

Patient Name: _____

Date: _____

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Please answer every section by marking the **ONE** statement that best applies to you or describes your daily situation the closest.

PAIN INTENSITY
<input type="checkbox"/> 5. I have no pain. <input type="checkbox"/> 4. The pain is limited. <input type="checkbox"/> 3. The pain comes and goes and is moderate <input type="checkbox"/> 2. The pain is moderate and does not vary much. <input type="checkbox"/> 1. The pain comes and goes and is severe. <input type="checkbox"/> 0. The pain is severe and does not vary much.
SLEEPING
<input type="checkbox"/> 5. I have no trouble sleeping. <input type="checkbox"/> 4. My sleep is slightly disturbed (less than 1 hr sleepless) <input type="checkbox"/> 3. My sleep is moderately disturbed (1-2 hrs sleepless) <input type="checkbox"/> 2. My sleep is moderately disturbed (2-3 hrs sleepless) <input type="checkbox"/> 1. My sleep is greatly disturbed (3-5 hrs sleepless) <input type="checkbox"/> 0. My sleep is completely disturbed (5-7 hrs sleepless)
READING
<input type="checkbox"/> 5. I can read as much as I want with no neck pain. <input type="checkbox"/> 4. I can read as much as I want with slight neck pain. <input type="checkbox"/> 3. I can read as much as I want with moderate neck pain. <input type="checkbox"/> 2. I cannot read as much as I want because of moderate neck pain. <input type="checkbox"/> 1. I cannot read as much as I want because of severe neck pain. <input type="checkbox"/> 0. I cannot read at all because of neck pain.
LIFTING or CARRYING
<input type="checkbox"/> 5. I can lift heavy weights without extra pain. <input type="checkbox"/> 4. I can lift heavy weights but it causes extra pain. <input type="checkbox"/> 3. Pain prevents me from lifting heavy weights off the floor, but I can if they are conveniently positioned. <input type="checkbox"/> 2. Pain prevents me from lifting heavy weights but can if light to medium & are conveniently positioned. <input type="checkbox"/> 1. I can lift very light weights. <input type="checkbox"/> 0. I cannot lift or carry anything at all.
WORK
<input type="checkbox"/> 5. I can do as much work as I want. <input type="checkbox"/> 4. I can only do my usual work but no more. <input type="checkbox"/> 3. I can do most of my usual work but no more. <input type="checkbox"/> 2. I cannot do my usual work. <input type="checkbox"/> 1. I can hardly do any work at all. <input type="checkbox"/> 0. I cannot do any work at all.

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PERSONAL CARE

- 5. I can look after myself without causing extra pain.
- 4. I can look after myself normally but it causes extra pain.
- 3. It is painful to look after myself and I am slow and careful.
- 2. I need some help but manage most of my personal care.
- 1. I need help every day in most aspects of self –care.
- 0. I do not get dressed; I wash with difficulty and stay in bed.

DRIVING

- 5. I can drive my car without neck pain.
- 4. I can drive my car as long as I want with slight neck pain.
- 3. I can drive my car as long as I want with moderate neck pain.
- 2. I can't drive my car as long as I want because of moderate neck pain.
- 1. I can hardly drive my car at all because of severe neck pain.
- 0. I cannot drive my car at all because of neck pain.

CONCENTRATION

- 5. I can concentrate fully when I want with no difficulty.
- 4. I can concentrate fully when I want with slight difficulty.
- 3. I have a fair degree of difficulty concentrating when I want.
- 2. I have a lot of difficulty concentrating when I want.
- 1. I have a great deal of difficulty concentrating when I want.
- 0. I cannot concentrate at all.

RECREATION

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

HEADACHES

- 5. I have no headaches at all.
- 4. I have slight headaches which come infrequently.
- 3. I have moderate headaches which come infrequently.
- 2. I have moderate headaches which come frequently.
- 1. I have severe headaches which come frequently.
- 0. I have headaches most of the time.