SYLVIA CHIROPRACTIC CENTER

PLEASE FILL OUT COMPLETELY

Check in PIN #: ___________
(6 digits)

Patient Title: *(check one)* ❑ Mr. ❑ Mrs. ❑ Ms. ❑ Miss ❑ Dr. ❑ Prof. ❑ Rev. Rank______ Other_______

First Name_________________________ **Nick Name**_________________________

Last Name _________________________ **Middle Name** _______________

Address 1 ____

Address 2 _________________________**City** _________________________

State ___________________ **Zip Code** __________ **Employer:** _________________

Primary Phone: _________________________ **SSN:** _________________________

Secondary Phone: _________________________ **Mobile Phone:** _________________________

Home Email: _________________________ **Work Email:** _________________________

By providing my email address, I authorize my doctor to contact me via the email address(es) provided.*

Emergency contact name: ___________________ Relationship: ___________ Phone number: ___________

How were you referred to our office? _________________________________

Your Date of Birth [/ /] **Age** ____ **Gender** *(check on* ❑ Male ❑ Female ❑ Other

Spouse's Name _________________________ **Marital Status** *(check one)* ❑ Single ❑ Married ❑ Widowed ❑ Divorced

Spouse's Date of Birth ___________________ **Primary Care Providers Name** ___________________

Race *(check one)* ❑ White ❑ Black/African American ❑ Hispanic ❑ Asian ❑ Other _____ ❑ I choose not to specify

I authorize ___________________ **to receive any medical or billing information in my account.**

Signature required at the bottom of this form for this authorization to be valid.

Have you had previous Chiropractic care? ❑ Yes ❑ No If yes, when &where? ___________________

What techniques were used _________________________________

Have you had an X-ray, CT scan, or MRI of your back or neck in the past 12 months? ❑ Yes ❑ No

What activity do you enjoy that has become difficult due to this problem? ___________________

Other doctors seen for this problem (please list): Chiropractor: ___________________

Medical Doctor: ___________________**Other:** ___________________

PLEASE CHECK THE ONE CHOICE THAT MOST CLOSELY DESCRIBES YOUR CURRENT GOALS FOR HEALTH/WELL-BEING

_____ I am only concerned about relief of a particular symptom.

_____ I am only concerned about relief of a particular symptom and preventing its return.

_____ I want optimum health and well-being on every level available to me

Today's Date [/ /] **Signature of Patient** _________________________

Review of Systems: Chiropractic care focuses on the integrity of your nervous system, which controls and regulates your entire body.

Please put a check (☑) beside any condition that you've Had or currently Have.

Musculoskeletal
Had Have
- ❑ ❑ Osteoporosis
- ❑ ❑ Knee Injuries
- ❑ ❑ Arthritis
- ❑ ❑ Foot/ankle pain
- ❑ ❑ Scoliosis
- ❑ ❑ Shoulder problems
- ❑ ❑ Neck Pain
- ❑ ❑ Elbow/ wrist pain
- ❑ ❑ Back problems
- ❑ ❑ TMJ issues
- ❑ ❑ Hip disorders
- ❑ ❑ Cramping
- ❑ ❑ Poor posture
- ❑ ❑ Swelling/deformity of joints

Neurological
Had Have
- ❑ ❑ Anxiety/ Panic
- ❑ ❑ Depression
- ❑ ❑ Headache/ Migraines
- ❑ ❑ Dizziness
- ❑ ❑ Pins and Needles
- ❑ ❑ Numbness
- ❑ ❑ Epilepsy/ seizures
- ❑ ❑ Memory issues
- ❑ ❑ Stroke
- ❑ ❑ Weak muscles
- ❑ ❑ Temporary loss of: Vision, smell, or hearing

Cardiovascular
Had Have
- ❑ ❑ Blood clots
- ❑ ❑ Chest pain/ tightness
- ❑ ❑ Coronary artery disease
- ❑ ❑ Heart attack
- ❑ ❑ High blood pressure
- ❑ ❑ High cholesterol
- ❑ ❑ Leg pain upon walking
- ❑ ❑ Low Blood Pressure
- ❑ ❑ Lower extremity edema
- ❑ ❑ Palpitations

Digestive
Had Have
- ❑ ❑ Abdominal pain
- ❑ ❑ Black/ bloody stool
- ❑ ❑ Changes in bowel habits
- ❑ ❑ Colon cancer or polyps
- ❑ ❑ Constipation
- ❑ ❑ Gastric reflux
- ❑ ❑ Heartburn
- ❑ ❑ IBS
- ❑ ❑ Liver disease
- ❑ ❑ Nausea/ vomiting
- ❑ ❑ Diarrhea
- ❑ ❑ Ulcer

Dermatological
Had Have
- ❑ ❑ Psoriasis
- ❑ ❑ Eczema
- ❑ ❑ Excessive hair loss
- ❑ ❑ Skin cancer
- ❑ ❑ Skin trouble/ rashes
- ❑ ❑ Change in hair/ nails

Respiratory
Had Have
- ❑ ❑ Asthma
- ❑ ❑ Emphysema
- ❑ ❑ Shortness of Breath
- ❑ ❑ Persistent cough
- ❑ ❑ Wheezing
- ❑ ❑ Breathing Difficulties

Endocrine
Had Have
- ❑ ❑ Excessive thirst
- ❑ ❑ Testosterone deficiency
- ❑ ❑ Thyroid problems

Genitourinary
Had Have
- ❑ ❑ Blood in the urine
- ❑ ❑ Incontinence
- ❑ ❑ Kidney stones
- ❑ ❑ Urgency
- ❑ ❑ Painful/frequent urination

Surgeries, which may or may not have included hospitalization and Dates
- ❑ Bypass surgery ____________________
- ❑ Cancer ____________________
- ❑ Elective surgery ____________________
- ❑ Hysterectomy ____________________
- ❑ Pacemaker____________________
- ❑ Spine____________________
- ❑ Wisdom teeth____________________
- ❑ Other: ____________________

Head and ENT
Had Have
- ❑ ❑ Blurred/ double vision
- ❑ ❑ Difficulty swallowing
- ❑ ❑ Ear/ hearing problems
- ❑ ❑ Sinus Trouble
- ❑ ❑ Ringing in the ears
- ❑ ❑ Swollen lymph nodes

Females only
Are you pregnant?
❑ Yes ❑ No
If yes, how many weeks? ___
If no, is there a chance you might be pregnant? ___

Social History Tell us about your health habits and stress levels. Please write **N/A** if it doesn't apply to you.

Employment Status: Occupation ____________________ Hours per week _____ Change due to current problem _____

Do you smoke? ____ **Yes** ____**No** **How long?** _______ **Packs a day?** ____
How long since you stopped smoking? ____________

How interested are you in quitting? - Please Circle: No 1 2 3 4 5 6 7 8 9 10 Yes

Alcohol use – ❑ None ❑ Social ❑ Light ❑ Moderate ❑ Heavy ❑ Alcoholic ❑ Recovering alcoholic

Recreational Drug use – ❑ None ❑ Social ❑ Light ❑ Moderate ❑ Heavy ❑ Drug addicted ❑ Recovering drug addict

Caffeine use – ❑ None ❑ 1cup/day ❑2-4cups/day ❑ 5+cups/day

Exercise habits – ❑ None ❑ Daily ❑ 2-3 times a week ❑ Weekly ❑ Occasionally **Type?** ____________

Is your diet restricted? ____________________ Any recent change in diet?____________________

Any Change in social habits due to current issue?____

Briefly list your main chief complaint ______________________________

When did this problem start? ____________________ **Have you had this problem before?** _________

Problem is due to: ❑Auto accident ❑Injury ❑Work related ❑Long-term problem ❑Other________________

Intensity of current symptoms? (better) ❑1 ❑2 ❑3 ❑4 ❑5 ❑6 ❑7 ❑8 ❑9 ❑10 (worst)

Duration and Timing of pain? ❑ Off & On ❑ Frequent ❑ Intermittent ❑Constant ❑Random ❑Recurring

What is most affected? ❑Employment ❑Homemaking ❑Personal Care ❑Sitting ❑Sleeping ❑Lifting

How are the symptoms changing with time? ❑Getting worse ❑Not changing ❑Getting better

Quality of Symptoms (What does it feel like?)

- ❑ Achy
- ❑ Annoying
- ❑ Burning
- ❑ Deep
- ❑ Dull
- ❑ Heavy
- ❑ Intolerable
- ❑ Pulling
- ❑ Sharp
- ❑ Shock like
- ❑ Stabbing
- ❑ Stiffness
- ❑ Throbbing
- ❑ Tightness
- ❑ Tingling
- ❑ Other________

Relieving Factors (What makes it better?)

- ❑ Chiropractic
- ❑ Heat
- ❑ Ice
- ❑ Exercise
- ❑ Support
- ❑ Massage
- ❑ Nothing
- ❑ OTC medication
- ❑ Rx medication
- ❑ Physical therapy
- ❑ Rest
- ❑ Stretching
- ❑ Work
- ❑ Other______

Aggravating Factors (What makes it worse?)

- ❑ Any movement
- ❑ Bathing
- ❑ Bending
- ❑ Caring for family
- ❑ Carrying objects
- ❑ Climbing stairs
- ❑ Computer use
- ❑ Concentrating
- ❑ Coughing/sneezing
- ❑ Daily child/pet care
- ❑ Dressing self
- ❑ Driving
- ❑ Eating
- ❑ Exercises
- ❑ Falling/staying asleep
- ❑ Getting in/out of car
- ❑ Getting up from lying down
- ❑ Grocery shopping
- ❑ Getting up from sitting
- ❑ Household chores
- ❑ Lifting
- ❑ Looking over shoulder
- ❑ Lying down
- ❑ Pushing
- ❑ Pulling
- ❑ Reaching
- ❑ Reading
- ❑ Resting
- ❑ Running
- ❑ Sitting
- ❑ Squatting
- ❑ Standing
- ❑ Stress
- ❑ Stretching
- ❑ Talking on the phone
- ❑ Turning
- ❑ Twisting
- ❑ Walking
- ❑ Working
- ❑ Yard work
- ❑ Other___________

Illnesses: Check the illnesses you have Had in the past or **Have** now.

Had	Have	
❑	❑	Diabetes Type1__Type II___
❑	❑	Stroke
❑	❑	Other: _______________

Injuries: Have you ever...

- ❑ Had a fractured or broken bone. Date_____
- ❑ Had a spine or nerve disorder. Date ______
- ❑ Been knocked unconscious. Date ________
- ❑ Been injured in an accident. Date ________
- ❑ Used neck or back bracing. Date ________

Family History: Some health issues are hereditary. Tell us about the health of your immediate family members.

Relative	Age	Illnesses	Age of death	Cause of death
Mother				
Father				
Sister				
Brother				
Children				
Children				
Children				

Current Medications (Rx & OTC)	What medication is treating	Frequency & Dosage	Start date

Person responsible for this account ______________________________
Family physician ______________________________ Phone # ______________________________
Address ______________________________ City______________ Zip Code ______________

Date you first saw any Doctor after the accident ______________________________
Is this workman's Compensation? YES NO
Is this a personal injury? YES NO
Have you received any medical treatment since the accident?
Hospital ______________________________ Cost ______________
Medical doctor ______________________________ Cost ______________
Chiropractor ______________________________ Cost ______________
Other ______________________________ Cost ______________

Health insurance information

Health insurance company ______________________________ Phone number ______________
Policy/Member ID # ______________________________ Group # ______________________________
Address ______________________________ City ______________ Zip code ______________
Phone # ______________ Adjuster ______________________________
Name of the insurance cardholder ______________________________ SSN ______________
Name of their employer ______________________________ Employer phone number ______________
Children's names and ages ______________________________

Car insurance information

Car insurance company ______________________________ Phone number ______________
Address ______________________________ City ______________ Zip code ______________
Agent ______________________________ Agent's phone number ______________________________
Policy # ______________________________ Claim # ______________________________
Driver's license ______________________________
Name of insured on your car policy ______________________________ Date of loss/accident ______________
Medical coverage? YES NO
Uninsured motorist coverage? YES NO
Underinsured motorist coverage? YES NO
Personal injury protection (PIP)? YES NO $ ______________________________
Lost wages since accident? $ ______________________________
What is the repair amount of your car? $ ______________________________
Lawyer/law firm ______________________________ Phone # ______________________________
Address ______________________________ City ______________ Zip code ______________

Today's Date: ______________________________ Signature of Patient ______________________________

SYLVIA CHIROPRACTIC CENTER

ACC DENT QUESTIONNAIRE

Name: ______________________ Date: ______________

Date of Accident: ______________________ Time of Accident: ______________

City of Accident: ______________________ Street of Accident: ______________

BEFORE the accident

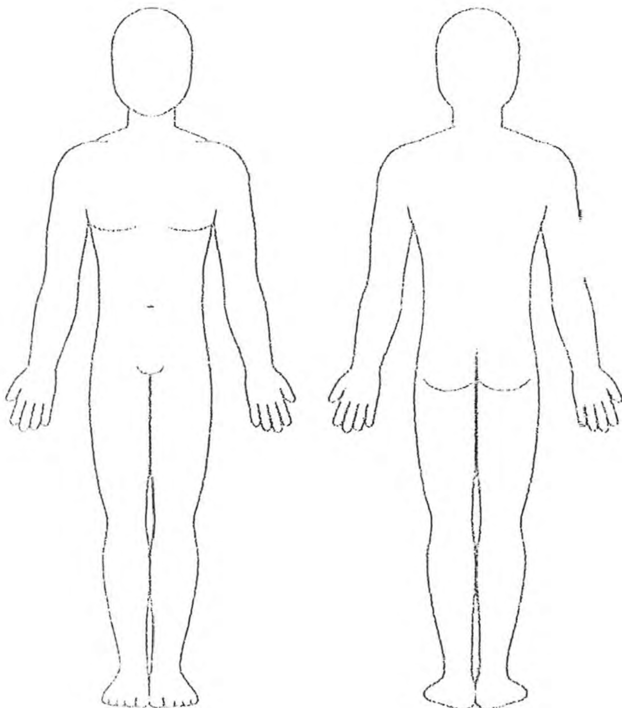
Who else was in the vehicle?	
Seatbelt?	ON OFF

AT MOMENT of accident

Road was	WET DRY ICY SANDY OTHER: __________
Weather condition was	CLEAR CLOUDY DRIZZILING FOGGY RAINY SNOWY STORMY SUNNY
Did it catch you by surprise or were you aware of the approaching collision?	SURPRISE AWARE
Did you receive a head injury?	YES NO
Did you lose consciousness? (Black out)	YES NO If yes, for how long? __________
Airbags deployed?	YES NO If yes, which one? __________

AFTER the accident

Did police arrive?	YES NO
Did EMS arrive?	YES NO
Did you go to the hospital?	YES NO If yes. how did you get there? SELF SOMEONE ELSE AMBULANCE When? __/__/__ What hospital? ______________________ What procedures where made? ______________________ X-rays taken? YES NO If yes, which ones? __________
Your release status from work?	NO WORK LIGHT WORK NORMAL WORK



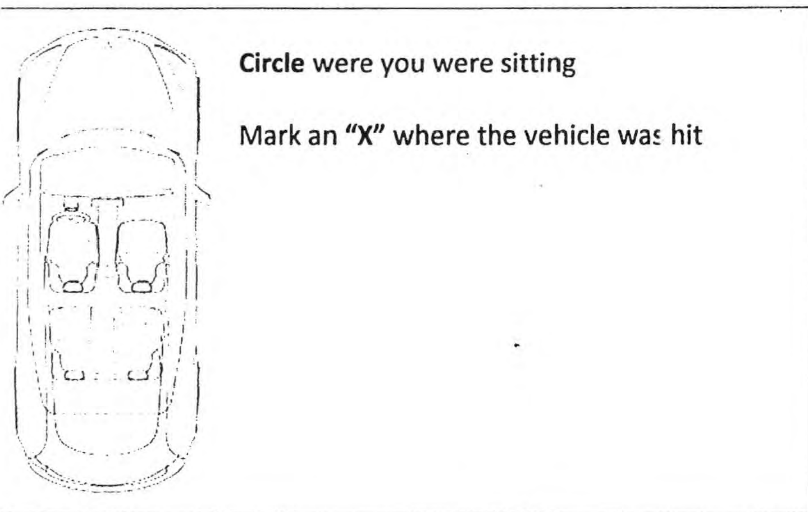
Symptoms felt **AT THE TIME** of accident:

A – Aching
H – Heavy
S – Stiffness
An – Annoying
In – Intolerable
Th – Throbbing
B – Burning
P – Pulling
T – Tightness
D – Deep
Sh – Sharp
Tin – Tingling
St – Stabbing
Du – Dull
Sh – Shock like
O – Other

YOUR descriptions

Your head was pointing?	STRAIGHT LEFT RIGHT
Your body was pointing?	STRAIGHT LEFT RIGHT

YOUR vehicle	**THEIR** vehicle
Type: ___________ Year: ___________ Make: __________ Model: __________	Type: ___________ Year: ___________ Make: __________ Model: __________
Adjustor estimate vehicle damage: $ _______ If unknown: **HEAVY MODERATE** **SLIGHT VISIBLE DAMAGE TOTALED**	Adjustor estimate vehicle damage: $ _______ If unknown: **HEAVY MODERATE** **SLIGHT VISIBLE DAMAGE TOTALED**
Was this vehicle moving at the time of collision? YES NO If yes, approximate speed: __________	Was this vehicle moving at the time of collision? YES NO If yes, approximate speed: __________
Was the vehicle towed from the scene? YES NO	Was the vehicle towed from the scene? YES NO



Circle were you were sitting

Mark an **"X"** where the vehicle was hit

Your emotions

None	Loss of appetite	Exhaustion
Depression	Tingling	Headaches
Facial pain	Difficulty breathing	Shock
Irritability	Dizziness	Muscle pain
Numbness	Gluteal pain	Stomach pain
Low energy	Low energy	Tiredness
Stress	Rib pain	
Upset	Soreness	
Stunned	Tightness	
Anxiety	Chest pain	
Disbelief	Exhaustion	
Genital pain	Difficulty breathing	

What part of **YOUR BODY** hit the interior of the vehicle?

My HEAD (TOP BACK LEFT RIGHT) hit the _______________
My CHEST (LEFT RIGHT) hit the ___________________________
My SHOULDER (LEFT RIGHT) hit the _______________________
My ARM (LEFT RIGHT) hit the ____________________________
My HIP (LEFT RIGHT) hit the _____________________________
My KNEE (LEFT RIGHT) hit the ____________________________
My ANKLE (LEFT RIGHT) hit the ___________________________

PLEASE DESCRIBE, TO THE BEST OF YOU KNOWLEDGE, WHAT HAPPENED DURING THIS ACCIDENT:
(CONTINUE ON BACK OF PAGE IF YOU NEED MORE SPACE)

____
____
____
____
____
____
____
____

Body position	LEANING FORWARD/ SLOUCHED/ STRAIGHT / TURNED RIGHT/ TURNED LEFT
Direction body was thrown	BACKWARD THEN FORWARD/ FORWARD THEM BACKWARD/ TO THE LEFT/ TO THE RIGHT/ ABOUT THE VEHICLE/ OUTSIDE THE VEHICLE/ UNDER THE VEHICLE
Head position at impact	STRAIGHT/ TILTED FORWARD/ TURNED TO THE LEFT/ TURNED TO THE RIGHT
Direction head was thrown	BACKWARD THEN FORWARD/ FORWARD THE BACKWARD/ SIDE TO SIDE

Do you have lacerations, cuts or bruising? YES NO

Where? ___________

Circle any of the following symptoms you experienced

- Headache
- Dizziness
- Difficulty walking
- Balance problems
- Rooms spins
- Disoriented
- Day dreaming
- Hearing problems
- Change in sense of smell or taste
- Difficulty speaking
- Memory problems
- Very tired or fatigues
- Appetite change
- sleep difficulties

Circle any area in which there is pain

Jaw (LEFT RIGHT BOTH)	CLICKING PAIN CHEWING PAIN TALKING PAIN YAWNING PAIN
Neck (LEFT RIGHT BOTH)	NUMBNESS TINGLING WEAKNESS PAIN OTHER: ______
Shoulder (LEFT RIGHT BOTH)	NUMBNESS TINGLING WEAKNESS PAIN OTHER: ______
Upper arm pain (LEFT RIGHT BOTH)	NUMBNESS TINGLING WEAKNESS PAIN OTHER: ______
Elbow (LEFT RIGHT BOTH)	NUMBNESS TINGLING WEAKNESS PAIN OTHER: ______
Forearm (LEFT RIGHT BOTH)	NUMBNESS TINGLING WEAKNESS PAIN OTHER: ______
Wrist (LEFT RIGHT BOTH)	NUMBNESS TINGLING WEAKNESS PAIN OTHER: ______
Hand (LEFT RIGHT BOTH)	NUMBNESS TINGLING WEAKNESS PAIN OTHER: ______
Upper back (LEFT RIGHT BOTH)	NUMBNESS TINGLING WEAKNESS PAIN OTHER: ______
Middle back (LEFT RIGHT BOTH)	NUMBNESS TINGLING WEAKNESS PAIN OTHER: ______
Lower back (LEFT RIGHT BOTH)	NUMBNESS TINGLING WEAKNESS PAIN OTHER: ______
Hips (LEFT RIGHT BOTH)	NUMBNESS TINGLING WEAKNESS PAIN OTHER: ______
Upper leg (LEFT RIGHT BOTH)	NUMBNESS TINGLING WEAKNESS PAIN OTHER: ______
Knee (LEFT RIGHT BOTH)	NUMBNESS TINGLING WEAKNESS PAIN OTHER: ______
Ankle (LEFT RIGHT BOTH)	NUMBNESS TINGLING WEAKNESS PAIN OTHER: ______
Foot (LEFT RIGHT BOTH)	NUMBNESS TINGLING WEAKNESS PAIN OTHER: ______
Chest	NUMBNESS TINGLING WEAKNESS PAIN OTHER: ______
Other (LEFT RIGHT BOTH)	NUMBNESS TINGLING WEAKNESS PAIN OTHER: ______

REVISED OSWESTRY CHRONIC LOW BACK PAIN DISABILITY QUESTIONNAIRE

NAME (Please Print): ______________________________ DATE: ______________

AGE: ________ DATE OF BIRTH: ______________ OCCUPATION: ______________________

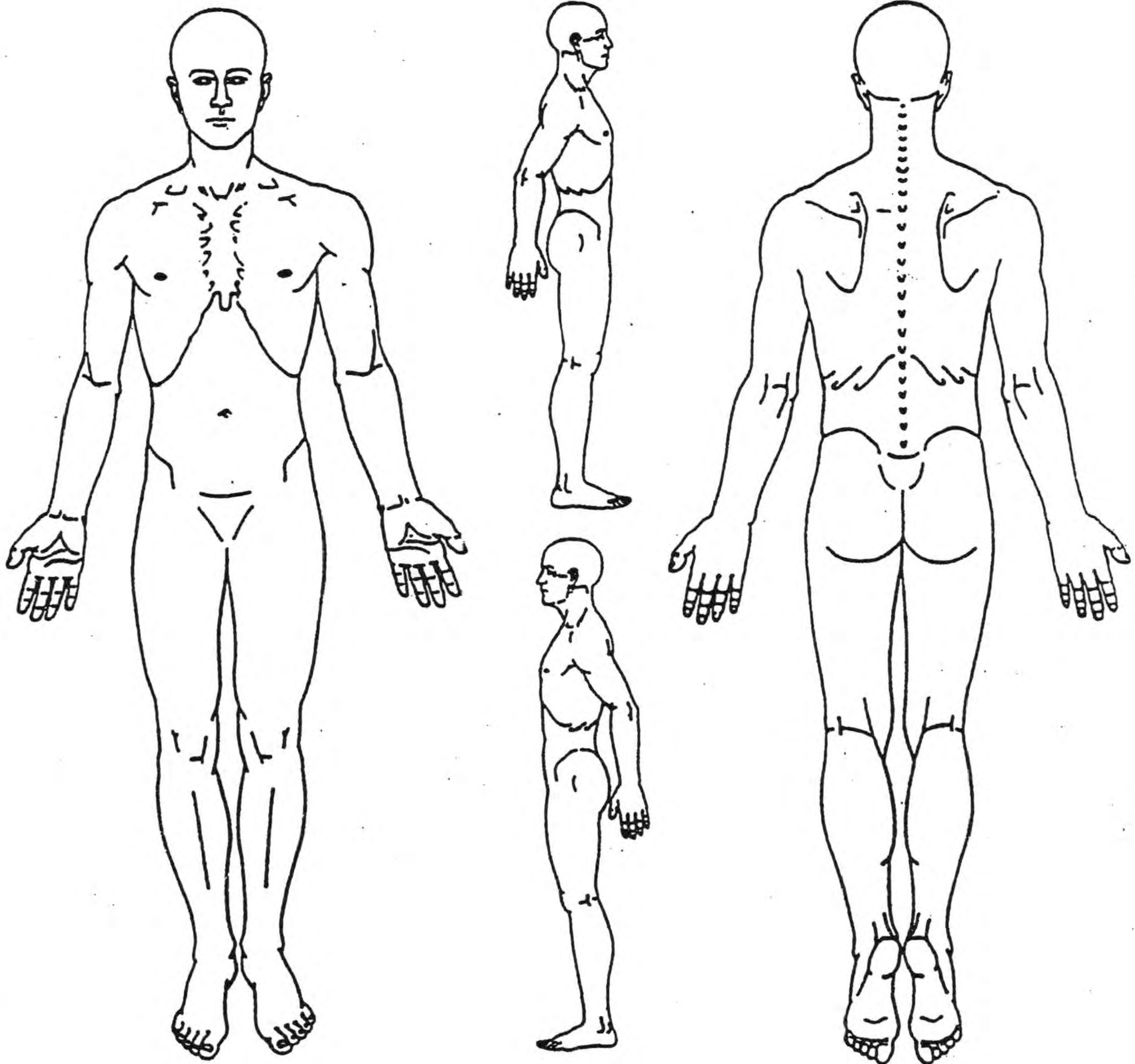
HOW LONG HAVE YOU HAD LOW BACK PAIN? ___YEARS ___MONTHS ___WEEKS

IS THIS YOUR FIRST EPISODE OF LOW BACK PAIN? ___YES ___NO

USE THE LETTERS BELOW TO INDICATE THE TYPE AND LOCATION OF YOUR SENSATIONS RIGHT NOW

(Please remember to complete both sides of this form.)

KEY: **A**=ACHE **B**=BURNING **N**=NUMBNESS
P=PINS & NEEDLES **S**=STABBING **O**=OTHER



REVISED OSWESTRY CHRONIC LOW BACK PAIN DISABILITY QUESTIONNAIRE

Please Read: This questionnaire is designed to enable us to understand how much your low back 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 The pain comes and goes and is very mild.
B The pain is mild and does not vary much.
C The pain comes and goes and is moderate.
D The pain is moderate and does not vary much.
E The pain comes and goes and is severe.
F The pain is severe and does not vary much.

SECTION 2 -- Personal Care

A I would not have to change my way of washing or dressing in order to avoid pain.
B I do not normally change my way of washing or dressing even though it causes some pain.
C Washing and dressing increases the pain, but I manage not to change my way of doing it.
D Washing and dressing increases the pain and I find it necessary to change my way of doing it.
E Because of the pain, I am unable to do some washing and dressing without help.
F Because of the pain, I am unable to do any washing or dressing without help.

SECTION 3 -- Lifting

A I can lift heavy weights without extra pain.
B I can lift heavy weights, but it causes extra pain.
C Pain prevents me from lifting heavy weights off the floor.
D Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned, e.g., on a table.
E Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
F I can only lift very light weights, at the most.

SECTION 4 -- Walking

A Pain does not prevent me from walking any distance.
B Pain prevents me from walking more than one mile.
C Pain prevents me from walking more than 1/2 mile.
D Pain prevents me from walking more than 1/4 mile.
E I can only walk while using a cane or on crutches.
F I am in bed most of the time and have to crawl to the toilet.

SECTION 5 -- Sitting

A I can sit in any chair as long as I like without pain.
B I can only sit in my favorite chair as long as I like.
C Pain prevents me from sitting more than one hour.
D Pain prevents me from sitting more than 1/2 hour.
E Pain prevents me from sitting more than ten minutes.
F Pain prevents me from sitting at all.

From: N. Hudson, K. Tome-Nicholson, A. Breen; 1989

REVISED 9/11/92

SECTION 6 -- Standing

A I can stand as long as I want without pain.
B I have some pain while standing, but it does not increase with time.
C I cannot stand for longer than one hour without increasing pain.
D I cannot stand for longer than 1/2 hour without increasing pain.
E I cannot stand for longer than ten minutes without increasing pain.
F I avoid standing, because it increases the pain straight away.

SECTION 7 -- Sleeping

A I get no pain in bed.
B I get pain in bed, but it does not prevent me from sleeping well.
C Because of pain, my normal night's sleep is reduced by less than one-quarter.
D Because of pain, my normal night's sleep is reduced by less than one-half.
E Because of pain, my normal night's sleep is reduced by less than three-quarters.
F Pain prevents me from sleeping at all.

SECTION 8 -- Social Life

A My social life is normal and gives me no pain.
B My social life is normal, but increases the degree of my pain.
C Pain has no significant effect on my social life apart from limiting my more energetic interests, e.g., dancing, etc.
D Pain has restricted my social life and I do not go out very often.
E Pain has restricted my social life to my home.
F I have hardly any social life because of the pain.

SECTION 9 -- Traveling

A I get no pain while traveling.
B I get some pain while traveling, but none of my usual forms of travel make it any worse.
C I get extra pain while traveling, but it does not compel me to seek alternative forms of travel.
D I get extra pain while traveling which compels me to seek alternative forms of travel.
E Pain restricts all forms of travel.
F Pain prevents all forms of travel except that done lying down.

SECTION 10 -- Changing Degree of Pain

A My pain is rapidly getting better.
B My pain fluctuates, but overall is definitely getting better.
C My pain seems to be getting better, but improvement is slow at present.
D My pain is neither getting better nor worse.
E My pain is gradually worsening.
F My pain is rapidly worsening.

Comments: ____________________

Patient Signature: ____________________ Date: __________

For re-ordering information, contact:
ACTIVATOR METHODS, INC., P.O. Box 80317, Phoenix, AZ 85060-0317
Phone: (602) 224-0220; Facsimile (602) 224-0230

NECK PAIN DISABILITY INDEX QUESTIONNAIRE

NAME (Please Print): ______________________________ DATE: ____________

AGE: ________ DATE OF BIRTH: ______________ OCCUPATION: ______________________

HOW LONG HAVE YOU HAD NECK PAIN? ___YEARS ___MONTHS ___WEEKS

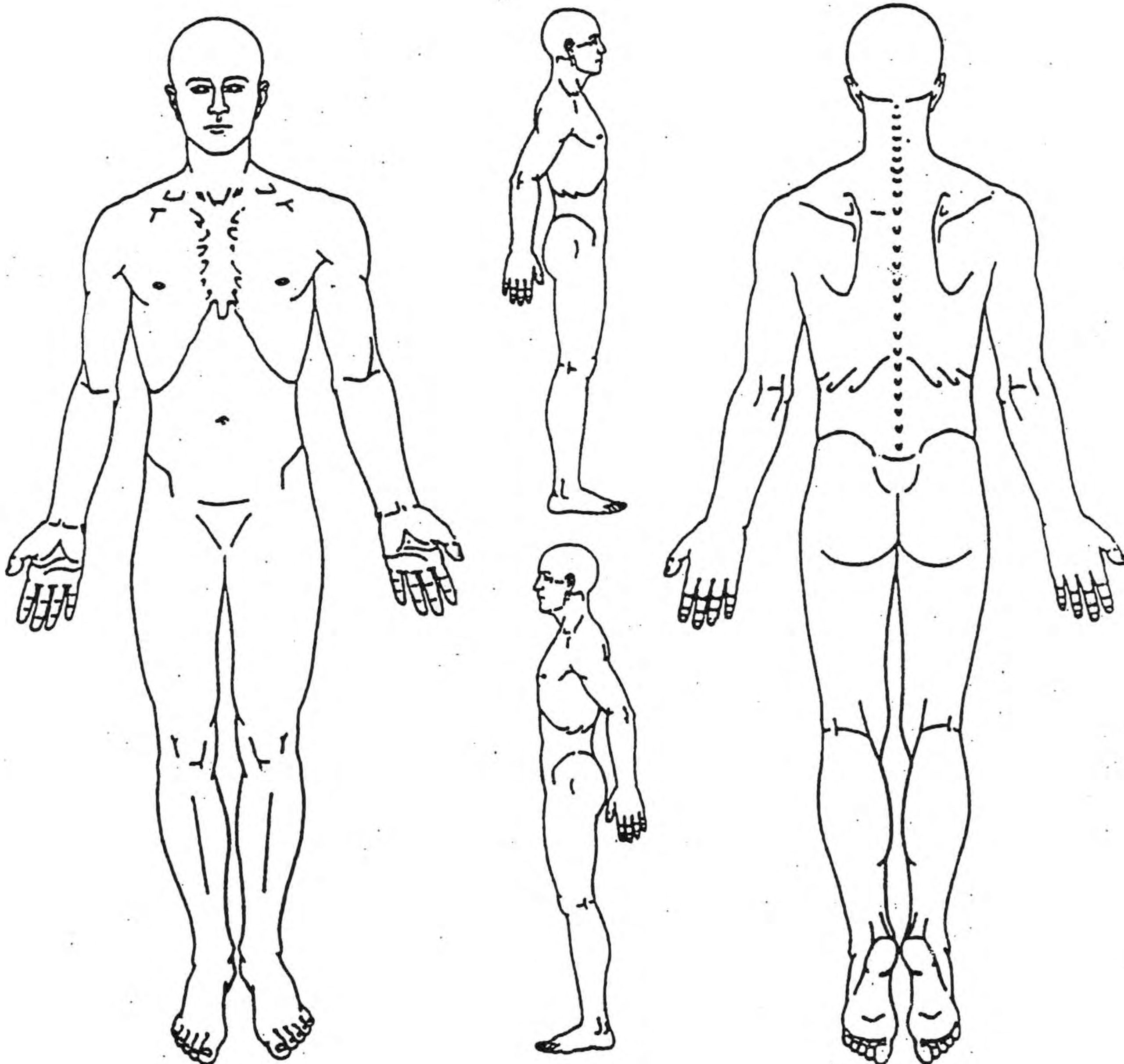
IS THIS YOUR FIRST EPISODE OF NECK PAIN? ___YES ___NO

USE THE LETTERS BELOW TO INDICATE THE TYPE AND LOCATION OF YOUR SENSATIONS RIGHT NOW

(Please remember to complete both sides of this form.)

KEY:

A=ACHE	B=BURNING	N=NUMBNESS
P=PINS & NEEDLES	S=STABBING	O=OTHER



OVER PLEASE

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 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.

After Vernon & Mior, 1991
Reprinted by permission of the Journal of Manipulative and Physiological Therapeutics

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 sleepless).

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 usual recreational activities because of pain in my neck.
D I am able to engage in a few of my usual 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.

REVISED January 1, 1995

Comments: ______________________________

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Patient Signature: ______________________________ Date: __________