

Name: \_\_\_\_\_

Date: \_\_\_\_\_

Chart#: \_\_\_\_\_

### Neck Pain and Disability Index (Oswestry / condensed)

Please rate the severity of your **NECK** pain: ☺ 1 2 3 4 5 6 7 8 9 10 ☹

<p><b>How has your NECK pain affected your ability to manage your everyday life?</b></p> <p><b>One answer per section.</b></p>	<p><b>Section 4 - Reading (I can read)</b></p> <ul style="list-style-type: none"> <li><input type="radio"/> A. No pain</li> <li><input type="radio"/> B. with slight pain</li> <li><input type="radio"/> C. With moderate pain</li> <li><input type="radio"/> D. Can't read because of moderate pain.</li> <li><input type="radio"/> E. Hardly read because of severe pain.</li> <li><input type="radio"/> F. Cannot read at all</li> </ul>	<p><b>Section 8 - Driving</b></p> <ul style="list-style-type: none"> <li><input type="radio"/> A. No neck pain</li> <li><input type="radio"/> B. Slight neck pain</li> <li><input type="radio"/> C. Moderate neck pain</li> <li><input type="radio"/> D. Limited / Moderate neck pain</li> <li><input type="radio"/> E. Severe neck pain</li> <li><input type="radio"/> F. Cannot drive</li> </ul>
<p><b>Section 1 - Pain Intensity at this moment</b></p> <ul style="list-style-type: none"> <li><input type="radio"/> A. No Pain</li> <li><input type="radio"/> B. Mild Pain</li> <li><input type="radio"/> C. Moderate</li> <li><input type="radio"/> D. Fairly Severe</li> <li><input type="radio"/> E. Very Severe</li> <li><input type="radio"/> F. Worst Imaginable</li> </ul>	<p><b>Section 5 - Headaches</b></p> <ul style="list-style-type: none"> <li><input type="radio"/> A. None</li> <li><input type="radio"/> B. Slight</li> <li><input type="radio"/> C. Moderate-infrequently</li> <li><input type="radio"/> D. Moderate - frequently</li> <li><input type="radio"/> E. Severe - Frequently</li> <li><input type="radio"/> F. All the time</li> </ul>	<p><b>Section 9 - Sleeping (is disturbed)</b></p> <ul style="list-style-type: none"> <li><input type="radio"/> A. No trouble</li> <li><input type="radio"/> B. Slight (less than 1 hr.)</li> <li><input type="radio"/> C. Mildly (1-2 hours)</li> <li><input type="radio"/> D. Moderate (2-3 hrs.)</li> <li><input type="radio"/> E. Severe (3-5 hrs.)</li> <li><input type="radio"/> F. Completely (5-7 hrs.)</li> </ul>
<p><b>Section 2 - Personal Care -</b></p> <ul style="list-style-type: none"> <li><input type="radio"/> A. Without pain</li> <li><input type="radio"/> B. Causes pain</li> <li><input type="radio"/> C. Painful, I am slow and careful</li> <li><input type="radio"/> D. Need some help</li> <li><input type="radio"/> E. Need help doing everything</li> <li><input type="radio"/> F. Do not get dressed and stay in bed</li> </ul>	<p><b>Section 6 - Concentration</b></p> <ul style="list-style-type: none"> <li><input type="radio"/> A. No difficulty</li> <li><input type="radio"/> B. Slight difficulty</li> <li><input type="radio"/> C. Moderate difficulty</li> <li><input type="radio"/> D. A lot of difficulty</li> <li><input type="radio"/> E. Severe difficulty</li> <li><input type="radio"/> F. Cannot concentrate</li> </ul>	<p><b>Section 10 - Recreation (I am able)</b></p> <ul style="list-style-type: none"> <li><input type="radio"/> A. All activities - No neck pain</li> <li><input type="radio"/> B. All activities some neck pain</li> <li><input type="radio"/> C. Most activities - some neck pain</li> <li><input type="radio"/> D. Few activities neck pain</li> <li><input type="radio"/> E. Hardly any activities neck pain</li> <li><input type="radio"/> F. No activities - neck pain</li> </ul>
<p><b>Section 3 - Lifting (I can lift heavy weight)</b></p> <ul style="list-style-type: none"> <li><input type="radio"/> A. Without pain</li> <li><input type="radio"/> B. It gives me extra pain</li> <li><input type="radio"/> C. If conveniently positioned</li> <li><input type="radio"/> D. Light weight if conveniently positioned</li> <li><input type="radio"/> E. Lift very light weights</li> <li><input type="radio"/> F. Cannot lift or carry anything</li> </ul>	<p><b>Section 7 - Work</b></p> <ul style="list-style-type: none"> <li><input type="radio"/> A. As much as I want</li> <li><input type="radio"/> B. Usual work - no more</li> <li><input type="radio"/> C. Some-no more</li> <li><input type="radio"/> D. Hardly do any work</li> <li><input type="radio"/> E. Cannot do my usual work</li> <li><input type="radio"/> F. No work at all</li> </ul>	

### Low Back Pain and Disability Index

(Rolland Morris / condensed)

Please rate the severity of your **LOW BACK** pain: ☺ 1 2 3 4 5 6 7 8 9 10 ☹

**How has your LOW BACK pain affected your ability to manage your everyday life?**

Check all that apply today

- |  |  |
|--|--|
| <input type="radio"/> 1 Stay at home most of the time        | <input type="radio"/> 13 Painful all the time            |
| <input type="radio"/> 2 Change position frequently           | <input type="radio"/> 14 Difficult to turn over in bed   |
| <input type="radio"/> 3 Walk more slowly                     | <input type="radio"/> 15 Appetite is not very good       |
| <input type="radio"/> 4 Not doing any jobs around the house  | <input type="radio"/> 16 Trouble putting socks on        |
| <input type="radio"/> 5 Use a handrail to go up stairs       | <input type="radio"/> 17 Only walk short distances       |
| <input type="radio"/> 6 Lie down to rest more often          | <input type="radio"/> 18 Sleep less                      |
| <input type="radio"/> 7 Hold on to get out of my chair       | <input type="radio"/> 19 Need help to get dressed        |
| <input type="radio"/> 8 Get other people to do things for me | <input type="radio"/> 20 Sit down most of the day        |
| <input type="radio"/> 9 Get dressed more slowly              | <input type="radio"/> 21 Avoid heavy jobs                |
| <input type="radio"/> 10 Only stand for short periods        | <input type="radio"/> 22 More irritable and bad tempered |
| <input type="radio"/> 11 Try not to bend or kneel down       | <input type="radio"/> 23 Go upstairs slowly              |
| <input type="radio"/> 12 Difficult to get out of my chair    | <input type="radio"/> 24 Stay in bed most of the time    |

Patient Signature:
Date: