Neck Disability Index

This questionnaire has been designed to give us information as to how your neck pain has affected your ability to manage in everyday life. Please answer every section and mark in each section only the one box that applies to you. We realise you may consider the two or more statements in any one section relate to you, but please just mark the box that most closely describes your problem.

SECTION 1: Pain Intensity

- I have no pain at the moment.
- The pain is mild at the moment.
- The pain comes and goes and is moderate.
- The pain is moderate and does not vary much.
- The pain is very severe, but comes and goes.
- The pain is severe and does not vary much.

SECTION 2: Personal Care (e.g. washing, dressing)

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

SECTION 3: Lifting

- I can lift heavy weights without extra pain.
- I can lift heavy weights, but it gives me extra pain.
- Pain prevents me from lifting heavy weights off the floor I can manage if they are conveniently placed (e.g., on a table.)
- Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
- I can only lift very light weights.
- I cannot lift or carry anything.

SECTION 4: Reading

- I can read as much as I want to with no neck pain.
- I can read as much as I want with slight neck pain.
- I can read as much as I want with moderate neck pain.
- I cannot read as much as I want because of moderate neck pain.
- I cannot read as much as I want because of severe neck pain.
- I cannot read at all.

SECTION 5: Headache

- I have no headaches at all.
- I have slight headaches which come infrequently
- I have moderate headaches which come infrequently.
- I have moderate headaches which come frequently.
- I have severe headaches which come frequently.
- I have headaches almost all the time.

SECTION 6: Concentration

- I can concentrate fully when I want to with no difficulty.
- I can concentrate fully when I want to with slight difficulty.
- I have a fair degree of difficulty in concentrating when I want to.
- I have a lot of difficulty in concentrating when I want to.
- I have a great deal of difficulty in concentrating when I want to.
- I cannot concentrate at all.

SECTION 7: Work

- I can do as much work as I want to.
- I can only do my usual work, but no more.
- I can do most of my usual work, but no more.
- I cannot do my usual work.
- I can hardly do any work at all.
- I cannot do any work at all.

SECTION 8: Driving

- I can drive my car without neck pain.
- I can drive my car as long as I want with slight pain in my neck.
- I can drive my car as long as I want with moderate pain in my neck.
- I cannot drive my car as long as I want because of moderate pain in my neck.
- I can hardly drive my car at all because of severe pain in my neck.
- I cannot drive my car at all.

SECTION 9: Sleeping

- I have no trouble sleeping.
- My sleep is slightly disturbed (less than 1 hour sleepless).
- My sleep is mildly disturbed (1-2 hours sleepless).
- My sleep is moderately disturbed (2-3 hours sleepless).
- My sleep is greatly disturbed (3-5 hours sleepless).
- My sleep is completely disturbed (5-7 hours sleepless)

SECTION 10: Recreation

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

Patient Name: Date: Score:

CHIROPRACTIC PATIENT UPDATE

PART A

Date:_________________ Name:____

Address:____________________________________City:___________________ State:______ Zip:__________

Primary Phone:_______________ Cell Phone:_______________ E-mail address:_________________________

Would you like appointment reminders? Y N If yes, how would you like to receive them? Call Text Email

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PART B

1. What is your major symptom? ____
2. Is this the same problem you originally saw the doctor for?____
3. If yes, is the symptom worse than the original occurrence or the same?_______________________________
4. Are there any other unrelated health problems that have occurred since you last saw the doctor?

   Yes _____ No _____. If yes, describe ____
5. Have you sought care with any other physicians for this problem since you last saw the doctor?

   Yes_____ No_____. If yes, explain____
6. Have you had any major accidents or traumas since you last saw the doctor? _______ ___________________

   ____
7. Remarks: ____

   ____

NO SYMPTOMS ———————————————————————— EXTREME SYMPTOMS

Please place an "X" on the line above to indicate your level of problem.

PART C

AUTHORIZATION AND RELEASE: I authorize payment of insurance benefits directly to the chiropractor or chiropractic office. I authorize the doctor to release all information necessary to communicate with personal physicians and other healthcare providers and payors and to secure the payment of benefits. I understand that I am responsible for all costs of chiropractic care, regardless of insurance coverage. I also understand that if I suspend or terminate my schedule of care as determined by my treating doctor, any fees for professional services will be immediately due and payable. I understand that interest is charged on overdue accounts at the annual rate of (16%).

The patient understands and agrees to allow this chiropractic office to use their Patient Health Information for the purpose of treatment, payment, healthcare operations, and coordination of care. We want you to know how your Patient Health Information is going to be used in this office and your rights concerning those records. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your Patient Health Information we encourage you to read the HIPAA NOTICE that is available to you at the front desk before signing this consent. If there is anyone you do not want to receive your medical records, please inform our office.

Signature: ____ Date: _______________________

Health Insurance Coverage ( ) Yes ( ) No

Company:____

Oswestry Low Back Pain Disability Questionnaire

Instructions

This questionnaire has been designed to give us information as to how your back or leg pain is affecting your ability to manage in everyday life. Please answer by checking ONE box in each section for the statement which best applies to you. We realise you may consider that two or more statements in any one section apply but please just shade out the spot that indicates the statement which most clearly describes your problem.

SECTION 1: Pain Intensity

- ○ I have no pain at the moment.
- ○ The pain is very mild at the moment.
- ○ The pain is moderate at the moment.
- ○ The pain is fairly severe at the moment.
- ○ The pain is very severe at the moment.
- ○ The pain is the worst imaginable at the moment.

SECTION 2: Personal Care (e.g. washing, dressing)

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

SECTION 3: Lifting

- ○ I can lift heavy weights without extra pain.
- ○ I can lift heavy weights, but it gives me extra pain.
- ○ Pain prevents me from lifting heavy weights off the floor I can manage if they are conveniently placed (e.g., on a table.)
- ○ Pain prevents me from lifting heavy weights but I can manage light to medium weights if they are conveniently positioned.
- ○ I can only lift very light weights.
- ○ I cannot lift or carry anything.

SECTION 4: Walking

- ○ Pain does not prevent me walking any distance.
- ○ Pain prevents me from walking more than 1 mile.
- ○ Pain prevents me from walking more than 1/2 mile.
- ○ Pain prevents me from walking more than 100 yards.
- ○ I can only walk using a stick or crutches.
- ○ I am in bed most of the time.

SECTION 5: Sitting

- ○ I can sit in any chair as long as I like.
- ○ I can only sit in my favorite chair as long as I like.
- ○ Pain prevents me sitting more than 1 hour.
- ○ Pain prevents me from sitting more than 30 minutes.
- ○ Pain prevents me from sitting more than 10 minutes.
- ○ Pain prevents me from sitting at all.

SECTION 6: Standing

- ○ I can stand as long as I want without extra pain.
- ○ I can stand as long as I want but it gives me extra pain.
- ○ Pain prevents me from standing more than 1 hour.
- ○ Pain prevents me from standing for more than 30 minutes.
- ○ Pain prevents me from standing for more than 10 minutes.
- ○ Pain prevents me from standing at all.

SECTION 7: Sleeping

- ○ My sleep is never disturbed by pain.
- ○ My sleep is occasionally disturbed by pain.
- ○ Because of pain I have less than 6 hours sleep.
- ○ Because of pain I have less than 4 hours sleep.
- ○ Because of pain I have less than 2 hours sleep.
- ○ Pain prevents me from sleeping at all.

SECTION 8: Sex Life (if applicable)

- ○ My sex life is normal and causes no extra pain.
- ○ My sex life is normal but causes some extra pain.
- ○ My sex life is nearly normal but is very painful.
- ○ My sex life is severely restricted by pain.
- ○ My sex life is nearly absent because of pain.
- ○ Pain prevents any sex life at all.

SECTION 9: Social Life

- ○ My social life is normal and gives me no extra pain.
- ○ My social life is normal but increases the degree of pain.
- ○ Pain has no significant effect on my social life apart from limiting my more energetic interests, e.g. sport.
- ○ Pain has restricted my social life and I do not go out as often.
- ○ Pain has restricted my social life to my home.
- ○ I have no social life because of pain.

SECTION 10: Traveling

- ○ I can travel anywhere without pain.
- ○ I can travel anywhere but it gives me extra pain.
- ○ Pain is bad but I manage journeys over 2 hours.
- ○ Pain restricts me to journeys of less than 1 hour.
- ○ Pain restricts me to short necessary journeys under 30 minutes.
- ○ Pain prevents me from traveling except to receive treatment.

Patient Name: Date: Score: