



PHYSICAL THERAPY

PATIENT IDENTIFICATION AREA

NECK DISABILITY INDEX

This questionnaire has been designed to give your therapist information as to how your neck pain has affected you in your everyday activities. Please answer each section, marking only **ONE** box which best describes your status **today**.

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 me 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 I stay in bed.

Section 3 – Lifting

- I can lift heavy weights without extra pain.
- I can lift heavy weights but it causes 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 positioned conveniently.
- I can only 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 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 – Headache

- I have no headache 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 of 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 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 do any work at all.
- I cannot do any work at all.

Section 8 – Driving

- I can drive my car without any neck pain.
- I can drive my car as long as I want to, with slight pain in my neck.
- I can drive my car as long as I want to, with moderate pain in my neck.
- I cannot drive my car as long as I want to because of moderate pain in my neck.
- I can hardly drive my car at all because of severe pain in my neck.
- I cannot drive my car at all.

Section 9 – Sleeping

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

Section 10 – Recreation

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

Therapist Name: _____

Date: _____ I/E F/U D/C

Score: _____%

Score = Sum of responses ÷ Number possible x 100
Each item is scored from 0-5 from top to bottom



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PHYSICAL THERAPY

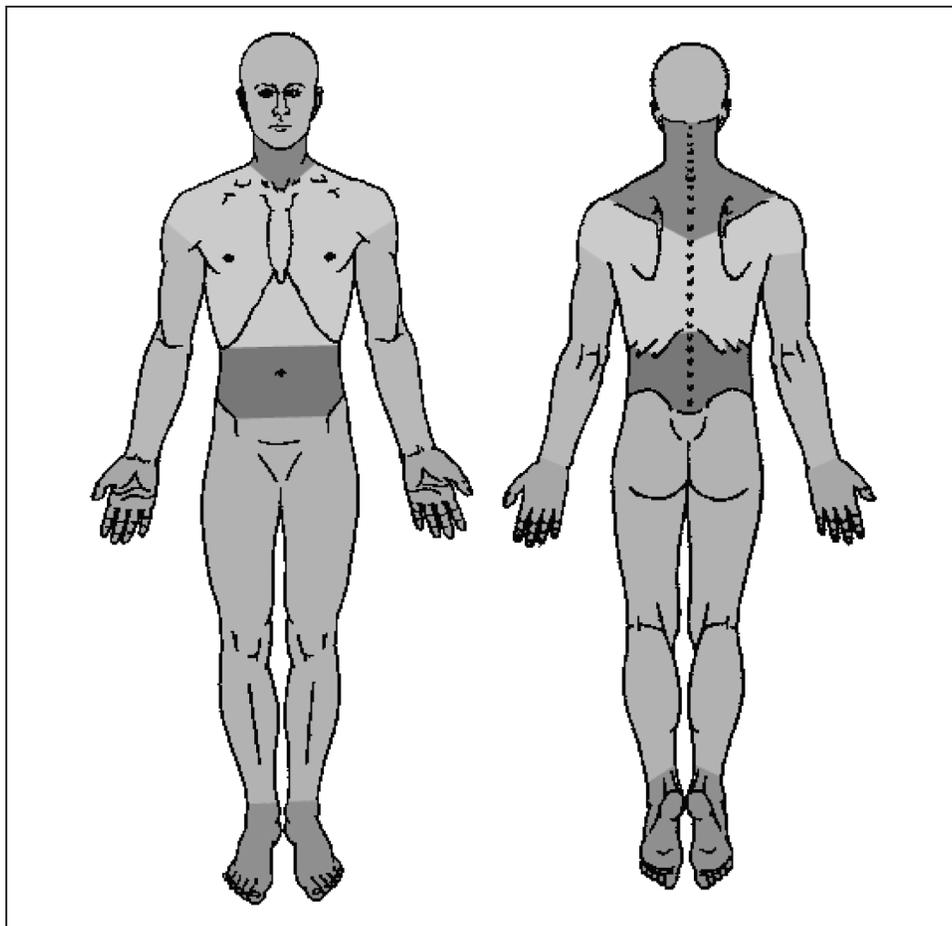
PATIENT IDENTIFICATION AREA

PAIN DIAGRAM AND RATING

Please use the diagram below to indicate the symptoms you have experienced over the past 24 hours. Be VERY precise when drawing the location of your pain. Use the key to indicate the type of symptoms

Key:

Pins and Needles	= 000000	Stabbing	= //////////////
Burning	= xxxxxx	Deep Ache	= zzzzzz



Please rate your *current* level of pain on the following scale (check one)

0	1	2	3	4	5	6	7	8	9	10
(no pain)										(worst imaginable pain)

Please rate your *worst* level of pain in the last 24 hours on the following scale (check one)

0	1	2	3	4	5	6	7	8	9	10
(no pain)										(worst imaginable pain)

Please rate your *best* level of pain in the last 24 hours on the following scale (check one)

0	1	2	3	4	5	6	7	8	9	10
(no pain)										(worst imaginable pain)

Therapist Name: _____

Date: _____ I/E F/U D/C