

Rate your neck pain on a scale from 1 – 10 with 1 being the least and 10 being the most severe.

1 2 3 4 5 6 7 8 9 10

Office Use		Section 1 – Pain Intensity	
Please check 1 box per section that best describes how you're feeling today.	1	<input type="checkbox"/>	I have no pain at the moment.
	2	<input type="checkbox"/>	The pain is mild at the moment.
	3	<input type="checkbox"/>	The pain comes and goes and is moderate.
	4	<input type="checkbox"/>	The pain is moderate and does not vary much.
	5	<input type="checkbox"/>	The pain is severe but comes and goes.
	6	<input type="checkbox"/>	The pain is severe and does not vary much.
Office Use		Section 2 – Personal Care	
Please check 1 box per section that best describes how you're feeling today.	1	<input type="checkbox"/>	I can look after myself normally without causing extra pain.
	2	<input type="checkbox"/>	I can look after myself normally, but it causes extra pain.
	3	<input type="checkbox"/>	It is painful to look after myself, and I am slow and careful.
	4	<input type="checkbox"/>	I need some help but manage most of my personal care.
	5	<input type="checkbox"/>	I need help everyday in most aspects of self-care.
	6	<input type="checkbox"/>	I do not get dressed. I wash with difficulty and stay in bed.
Office Use		Section 3 - Lifting	
Please check 1 box per section that best describes how you're feeling today.	1	<input type="checkbox"/>	I can lift heavy weights without causing extra pain.
	2	<input type="checkbox"/>	I can lift heavy weights, but it gives me extra pain.
	3	<input type="checkbox"/>	Pain prevents me from lifting heavy weights off the floor, but I can manage if items are conveniently positioned, ie. On a table.
	4	<input type="checkbox"/>	Pain prevents me from lifting heavy weights, but I can manage light to medium weights if items are conveniently positioned.
	5	<input type="checkbox"/>	I can lift only very light weights.
	6	<input type="checkbox"/>	I cannot lift or carry anything at all.
Office Use		Section 4 - Reading	
Please check 1 box per section that best describes how you're feeling today.	1	<input type="checkbox"/>	I can read as much as I want to with no pain in my neck.
	2	<input type="checkbox"/>	I can read as much as I want to with slight pain in my neck.
	3	<input type="checkbox"/>	I can read as much as I want to with moderate pain in my neck.
	4	<input type="checkbox"/>	I cannot read as much as I want because of moderate pain in my neck.
	5	<input type="checkbox"/>	I cannot read as much as I want because of severe pain in my neck.
	6	<input type="checkbox"/>	I cannot read at all.
Office Use		Section 5 - Headache	
Please check 1 box per section that best describes how you're feeling today.	1	<input type="checkbox"/>	I have no headaches at all.
	2	<input type="checkbox"/>	I have slight headaches which come infrequently.
	3	<input type="checkbox"/>	I have moderate headaches which come infrequently.
	4	<input type="checkbox"/>	I have moderate headaches which come frequently.
	5	<input type="checkbox"/>	I have severe headaches which come frequently.
	6	<input type="checkbox"/>	I have headaches almost all of the time.

Office Use		Section 6 - Concentration	
Please check 1 box per section that best describes how you're feeling today.	1	<input type="checkbox"/>	I can concentrate fully when I want to with no difficulty.
	2	<input type="checkbox"/>	I can concentrate fully when I want to with slight difficulty.
	3	<input type="checkbox"/>	I have a fair degree of difficulty in concentrating when I want to.
	4	<input type="checkbox"/>	I have a lot of difficulty in concentrating when I want to.
	5	<input type="checkbox"/>	I have a great deal of difficulty in concentrating when I want to.
	6	<input type="checkbox"/>	I cannot concentrate at all.
Office Use		Section 7 - Work	
Please check 1 box per section that best describes how you're feeling today.	1	<input type="checkbox"/>	I can do as much work as I want to.
	2	<input type="checkbox"/>	I can only do my usual work, but no more.
	3	<input type="checkbox"/>	I can do most of my usual work, but no more.
	4	<input type="checkbox"/>	I cannot do my usual work.
	5	<input type="checkbox"/>	I can hardly do any work at all.
	6	<input type="checkbox"/>	I cannot do any work at all.
Office Use		Section 8 – Driving	
Please check 1 box per section that best describes how you're feeling today.	1	<input type="checkbox"/>	I can drive my car without neck pain.
	2	<input type="checkbox"/>	I can drive my car as long as I want with slight pain in my neck.
	3	<input type="checkbox"/>	I can drive my car as long as I want with moderate pain in my neck.
	4	<input type="checkbox"/>	I cannot drive my car as long as I want because of moderate pain in my neck.
	5	<input type="checkbox"/>	I can hardly drive my car at all because of severe pain in my neck.
	6	<input type="checkbox"/>	I cannot drive my car at all.
Office Use		Section 9 – Sleeping	
Please check 1 box per section that best describes how you're feeling today.	1	<input type="checkbox"/>	I have no trouble sleeping
	2	<input type="checkbox"/>	My sleep is slightly disturbed. (Less than 1 hour sleeplessness).
	3	<input type="checkbox"/>	My sleep is mildly disturbed. (1-2 hours sleeplessness).
	4	<input type="checkbox"/>	My sleep is moderately disturbed. (2-3 hours sleeplessness)..
	5	<input type="checkbox"/>	My sleep is greatly disturbed. (3-5 hours sleeplessness).
	6	<input type="checkbox"/>	My sleep is completely disturbed. (5-7 hours sleeplessness).
Office Use		Section 10 - Recreation	
Please check 1 box per section that best describes how you're feeling today.	1	<input type="checkbox"/>	I am able to engage in all recreational activities with no pain in my neck at all.
	2	<input type="checkbox"/>	I am able to engage in all recreational activities with some pain in my neck.
	3	<input type="checkbox"/>	I am able to engage in most, but not all recreational activities because of pain in my neck.
	4	<input type="checkbox"/>	I am able to engage in a few of my usual recreational activities because of pain in my neck.
	5	<input type="checkbox"/>	I can hardly do any recreational activities because of pain in my neck.
	6	<input type="checkbox"/>	I cannot do any recreational activities at all.

PATIENT SIGNATURE _____ DATE _____ DISABILITY SCORE _____
 PRINT NAME _____