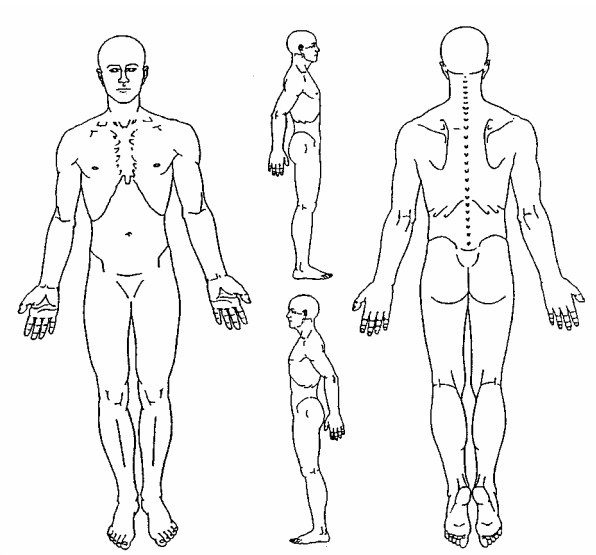
USE THE LETTERS LISTED BELOW TO INDICATE
THE *TYPE* AND *LOCATION* OF YOUR PAIN & SENSATIONS

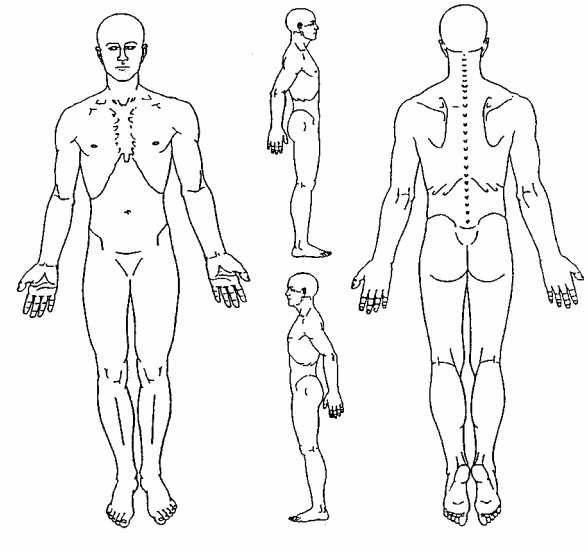
A = ACHE	B = BURNING	S = STABBING
N = NUMBNESS	P = PINS & NEEDLES	O = OTHER



COMMENTS: _____

_____

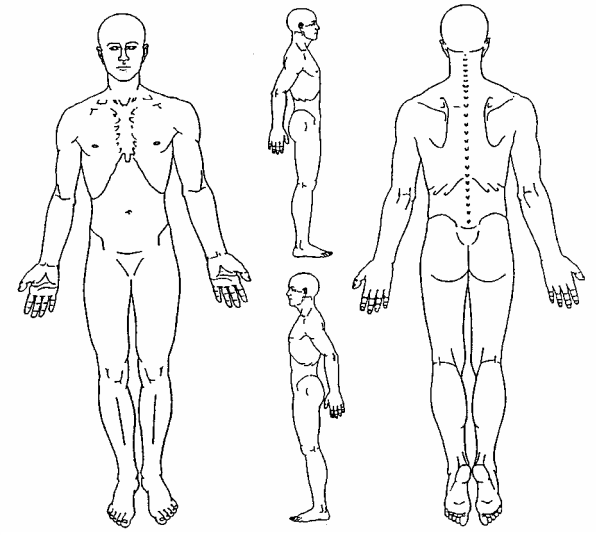
PT INITIALS _____ DATE _____



COMMENTS: _____

_____

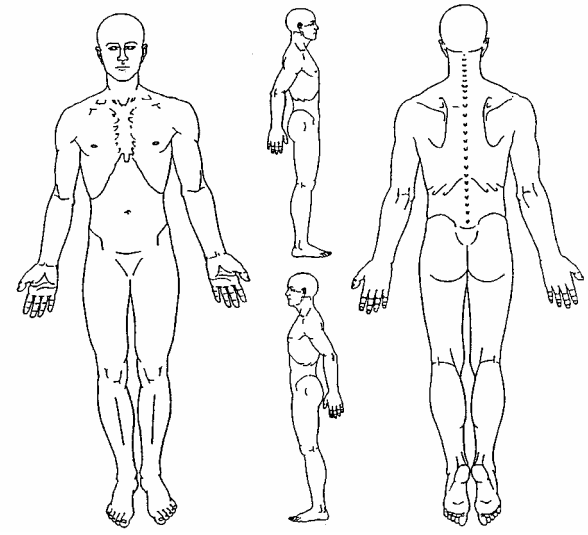
PT INITIALS _____ DATE _____



COMMENTS: _____

_____

PT INITIALS _____ DATE _____



COMMENTS: _____

_____

PT INITIALS _____ DATE _____

Examiner:

Comments:

Activities Discomfort Scale

For each of the following activities, please place a check in the one column that best describes how much pain the activity presently causes, on the average (does not include unusual or prolonged activity).

Activity	Doesn't Hurt At All	Hurts A Little	Hurts Very Much	Almost Unbearable	Unbearable Pain Prevents Activity
1. Walking					
2. Sitting					
3. Bending					
4. Standing					
5. Sleeping					
6. Lifting					
7. Running or jogging					
8. Climbing Stairs					
9. Carrying					
10. Pushing or Pulling					
11. Driving					
12. Dressing					
13. Reading					
14. Watching TV					
15. Household Chores					
16. Gardening					
17. Sports					
18. Employment					

ADDITIONAL COMMENTS:

PATIENT NAME _____ PATIENT SIGNATURE _____

EXAMINER _____ DATE _____ Score _____ [72]

Turner JA, Robinson J, McCreary CP. Chronic low back pain: Predicting response to nonsurgical treatment. *Arch Phys Med Rehabilitation* 1983; 64: 560-563

GENERAL PAIN INDEX QUESTIONNAIRE

We would like to know how much your pain ***presently*** prevents you from doing what you would normally do. Regarding each category, please indicate the ***overall*** impact your present pain has on your life, not just when the pain is at its worst. Please ***circle the number*** which best describes how your typical level of pain affects these six categories of activities.

1. **FAMILY / AT -HOME RESPONSIBILITIES** SUCH AS YARD WORK, CHORES AROUND THE HOUSE OR DRIVING THE KIDS TO SCHOOL -

0	1	2	3	4	5	6	7	8	9	10
COMPLETELY ABLE TO FUNCTION										TOTALLY UNABLE TO FUNCTION

2. **RECREATION** INCLUDING HOBBIES, SPORTS OR OTHER LEISURE ACTIVITIES –

0	1	2	3	4	5	6	7	8	9	10
COMPLETELY ABLE TO FUNCTION										TOTALLY UNABLE TO FUNCTION

3. **SOCIAL ACTIVITIES** INCLUDING PARTIES, THEATER, CONCERTS, DINING –OUT AND ATTENDING OTHER SOCIAL FUNCTIONS WITH FRIENDS -

0	1	2	3	4	5	6	7	8	9	10
COMPLETELY ABLE TO FUNCTION										TOTALLY UNABLE TO FUNCTION

4. **EMPLOYMENT** INCLUDING VOLUNTEER WORK AND HOMEMAKING TASKS -

0	1	2	3	4	5	6	7	8	9	10
COMPLETELY ABLE TO FUNCTION										TOTALLY UNABLE TO FUNCTION

5. **SELF -CARE** SUCH AS TAKING A SHOWER, DRIVING OR GETTING DRESSED -

0	1	2	3	4	5	6	7	8	9	10
COMPLETELY ABLE TO FUNCTION										TOTALLY UNABLE TO FUNCTION

6. **LIFE -SUPPORT ACTIVITIES** SUCH AS EATING AND SLEEPING –

0	1	2	3	4	5	6	7	8	9	10
COMPLETELY ABLE TO FUNCTION										TOTALLY UNABLE TO FUNCTION

ADDITIONAL COMMENTS:

PATIENT NAME _____ PATIENT SIGNATURE _____

EXAMINER _____ DATE _____ Score _____ [60]

Fuerstein M. Multidisciplinary rehabilitation of occupational musculoskeletal disorders. LACC Chiro Rehab. Chicago: Session 1, 9/95

QUADRUPLE VISUAL ANALOGUE SCALE

Patient Name _____ Date _____

Please read carefully:

Instructions: Please circle the number that best describes the question being asked.

Note: If you have more than one complaint, please answer each question for each individual complaint and indicate the score for each complaint. Please indicate your pain level right now, average pain, and pain at its best and worst.

Example:

	Headache				Neck				Low Back		
No pain											**worst possible pain**
0	**1**	**(2)**	**3**	**4**	**(5)**	**6**	**7**	**(8)**	**9**	**10**	

---

1 – What is your pain RIGHT NOW?

No pain											**worst possible pain**
0	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	

2 – What is your TYPICAL or AVERAGE pain?

No pain											**worst possible pain**
0	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	

3 – What is your pain level AT ITS BEST (How close to "0" does your pain get at its best)?

No pain											**worst possible pain**
0	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	

4 – What is your pain level AT ITS WORST (How close to "10" does your pain get at its worst)?

No pain											**worst possible pain**
0	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	

Other Comments: _____

PATIENT NAME _____ PATIENT SIGNATURE _____

EXAMINER _____ DATE _____

Score: Total all scores; divide by number of regions x 10 = _____ (< 50 LI / > 50 HI)

Reprinted from *Spine*, 18, Von Korff M, Deyo RA, Cherkin D, Barlow SF, Back pain in primary care: Outcomes at 1 year, 855-862, 1993, w/ permission from Elsevier Science.

NECK DISABILITY INDEX

This questionnaire is designed to help us better understand how your neck pain affects your ability to manage everyday -life activities. Please mark in each section the **one box** that applies to you. Although you may consider that two of the statements in any one section relate to you, please mark the box that **most closely** describes your present -day situation.

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

- ❑ 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 manage most of my personal care.
- ❑ I need help every day in most aspects of self -care.
- ❑ I do not get dressed. I wash with difficulty and stay in bed.

SECTION 3 – LIFTING

- ❑ I can lift heavy weights without causing extra pain.
- ❑ I can lift heavy weights, but it gives me extra pain.
- ❑ Pain prevents me from lifting heavy weights off the floor but I can manage if items are conveniently positioned, ie. on a table.
- ❑ Pain prevents me from lifting heavy weights, but I can manage light weights if they are conveniently positioned.
- ❑ I can lift only very light weights.
- ❑ I cannot lift or carry anything at all.

SECTION 4 – WORK

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

SECTION 5 – HEADACHES

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

SECTION 6 – CONCENTRATION

- ❑ I can concentrate fully without difficulty.
- ❑ I can concentrate fully with slight difficulty.
- ❑ I have a fair degree of difficulty concentrating.
- ❑ I have a lot of difficulty concentrating.
- ❑ I have a great deal of difficulty concentrating.
- ❑ I can't concentrate at all.

SECTION 7 – SLEEPING

- ❑ I have no trouble sleeping.
- ❑ My sleep is slightly disturbed for less than 1 hour.
- ❑ My sleep is mildly disturbed for up to 1-2 hours.
- ❑ My sleep is moderately disturbed for up to 2-3 hours.
- ❑ My sleep is greatly disturbed for up to 3-5 hours.
- ❑ My sleep is completely disturbed for up to 5-7 hours.

SECTION 8 – DRIVING

- ❑ I can drive my car without neck pain.
- ❑ I can drive as long as I want with slight neck pain.
- ❑ I can drive as long as I want with moderate neck pain.
- ❑ I can't drive as long as I want because of moderate neck pain.
- ❑ I can hardly drive at all because of severe neck pain.
- ❑ I can't drive my care at all because of neck pain.

SECTION 9 – READING

- ❑ I can read as much as I want 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 can't read as much as I want because of moderate neck pain.
- ❑ I can't read as much as I want because of severe neck pain.
- ❑ I can't read at all.

SECTION 10 – RECREATION

- ❑ I have no neck pain during all recreational activities.
- ❑ I have some neck pain with all recreational activities.
- ❑ I have some neck pain with a few recreational activities.
- ❑ I have neck pain with most recreational activities.
- ❑ I can hardly do recreational activities due to neck pain.
- ❑ I can't do any recreational activities due to neck pain.

ADDITIONAL COMMENTS:

PATIENT NAME _____ PATIENT SIGNATURE _____

EXAMINER _____ DATE _____ Score _____ [50]

COPENHAGEN NECK FUNCTIONAL DISABILITY SCALE

This questionnaire is designed to help us better understand how your neck pain affects your ability to manage everyday activities. In response to each question, please mark the one box that applies to you.

	YES	OCCASIONALLY	NO
1. Can you sleep at night without neck pain interfering?	❑	❑	❑
2. Can you manage daily activities without neck pain reducing activity levels?	❑	❑	❑
3. Can you manage daily activities without help from others?	❑	❑	❑
4. Can you manage putting your clothes on in the morning without taking more time than usual?	❑	❑	❑
5. Can you bend over the sink to brush your teeth without getting neck pain?	❑	❑	❑
6. Do you spend more time than usual at home because of your neck pain?	❑	❑	❑
7. Are you prevented from lifting objects weighing 5-10 pounds due to neck pain?	❑	❑	❑
8. Have you reduced your reading activity due to neck pain?	❑	❑	❑
9. Have you been bothered by headaches during the time you have had neck pain?	❑	❑	❑
10. Do you feel that your ability to concentrate is reduced due to neck pain?	❑	❑	❑
11. Are you prevented from participating in your usual leisure time activities due to neck pain?	❑	❑	❑
12. Do you remain in bed longer than usual due to neck pain?	❑	❑	❑
13. Do you feel neck pain has influenced your emotional relationship with your family?	❑	❑	❑
14. Have you had to give up social contact with other people during the past two weeks due to neck pain?	❑	❑	❑
15. Do you feel that neck pain will influence your future?	❑	❑	❑

ADDITIONAL COMMENTS:

PATIENT NAME _____ PATIENT SIGNATURE _____

EXAMINER _____ DATE _____ Score _____ [30]

The Copenhagen Neck Functional Disability Scale: A study of reliability and validity. JMPT 1998; Vol 21, #8:520-27.
1-5: 2 “no”, 1 “occasionally”, 0 “yes” / 6-15: 2 “yes”, 1 “occasionally”, 0 “no”.

NECK BOURNEMOUTH QUESTIONNAIRE

Instructions: The following scales have been designed to find out about your neck pain and how it is affecting you. Please answer ALL the scales, and mark the ONE number on EACH scale that best describes how you feel.

1. Over the past week, on average, how would you rate your neck pain?

No pain — Worst pain possible

0 1 2 3 4 5 6 7 8 9 10

2. Over the past week, how much has your neck pain interfered with your daily activities (housework, washing, dressing, lifting, reading, driving)?

No interference — Unable to carry out activity

0 1 2 3 4 5 6 7 8 9 10

3. Over the past week, how much has your neck pain interfered with your ability to take part in recreational, social, and family activities?

No interference — Unable to carry out activity

0 1 2 3 4 5 6 7 8 9 10

4. Over the past week, how anxious (tense, uptight, irritable, difficulty in concentrating/relaxing) have you been feeling?

Not at all anxious — Extremely anxious

0 1 2 3 4 5 6 7 8 9 10

5. Over the past week, how depressed (down-in-the-dumps, sad, in low spirits, pessimistic, unhappy) have you been feeling?

Not at all depressed — Extremely depressed

0 1 2 3 4 5 6 7 8 9 10

6. Over the past week, how have you felt your work (both inside and outside the home) has affected (or would affect) your neck pain?

Have made it no worse — Have made it much worse

0 1 2 3 4 5 6 7 8 9 10

7. Over the past week, how much have you been able to control (reduce/help) your neck pain on your own?

Completely control it — No control whatsoever

0 1 2 3 4 5 6 7 8 9 10

OTHER COMMENTS: _____

Patient Name _____ Patient Signature _____

Examinner _____ Date _____ Score _____ (70)

With Permission from: Bolton JE, Humphreys BK: The Bournemouth Questionnaire: A Short-form Comprehensive Outcome Measure. II. Psychometric Properties in Neck Pain Patients. *JMPT* 2002; 25 (3): 141-148.

BACK BOURNEMOUTH QUESTIONNAIRE

Patient Name _____ Date _____

Instructions: The following scales have been designed to find out about your back pain and how it is affecting you. Please answer ALL the scales, and mark the ONE number on EACH scale that best describes how you feel.

1. Over the past week, on average, how would you rate your back pain?

No pain Worst pain possible

0 1 2 3 4 5 6 7 8 9 10

2. Over the past week, how much has your back pain interfered with your daily activities (housework, washing, dressing, walking, climbing stairs, getting in/out of bed/chair)?

No interference Unable to carry out activity

0 1 2 3 4 5 6 7 8 9 10

3. Over the past week, how much has your back pain interfered with your ability to take part in recreational, social, and family activities?

No interference Unable to carry out activity

0 1 2 3 4 5 6 7 8 9 10

4. Over the past week, how anxious (tense, uptight, irritable, difficulty in concentrating/relaxing) have you been feeling?

Not at all anxious Extremely anxious

0 1 2 3 4 5 6 7 8 9 10

5. Over the past week, how depressed (down-in-the-dumps, sad, in low spirits, pessimistic, unhappy) have you been feeling?

Not at all depressed Extremely depressed

0 1 2 3 4 5 6 7 8 9 10

6. Over the past week, how have you felt your work (both inside and outside the home) has affected (or would affect) your back pain?

Have made it no worse Have made it much worse

0 1 2 3 4 5 6 7 8 9 10

7. Over the past week, how much have you been able to control (reduce/help) your back pain on your own?

Completely control it No control whatsoever

0 1 2 3 4 5 6 7 8 9 10

_____
Examiner

OTHER COMMENTS: _____

With Permission from: Bolton JE, Breen AC: The Bournemouth Questionnaire: A Short-form Comprehensive Outcome Measure. I. Psychometric Properties in Back Pain Patients. *JMPT* 1999; 22 (9): 503-510.

ROLAND MORRIS QUESTIONNAIRE

When your back hurts you may find it difficult to perform many activities throughout the day. Statements listed below have been used by people to describe those times when they are experiencing back pain. As you read them, some may stand out because they describe your pain *today*.

Therefore, please check the box that best describes your pain today. If the sentence does not fit, then just leave it blank and move on to the next one.

- ❑ I stay at home most of the time because of my back.
- ❑ I change positions frequently to try to get my back comfortable.
- ❑ I walk more slowly than usual because of my back.
- ❑ Because of my back, I am not doing any of the jobs that I usually do around the house.
- ❑ Because of my back, I use a handrail to walk upstairs.
- ❑ Because of my back, I lie down to rest more often.
- ❑ Because of my back, I have to hold on to something to get out of my chair.
- ❑ Because of my back, I try to get other people to do things for me.
- ❑ I get dressed more slowly than usual because of my back.
- ❑ I only stand up for short periods of time because of my back.
- ❑ Because of my back, I try not to bend or kneel down.
- ❑ I find it difficult to get out of a chair because of my back.
- ❑ My back is painful almost all the time.
- ❑ I find it difficult to turn over in bed because of my back.
- ❑ My appetite is not very good because of my back pain.
- ❑ I have trouble putting on my socks or stockings because of my back .
- ❑ I only walk short distances because of my back pain.
- ❑ I don't sleep well because of my back.
- ❑ Because of my back pain, I get dressed with help from someone else.
- ❑ I sit down for most of the day because of my back.
- ❑ I avoid heavy jobs around the house because of my back.
- ❑ Because of my back pain, I am more irritable and bad –tempered with people than usual.
- ❑ Because of my back pain, I walk upstairs more slowly than usual.
- ❑ I stay in bed most of the time because of my back.

Additional Comments:

Patient Name _____ Patient Signature _____

Examiner _____ Date _____ SCORE _____ (24)

Roland M, Morris R. A study of the natural history of back pain: Part I: Development of a reliable and sensitive measure of disability in low back pain. Spine 1983: 8:141-144.

OSWESTRY INDEX QUESTIONNAIRE

This questionnaire is designed to help us better understand how your back pain affects your ability to manage everyday-life activities. Please mark in each section the **one box** that applies to you. Although you may consider that two of the statements in any one section relate to you, please mark the box that **most closely** describes your present -day situation.

SECTION 1 - PAIN INTENSITY

- ❑ My pain is mild to moderate. I do not need pain killers.
- ❑ The pain is bad, but I manage without taking pain killers
- ❑ Pain killers give complete relief from pain.
- ❑ Pain killers give moderate relief from pain.
- ❑ Pain killers give very little relief from pain.
- ❑ Pain killers have no effect on the pain.

SECTION 2 - PERSONAL CARE

- ❑ 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 manage most of my personal care.
- ❑ I need help every day in most aspects of self -care.
- ❑ I do not get dressed. I wash with difficulty and stay in bed.

SECTION 3 – LIFTING

- ❑ I can lift heavy weights without causing extra pain.
- ❑ I can lift heavy weights, but it gives me extra pain.
- ❑ Pain prevents me from lifting heavy weights off the floor, but I can manage if items are conveniently positioned, ie. on a table.
- ❑ Pain prevents me from lifting heavy weights, but I can manage light weights if they are conveniently positioned.
- ❑ I can lift only very light weights.
- ❑ I cannot lift or carry anything at all.

SECTION 4 – WALKING

- ❑ I can walk as far as I wish.
- ❑ 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 1/4 mile.
- ❑ I can walk only if I use a cane or crutches.
- ❑ I am in bed or in a chair for most of every day.

SECTION 5 – SITTING

- ❑ I can sit in any chair for as long as I like.
- ❑ I can sit in my favorite chair only, but for as long as I like.
- ❑ Pain prevents me from sitting for more than 1 hour.
- ❑ Pain prevents me from sitting for more than 1/2 hour.
- ❑ Pain prevents me from sitting for 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 for more than 1 hour
- ❑ Pain prevents me from standing more than 1/2 hour.
- ❑ Pain prevents me from standing more than 10 minutes.
- ❑ Pain prevents me from standing at all.

SECTION 7 – SLEEPING

- ❑ Pain does not prevent me from sleeping well.
- ❑ I sleep well but only when taking medication.
- ❑ Even when I take medication, I sleep less than 6 hours.
- ❑ Even when I take medication, I sleep less than 4 hours.
- ❑ Even when I take medication, I sleep less than 2 hours.
- ❑ Pain prevents me from sleeping at all.

SECTION 8 - SOCIAL LIFE

- ❑ Social life is normal and causes me no extra pain.
- ❑ Social life is normal, but increases the degree of pain.
- ❑ Pain affects my social life by limiting only my more energetic interests, such as dancing, sports, etc.
- ❑ 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 9 - SEXUAL ACTIVITY

- ❑ Sexual activity is normal and causes no extra pain.
- ❑ Sexual activity is normal, but causes some extra pain.
- ❑ Sexual activity is nearly normal, but is very painful.
- ❑ Sexual activity is severely restricted by pain.
- ❑ Sexual activity is nearly absent because of pain.
- ❑ Pain prevents any sexual activity at all.

SECTION 10 – TRAVELING

- ❑ I can travel anywhere without extra 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 necessary journeys under ½ hr.
- ❑ Pain prevents traveling except to the doctor/hospital.

ADDITIONAL COMMENTS:

PATIENT NAME _____ PATIENT SIGNATURE _____

EXAMINER _____ DATE _____ Score _____ [50]