly severe at the moment. <input type="checkbox"/> 4. The pain is very severe at the moment <input type="checkbox"/> 5. The pain is the worst imaginable at the moment.	Section 6 – Standing <input type="checkbox"/> 0. I can stand as long as I want without extra pain. <input type="checkbox"/> 1. I can stand as long as I want but it gives me extra pain. <input type="checkbox"/> 2. Pain prevents me from standing for more than 1 hour. <input type="checkbox"/> 3. Pain prevents me from standing for more than 1/2 hour. <input type="checkbox"/> 4. Pain prevents me from standing for more than 10 minutes. <input type="checkbox"/> 5. Pain prevents me from standing at all.
Section 2 – Personal Care (Washing, Dressing, etc.) <input type="checkbox"/> 0. I can look after myself normally without causing extra pain. <input type="checkbox"/> 1. I can look after myself normally, but it is very painful. <input type="checkbox"/> 2. It is painful to look after myself and I am slow and careful. <input type="checkbox"/> 3. I need some help, but manage most of my personal care. <input type="checkbox"/> 4. I need help every day in most aspects of self care. <input type="checkbox"/> 5. I do not get dressed; I wash with difficulty and stay in bed.	Section 7 – Sleeping <input type="checkbox"/> 0. My sleep is never disturbed by pain. <input type="checkbox"/> 1. My sleep is occasionally disturbed by pain. <input type="checkbox"/> 2. Because of pain I have less than 6 hours' sleep. <input type="checkbox"/> 3. Because of pain I have less than 4 hours' sleep. <input type="checkbox"/> 4. Because of pain I have less than 2 hours' sleep. <input type="checkbox"/> 5. Pain prevents me from sleeping at all.
Section 3 – Lifting <input type="checkbox"/> 0. I can lift heavy weights without extra pain. <input type="checkbox"/> 1. I can lift heavy weights, but it causes extra pain. <input type="checkbox"/> 2. Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned, for example, on a table. <input type="checkbox"/> 3. Pain prevents me from lifting heavy weights, but I can manage light to medium weight if they are conveniently positioned. <input type="checkbox"/> 4. I can only lift very light weights, at the most <input type="checkbox"/> 5. I cannot lift or carry anything at all.	Section 8 – Sex Life (if applicable) <input type="checkbox"/> 0. My sex life is normal and causes me no extra pain. <input type="checkbox"/> 1. My sex life is normal and causes me some extra pain. <input type="checkbox"/> 2. My sex life is nearly normal, but is very painful. <input type="checkbox"/> 3. My sex life is severely restricted by pain. <input type="checkbox"/> 4. My sex life is nearly absent because of pain. <input type="checkbox"/> 5. Pain prevents any sex life at all.
Section 4 – Walking <input type="checkbox"/> 0. Pain does not prevent me from walking any distance. <input type="checkbox"/> 1. Pain prevents me from walking more than one mile. <input type="checkbox"/> 2. Pain prevents me from walking more than 1/4 th mile. <input type="checkbox"/> 3. Pain prevents me from walking more than 100 yds. <input type="checkbox"/> 4. I can only walk while using a stick or crutches <input type="checkbox"/> 5. I am in bed most of the time and have to crawl to the toilet.	Section 9 – Social Life <input type="checkbox"/> 0. My social life is normal and causes me no extra pain. <input type="checkbox"/> 1. My social life is normal, but increases the degree of pain. <input type="checkbox"/> 2. Pain has no significant effect on my social life apart from limiting my more energetic interest, eg., sports. <input type="checkbox"/> 3. Pain has restricted my social life and I do not go out as often. <input type="checkbox"/> 4. Pain has restricted my social life to my home. <input type="checkbox"/> 5. I have no social life because of the pain.
Section 5 – Sitting <input type="checkbox"/> 0. I can sit in any chair as long as I like. <input type="checkbox"/> 1. I can only sit in my favorite chair as long as I like. <input type="checkbox"/> 2. Pain prevents me from sitting more than 1 hour. <input type="checkbox"/> 3. Pain prevents me from sitting more than 1/2 hour. <input type="checkbox"/> 4. Pain prevents me from sitting more than ten minutes. <input type="checkbox"/> 5. Pain prevents me from sitting at all.	Section 10 – Traveling <input type="checkbox"/> 0. I can travel anywhere without pain. <input type="checkbox"/> 1. I can travel anywhere but it gives me extra pain. <input type="checkbox"/> 2. Pain is bad but I manage journeys over 2 hours. <input type="checkbox"/> 3. Pain restricts me to journeys of less than 1 hour. <input type="checkbox"/> 4. Pain restricts me to short necessary journeys under 30 minutes. <input type="checkbox"/> 5. Pain prevents me from traveling except to receive treatment.

Comments: _____



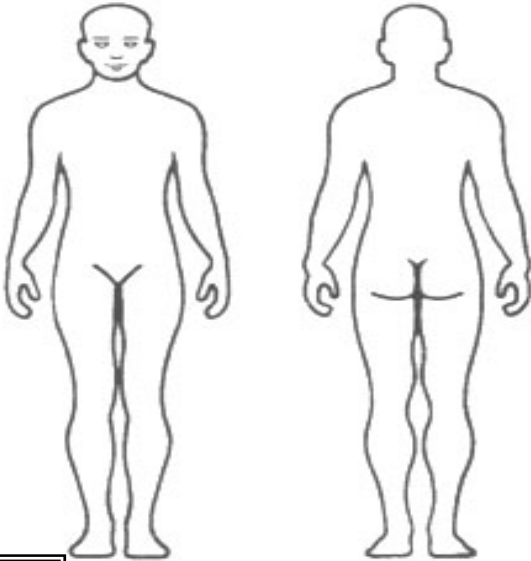
Lake Cities Chiropractic Center

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Patient Name: _____ Date: ___/___/___ Case: _____

1

Please indicate on the chart where you are experiencing pain, concern, or seeking treatment for this office visit.



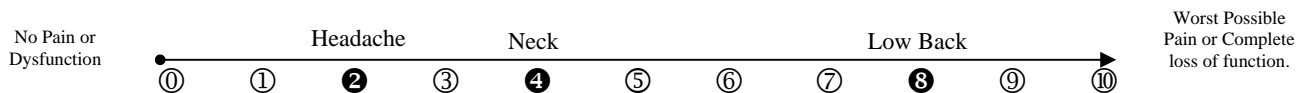
Describe the LOCATION and SYMPTOMS you are experiencing below:

^^^ Ache === Numbness 000 Pins & Needles/ Numbness
xxx Burning Sensation /// Sharp or Stabbing Pain

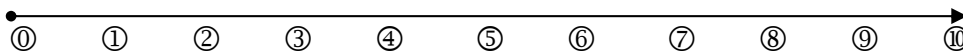
2

INSTRUCTIONS: Please fill in the circle of the number that best describes the question being asked. (0= NO PAIN or DYSFUNCTION, 5=MODERATE PAIN or DYSFUNCTION, and 10=WORST PAIN IMMAGINABLE or COMPLETE LOSS OF FUNCTION) *Dysfunction = impaired or abnormal function of a muscle or joint of the body.*

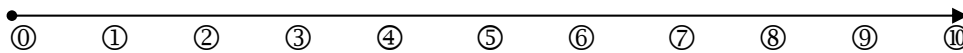
Example:



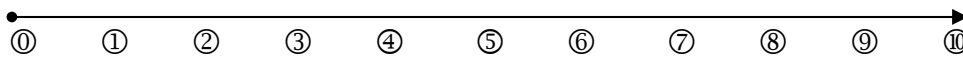
1. What is your pain/dysfunction level right now?



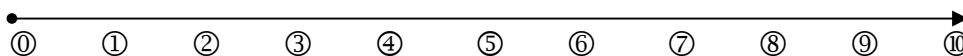
2. What is your typical or average pain/dysfunction?



3. What is your pain/dysfunction level at it's best? (How close to "0" does you pain get at it's best)



4. What is you pain/dysfunction level at it's worst (how close to "10" does your pain get at it's worst)



((1+2+4)/3) x10 Score: _____