

Berkeley 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 one) 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**.

<p>Musculoskeletal Had Have</p> <input type="checkbox"/> Osteoporosis <input type="checkbox"/> Knee Injuries <input type="checkbox"/> Arthritis <input type="checkbox"/> Foot/ankle pain <input type="checkbox"/> Scoliosis <input type="checkbox"/> Shoulder problems <input type="checkbox"/> Neck Pain <input type="checkbox"/> Elbow/ wrist pain <input type="checkbox"/> Back problems <input type="checkbox"/> TMJ issues <input type="checkbox"/> Hip disorders <input type="checkbox"/> Cramping <input type="checkbox"/> Poor posture <input type="checkbox"/> Swelling/deformity of joints	<p>Neurological Had Have</p> <input type="checkbox"/> Anxiety/ Panic <input type="checkbox"/> Depression <input type="checkbox"/> Headache/ Migraines <input type="checkbox"/> Dizziness <input type="checkbox"/> Pins and Needles <input type="checkbox"/> Numbness <input type="checkbox"/> Epilepsy/ seizures <input type="checkbox"/> Memory issues <input type="checkbox"/> Stroke <input type="checkbox"/> Weak muscles <input type="checkbox"/> Temporary loss of: Vision, smell, or hearing	<p>Cardiovascular Had Have</p> <input type="checkbox"/> Blood clots <input type="checkbox"/> Chest pain/ tightness <input type="checkbox"/> Coronary artery disease <input type="checkbox"/> Heart attack <input type="checkbox"/> High blood pressure <input type="checkbox"/> High cholesterol <input type="checkbox"/> Leg pain upon walking <input type="checkbox"/> Low Blood Pressure <input type="checkbox"/> Lower extremity edema <input type="checkbox"/> Palpitations	<p>Digestive Had Have</p> <input type="checkbox"/> Abdominal pain <input type="checkbox"/> Black/ bloody stool <input type="checkbox"/> Changes in bowel habits <input type="checkbox"/> Colon cancer or polyps <input type="checkbox"/> Constipation <input type="checkbox"/> Gastric reflux <input type="checkbox"/> Heartburn <input type="checkbox"/> IBS <input type="checkbox"/> Liver disease <input type="checkbox"/> Nausea/ vomiting <input type="checkbox"/> Diarrhea <input type="checkbox"/> Ulcer
<p>Dermatological Had Have</p> <input type="checkbox"/> Psoriasis <input type="checkbox"/> Eczema <input type="checkbox"/> Excessive hair loss <input type="checkbox"/> Skin cancer <input type="checkbox"/> Skin trouble/ rashes <input type="checkbox"/> Change in hair/ nails	<p>Respiratory Had Have</p> <input type="checkbox"/> Asthma <input type="checkbox"/> Emphysema <input type="checkbox"/> Shortness of Breath <input type="checkbox"/> Persistent cough <input type="checkbox"/> Wheezing <input type="checkbox"/> Breathing Difficulties	<p>Endocrine Had Have</p> <input type="checkbox"/> Excessive thirst <input type="checkbox"/> Testosterone deficiency <input type="checkbox"/> Thyroid problems	<p>Genitourinary Had Have</p> <input type="checkbox"/> Blood in the urine <input type="checkbox"/> Incontinence <input type="checkbox"/> Kidney stones <input type="checkbox"/> Urgency <input type="checkbox"/> Painful/frequent urination
<p>Surgeries, which may or may not have included hospitalization and Dates</p> <input type="checkbox"/> Bypass surgery _____ <input type="checkbox"/> Cancer _____ <input type="checkbox"/> Elective surgery _____ <input type="checkbox"/> Hysterectomy _____ <input type="checkbox"/> Pacemaker _____ <input type="checkbox"/> Spine _____ <input type="checkbox"/> Wisdom teeth _____ <input type="checkbox"/> Other: _____	<p>Head and ENT Had Have</p> <input type="checkbox"/> Blurred/ double vision <input type="checkbox"/> Difficulty swallowing <input type="checkbox"/> Ear/ hearing problems <input type="checkbox"/> Sinus Trouble <input type="checkbox"/> Ringing in the ears <input type="checkbox"/> Swollen lymph nodes	<p>Females only Are you pregnant? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, how many weeks? ____ If no, is there a chance you might be pregnant? ____</p>	

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

<p>Quality of Symptoms (What does it feel like?)</p> <input type="checkbox"/> Achy <input type="checkbox"/> Annoying <input type="checkbox"/> Burning <input type="checkbox"/> Deep <input type="checkbox"/> Dull <input type="checkbox"/> Heavy <input type="checkbox"/> Intolerable <input type="checkbox"/> Pulling <input type="checkbox"/> Sharp <input type="checkbox"/> Shock like <input type="checkbox"/> Stabbing <input type="checkbox"/> Stiffness <input type="checkbox"/> Throbbing <input type="checkbox"/> Tightness <input type="checkbox"/> Tingling <input type="checkbox"/> Other _____	<p>Relieving Factors (What makes it better?)</p> <input type="checkbox"/> Chiropractic <input type="checkbox"/> Heat <input type="checkbox"/> Ice <input type="checkbox"/> Exercise <input type="checkbox"/> Support <input type="checkbox"/> Massage <input type="checkbox"/> Nothing <input type="checkbox"/> OTC medication <input type="checkbox"/> Rx medication <input type="checkbox"/> Physical therapy <input type="checkbox"/> Rest <input type="checkbox"/> Stretching <input type="checkbox"/> Work <input type="checkbox"/> Other _____	<p>Aggravating Factors (What makes it worse?)</p> <input type="checkbox"/> Any movement <input type="checkbox"/> Bathing <input type="checkbox"/> Bending <input type="checkbox"/> Caring for family <input type="checkbox"/> Carrying objects <input type="checkbox"/> Climbing stairs <input type="checkbox"/> Computer use <input type="checkbox"/> Concentrating <input type="checkbox"/> Coughing/sneezing <input type="checkbox"/> Daily child/pet care <input type="checkbox"/> Dressing self <input type="checkbox"/> Driving <input type="checkbox"/> Eating <input type="checkbox"/> Exercises <input type="checkbox"/> Falling/staying asleep <input type="checkbox"/> Getting in/out of car <input type="checkbox"/> Getting up from lying down <input type="checkbox"/> Grocery shopping <input type="checkbox"/> Getting up from sitting <input type="checkbox"/> Household chores <input type="checkbox"/> Lifting <input type="checkbox"/> Looking over shoulder <input type="checkbox"/> Lying down <input type="checkbox"/> Pushing <input type="checkbox"/> Pulling <input type="checkbox"/> Reaching <input type="checkbox"/> Reading <input type="checkbox"/> Resting <input type="checkbox"/> Running <input type="checkbox"/> Sitting <input type="checkbox"/> Squatting <input type="checkbox"/> Standing <input type="checkbox"/> Stress <input type="checkbox"/> Stretching <input type="checkbox"/> Talking on the phone <input type="checkbox"/> Turning <input type="checkbox"/> Twisting <input type="checkbox"/> Walking <input type="checkbox"/> Working <input type="checkbox"/> Yard work <input type="checkbox"/> Other _____
<p>Illnesses: Check the illnesses you have Had in the past or Have now.</p> <p>Had Have</p> <input type="checkbox"/> <input type="checkbox"/> Diabetes Type I __ Type II __ <input type="checkbox"/> <input type="checkbox"/> Stroke <input type="checkbox"/> <input type="checkbox"/> Other: _____		<p>Injuries: Have you ever...</p> <input type="checkbox"/> Had a fractured or broken bone. Date _____ <input type="checkbox"/> Had a spine or nerve disorder. Date _____ <input type="checkbox"/> Been knocked unconscious. Date _____ <input type="checkbox"/> Been injured in an accident. Date _____ <input type="checkbox"/> 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 _____

**BERKELEY CHIROPRACTIC CENTER
ACCIDENT QUESTIONNAIRE**

Name: _____ Date: _____
 Date of Accident: _____ Time of Accident: _____
 City of Accident: _____ Street of Accident: _____

BEFORE the accident

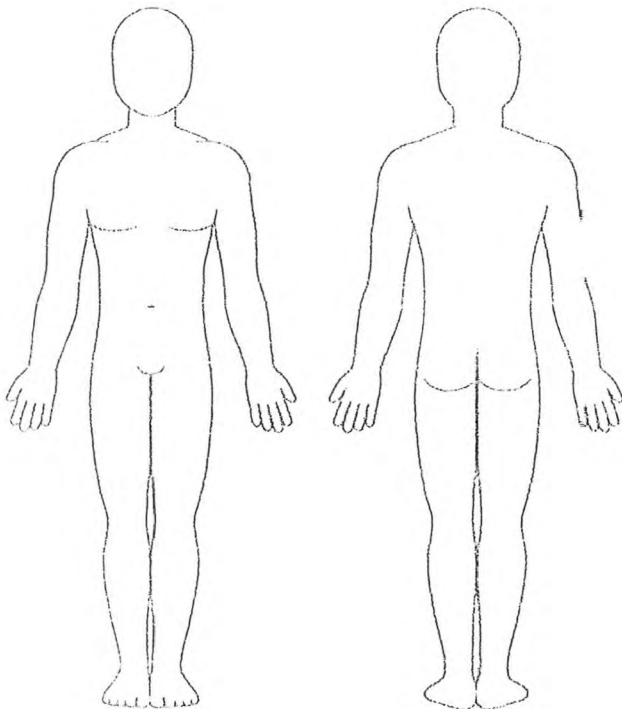
Who else was in the vehicle?	_____
Seatbelt?	ON OFF

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 were made? _____ X-rays taken? YES NO If yes, which ones? _____
Your release status from work?	NO WORK LIGHT WORK NORMAL WORK



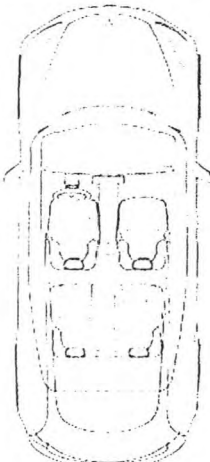
Symptoms felt **AT THE TIME** of accident:

- 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 where 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 THEN 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 THEN 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

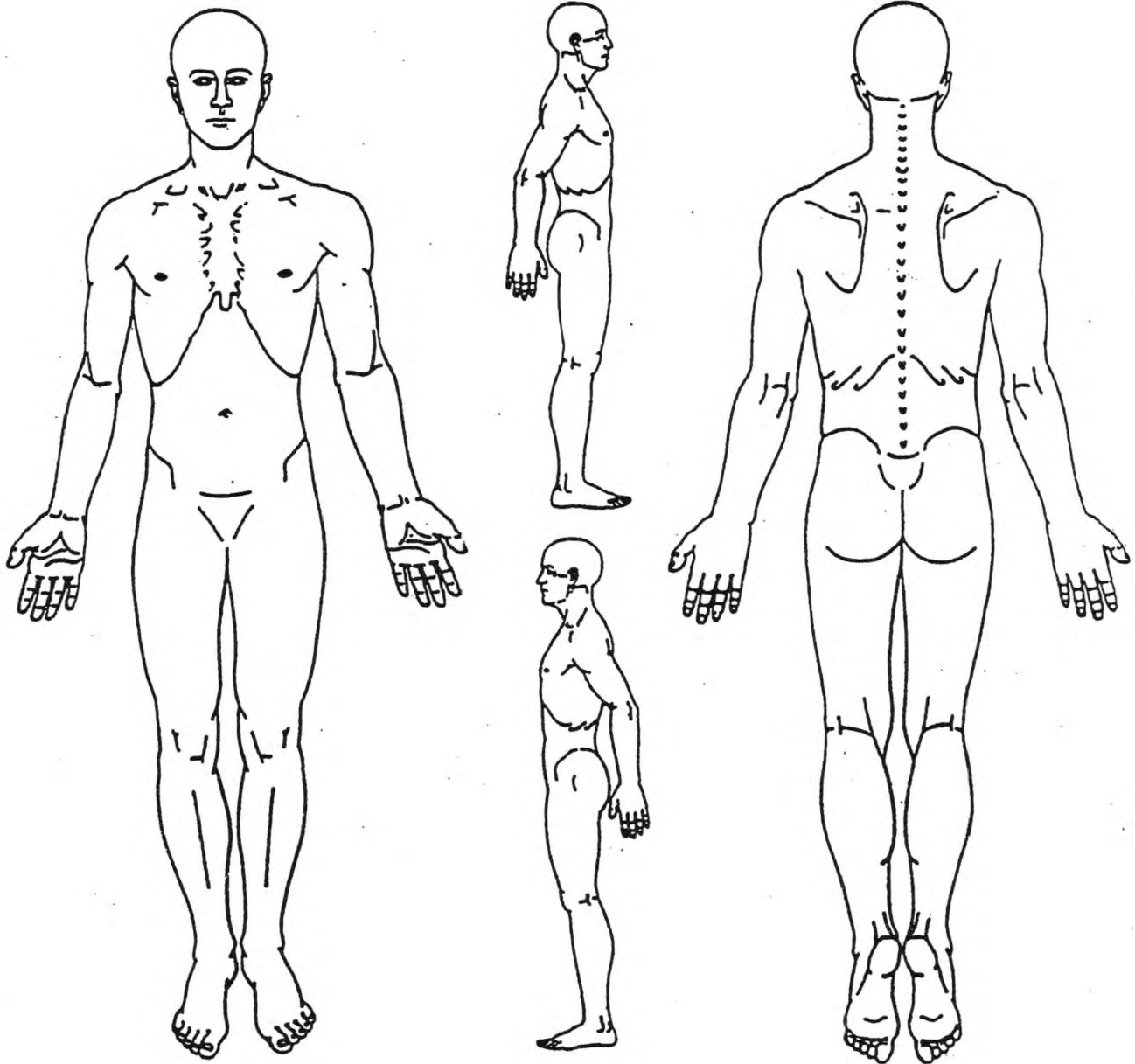
B=BURNING

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

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.

REVISED 9/11/92

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

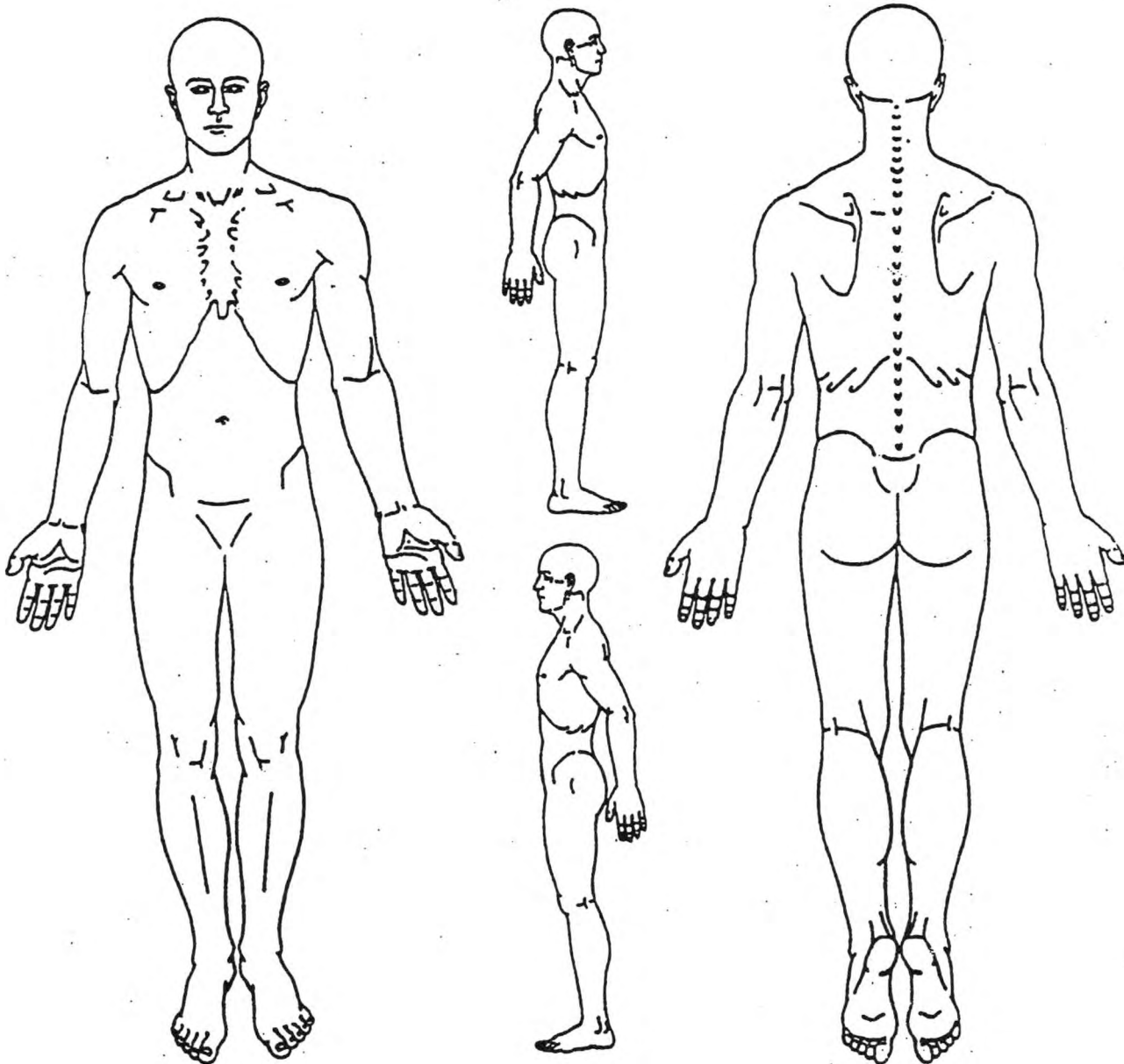
B=BURNING

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.

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.

*After Vernon & Mior, 1991
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Physiological Therapeutics*

REVISED January 1, 1995

Comments: _____

Patient Signature: _____

Date: _____