Neck Pain and Disability Index (Vernon-Mior)

Patient Name: _____ File # _____ Date: _____

This questionnaire has been designed to give the doctor 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 which applies to you. We realize you may consider that two of the statements in any one section relate to you, but please just mark the box which most closely 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 (Washing, Dressing, etc)

☐ 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 extra pain.
☐ I can lift heavy weights but it gives extra pain.
☐ Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned, for example 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 lift very light weights.
☐ I cannot lift or carry anything at all.

SECTION 4 – READING

☐ I can read as much as I want to with no pain in my neck.
☐ I can read as much as I want to with slight pain in my neck.
☐ I can read as much as I want with moderate pain in my neck.
☐ I can't read as much as I want because of moderate pain in my neck.
☐ I can hardly read at all because of severe pain in my neck.
☐ I cannot read at all.

SECTION 5 – HEADACHES

☐ 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 can't do any work at all.

SECTION 8 – DRIVING

☐ I can drive my car without any 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 can't drive my car as long as I want because of moderate pain in my neck.
☐ I can hardly drive at all because of severe pain in my neck.
☐ I can't drive my car at all.

SECTION 9 – SLEEPING

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

SECTION 10 – RECREATION

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

Pain Severity Scale: Rate the Severity of your pain by checking one box of the following scale.

No Pain	0	1	2	3	4	5	6	7	8	9	10	Excruciating Pain

Patient Signature _____ *Zak Chiropractic Lee's Summit, MO*

Low Back Pain and Disability Questionnaire (Revised Oswestry)

Patient Name: _____ File # _____ Date: _____

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

SECTION 1 – PAIN INTENSITY

☐ The pain comes and goes and is very mild.
☐ The pain is mild and does not vary much.
☐ The pain comes and goes and is moderate.
☐ The pain is moderate and does not vary much.
☐ The pain comes and goes and is very severe.
☐ The pain is severe and does not vary much.

SECTION 2 – PERSONAL CARE

☐ I would not have to change my way of washing or dressing in order to avoid pain.
☐ I do not normally change my way of washing or dressing even though it causes some pain.
☐ Washing and dressing increase the pain but I manage not to change my way of doing it.
☐ Washing and dressing increase the pain and I find it necessary to change my way of doing it.
☐ Because of the pain I am unable to do some washing and dressing without help.
☐ Because of the pain I am unable to do any washing and dressing without help.

SECTION 3 – LIFTING

☐ I can lift heavy weights without extra pain.
☐ I can lift heavy weights but it causes extra pain.
☐ Pain prevents me from lifting heavy weights off the floor.
☐ Pain prevents me from lifting heavy weights off the floor, but I manage if they are conveniently positioned (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 at the most.

SECTION 4 – WALKING

☐ I have no pain on walking.
☐ I have some pain on walking but it does not increase with distance.
☐ I cannot walk more than one mile without increasing pain.
☐ I cannot walk more than ½ mile without increasing pain.
☐ I cannot walk more than ¼ mile without increasing pain.
☐ I cannot walk at all without increasing pain.

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 from sitting more than one hour.
☐ Pain prevents me from sitting more than half hour.
☐ Pain prevents me from sitting more than 10 minutes.
☐ I avoid sitting because it increases pain straight away.

SECTION 6 - STANDING

☐ I can stand as long as I want without pain.
☐ I have some pain on standing but it does not increase with time.
☐ I cannot stand for longer than one hour without increasing pain.
☐ I cannot stand for longer than ½ hour without increasing pain.
☐ I cannot stand for longer than 10 minutes without increasing pain.
☐ I avoid standing because it increases the pain straight away.

SECTION 7 – SLEEPING

☐ I get not pain in bed.
☐ I get pain in bed but it does not prevent me from sleeping well.
☐ Because of pain my normal night's sleep is reduced by less than ¼.
☐ Because of pain my normal night's sleep is reduced by less than ½.
☐ Because of pain my normal night's sleep is reduced by less than ¾.
☐ Pain prevents me from sleeping at all.

SECTION 8 – SOCIAL LIFE

☐ My social life is normal and gives me no 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. dancing, etc.
☐ Pain has restricted my social life and I do not go out very often.
☐ Pain has restricted my social life to my home.
☐ I have hardly any social life because of the pain.

SECTION 9 – TRAVELLING

☐ I get no pain whilst travelling.
☐ I get some pain whilst travelling but none of my usual forms of travel make it any worse.
☐ I get extra pain whilst travelling but it does not compel me to seek alternative forms of travel.
☐ I get extra pain whilst travelling which compels me to seek alternative forms of travel.
☐ Pain restricts all forms of travel.
☐ Pain prevents all forms of travel except that done lying down.

SECTION 10 – CHANGING DEGREE OF PAIN

☐ My pain is rapidly getting better.
☐ My pain fluctuates but overall is definitely getting better.
☐ My pain seems to be getting better but improvement is slow at present.
☐ My pain is neither getting better nor worse.
☐ My pain is gradually worsening.
☐ My pain is rapidly worsening.

Pain Severity Scale: Rate the Severity of your pain by checking one box of the following scale.

No Pain	0	1	2	3	4	5	6	7	8	9	10	Excruciating Pain

Patient Signature _____ *Zak Chiropractic Lee's Summit, MO*

Low Back Pain and Disability Questionnaire (Roland-Morris)

Patient Name: _____ File # _____ Date: _____

WHEN YOUR BACK HURTS, YOU MAY FIND IT DIFFICULT TO DO SOME OF THE THINGS YOU NORMALLY DO. MARK ONLY THE SENTENCES THAT DESCRIBE YOU TODAY.

- ☐ I stay at home most of the time because of my back.
- ☐ I change position frequently to try and get my back comfortable.
- ☐ I walk more slowly than usual because of my back.
- ☐ Because of my back, I am not doing any jobs that I usually do around the house.
- ☐ Because of my back, I use a handrail to get 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 an easy 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 of 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 the pain in my back.
- ☐ I only walk short distances because of my back pain.
- ☐ I sleep less 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 back pain, I am more irritable and bad tempered with people than usual.
- ☐ Because of my back, I go upstairs more slowly than usual.
- ☐ I stay in bed most of the time because of my back.

Patient signature _____ *Zak Chiropractic Lee's Summit, MO*

ACCIDENT INFORMATION

Date of accident _____ Hour of accident _____ A.M./P.M.

Have you missed any work? Yes____ No____ If yes, how many days? _____

Type of accident: Work related_____ Traffic _____

Work Related Accident:

Employer_____ Type of Business _____

Was any equipment, machinery and/or object related to accident? _____

Was accident reported to supervisor and/or employer? Yes_____ No_____

Has a worker's compensation claim been filed? Yes _____ No_____

Describe circumstances surrounding accident: _____

_____

_____

Traffic Accident:

What kind of vehicle was involved? _____

Were you a Driver _____ Passenger _____ Pedestrian_____

If a passenger, please indicate your location in the car._____

Was your vehicle moving when the accident occurred? Yes _____ No _____ MPH _____

Did you see the accident coming? Yes_____ No_____

At the time of impact, were you looking straight ahead? Yes_____ No_____

Did the air bag/s deploy? Yes_____ No_____

Did your vehicle hit other vehicle/s? Yes _____ No _____ Where _____

Did other vehicle/s hit your vehicle? Yes _____ No _____ Where _____

Were you wearing a seat belt? Yes_____ No_____

Were you wearing a shoulder harness? Yes_____ No_____

Were the streets wet? Yes_____ No_____

Was the accident reported to the police department? Yes _____ No _____

Were traffic citations issued? Yes_____ No _____ To Whom? _____

Describe circumstances surrounding accident: _____

_____

_____

_____

_____ _____ _____

Print Name Signature Date