# 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 car 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.

Scoring: Questions are scored on a vertical scale of 0 - 5.
SCORE _____ [50] MCID = ± 5 - 8 points (10%-16%)
(Minimum Clinically Important Difference)

_____ _____ _____ _____
Patient Signature Patient Print Name Date Time

_____ _____
Person completing form if other than patient Relationship to Patient

Instructions to Provider:
Your signature below indicates that you have reviewed the information contained in the entire questionnaire and that you have reviewed the pertinent or key finding(s) with the patient and/or family. Key finding(s) must be summarized in your progress note; however, the questionnaire should be referenced for additional details.

_____ _____ _____ _____
Provider Signature/Title Provider Print Name Date Time

Medical Record Number

Patient Name

Addressograph or Label - Patient Name, Medical Record Number

STANFORD HOSPITAL and CLINICS
STANFORD, CALIFORNIA 94305

# CLINICS REHAB PATIENT-SPECIFIC FUNCTIONAL SCALE QUESTIONNAIRE

PATIENT'S NAME: _____ DATE: _____

Please identify 3 important activities that you are unable to do or are having difficulty with as a result of your pain. Use the scale immediately below the activity and rate the degree of limitation for each of the activities you list by circling one of the options:

0 – unable to perform activity
10 – able to perform activity at same activity level as before this problem

**ACTIVITY #1**: _____

| 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
|---|---|---|---|---|---|---|---|---|---|---|

**ACTIVITY #2**: _____

| 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
|---|---|---|---|---|---|---|---|---|---|---|

**ACTIVITY #3**: _____

| 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
|---|---|---|---|---|---|---|---|---|---|---|

TOTAL SCORE: Sum of activity scores/number of activities to get mean score _____/_____
MDC (90% CI) avg score = 2 points MDC (90%) CI Single activity = 3 points

Comments: _____

| Patient Signature | Patient Print Name | Date | Time |
|---|---|---|---|

| Person completing form if other than patient | Relationship to Patient |
|---|---|

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| Provider Signature/Title | Provider Print Name | Date | Time |
|---|---|---|---|

MDC = Minimal Detectable Change
CI = Confidence Interval

Medical Record Number

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# CLINIC REHAB MEDICAL SCREENING QUESTIONNAIRE



To help us better understand your medical history, please mark Yes or No if you have or have had the below symptoms/diagnoses and fill in all pertinent blank spaces.

| | | | |
|---|---|---|---|
| Cardiovascular disease | ❑ Yes ❑ No | Hepatitis | ❑ Yes ❑ No |
| Smoking | ❑ Yes ❑ No | Rheumatoid arthritis | ❑ Yes ❑ No |
| Anemia | ❑ Yes ❑ No | Osteoporosis/ Osteopenia | ❑ Yes ❑ No |
| High cholesterol | ❑ Yes ❑ No | Osteoarthritis | ❑ Yes ❑ No |
| Emphysema or Bronchitis | ❑ Yes ❑ No | Blurred vision | ❑ Yes ❑ No |
| History of stroke or TIA | ❑ Yes ❑ No | Dizziness/vertigo | ❑ Yes ❑ No |
| Persistent cough | ❑ Yes ❑ No | Double vision | ❑ Yes ❑ No |
| Chest pain | ❑ Yes ❑ No | Difficulty talking/swallowing | ❑ Yes ❑ No |
| Shortness of breath | ❑ Yes ❑ No | Headache | ❑ Yes ❑ No |
| Asthma | ❑ Yes ❑ No | Kidney disease | ❑ Yes ❑ No |
| Tuberculosis | ❑ Yes ❑ No | Immune disorder | ❑ Yes ❑ No |
| Abdominal pain | ❑ Yes ❑ No | Active Herpes, Shingles | ❑ Yes ❑ No |
| Change in hair or nail growth | ❑ Yes ❑ No | Change in bowel or bladder | ❑ Yes ❑ No |
| Stomach ulcers | ❑ Yes ❑ No | Incontinence | ❑ Yes ❑ No |
| Fever/chills/sweats | ❑ Yes ❑ No | Sudden loss of consciousness | ❑ Yes ❑ No |
| Fatigue | ❑ Yes ❑ No | Seizures | ❑ Yes ❑ No |
| Unexplained weakness | ❑ Yes ❑ No | Confusion | ❑ Yes ❑ No |
| Unexplained weight loss/gain | ❑ Yes ❑ No | Multiple sclerosis | ❑ Yes ❑ No |
| Thyroid problems | ❑ Yes ❑ No | Depression | ❑ Yes ❑ No |
| Diabetes | ❑ Yes ❑ No | Chemical dependency | ❑ Yes ❑ No |
| Liver disease | ❑ Yes ❑ No | Tingling/numbness at the inner thigh | ❑ Yes ❑ No |

| | |
|---|---|
| During the past month, have you often been bothered by feeling down, depressed or hopeless? | ❑ Yes ❑ No |
| During the past month, have you often been bothered by little interest or pleasure in doing things? | ❑ Yes ❑ No |
| Do you ever feel unsafe at home or has anyone hit you or tried to injure you in any way? | ❑ Yes ❑ No |
| Do you have a history of cancer? | ❑ Yes ❑ No<br>Explain: |
| Do you have a current infection: | ❑ Yes ❑ No<br>Explain: |
| Have you noticed discoloration in urine or stool? | ❑ Yes ❑ No |
| Does eating certain foods make your pain worse? | ❑ Yes ❑ No |

Please complete on reverse side →

Medical Record Number

Patient Name

Addressograph or Label - Patient Name, Medical Record Number

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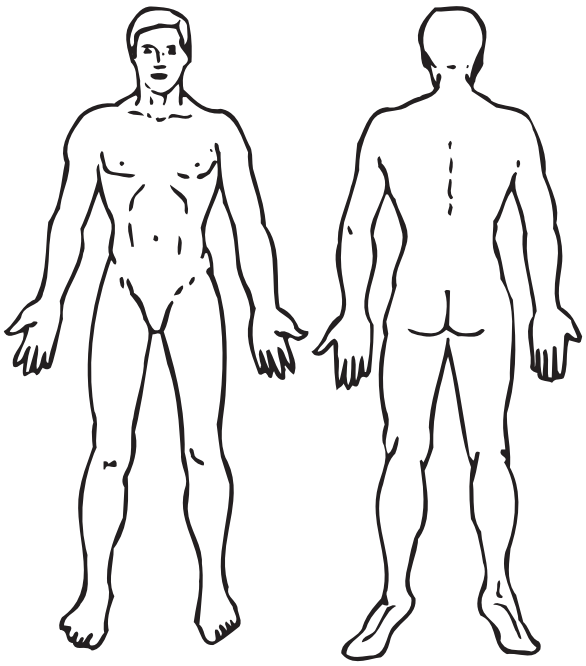
**CLINIC REHAB MEDICAL SCREENING QUESTIONNAIRE**



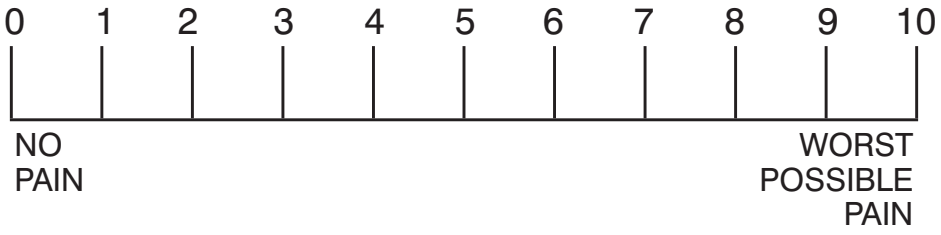


This pain drawing will help us to understand the pain that you have been experiencing. Please diagram the location of your pain.



Right Left Left Right

Please mark your current pain intensity:




DATE TIME SIGNATURE (Patient, or Properly Designated Representative)

PRINT NAME RELATIONSHIP TO PATIENT

**Provider:** Your signature below indicates that you have reviewed the information contained in the entire questionnaire and that you have reviewed the pertinent or key find(s) with the patient and/or family. Key finding (s) must be summarized in your progress note; however, the questionnaire should be referenced for additional details.

DATE TIME PROVIDER/TITLE PRINT NAME