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## PATIENT CONDITION UPDATE

Name \_\_\_\_\_ Date of Accident \_\_\_\_\_

1. Do you feel that you have been returned to your pre-injury condition? Yes \_\_\_\_\_ No \_\_\_\_\_

2. If no, what percentage of recovery do you feel that you have attained? \_\_\_\_\_

3. What complaints do you continue to experience? \_\_\_\_\_

\_\_\_\_\_

4. How often do you continue to feel pain / discomfort?

- Never \_\_\_\_\_
- 0 - 25% \_\_\_\_\_
- 26 - 50% \_\_\_\_\_
- 51 - 75% \_\_\_\_\_
- 76 - 100% \_\_\_\_\_

5. On average, how severe are your symptoms? 0 1 2 3 4 5 6 7 8 9 10

6. What activities make your symptoms worse? \_\_\_\_\_

\_\_\_\_\_

7. What do you do to make it feel better? Rest \_\_\_\_\_ Heat \_\_\_\_\_ Ice \_\_\_\_\_ Meds \_\_\_\_\_

Other \_\_\_\_\_

8. Is it better or worse at any time of day? \_\_\_\_\_

9. Do you have any difficulties with your daily activities? Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, please explain: \_\_\_\_\_

\_\_\_\_\_

Signature \_\_\_\_\_ Date \_\_\_\_\_

# NECK DISABILITY INDEX QUESTIONNAIRE

NAME \_\_\_\_\_ AGE \_\_\_\_\_ DATE \_\_\_\_\_ SCORE \_\_\_\_\_

**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 THAT MOST CLOSELY DESCRIBES YOUR PROBLEM RIGHT NOW.**

<p><i>SECTION 1 - Pain Intensity</i></p> <p>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.</p>	<p><i>SECTION 6 - Concentration/</i></p> <p>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.</p>
<p><i>SECTION 2 -Personal Care (Washing, Dressing, etc.)</i></p> <p>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.</p>	<p><i>SECTION 7 - Work</i></p> <p>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.</p>
<p><i>SECTION 3 - Lifting</i></p> <p>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.</p>	<p><i>SECTION 8 - Driving</i></p> <p>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.</p>
<p><i>SECTION 4 - Reading</i></p> <p>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 to 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.</p>	<p><i>SECTION 9 - Sleeping</i></p> <p>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)</p>
<p><i>SECTION 5 - Headaches</i></p> <p>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.</p>	<p><i>SECTION 10 - Recreation</i></p> <p>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 recreational activities because of pain in my neck.          D. I am able to engage in a few of my 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.</p>

COMMENTS: \_\_\_\_\_

# OSWESTRY DISABILITY INDEX 2.0

NAME \_\_\_\_\_ DATE \_\_\_\_\_ SCORE \_\_\_\_\_

**PLEASE READ:** Could you please complete this questionnaire. It is designed to give us information as to how your back (or leg) trouble has affected your ability to manage in everyday life.

Please answer **every section**. Mark **one box only** in each section that most closely describes you **today**.

<p><b>SECTION 1 - Pain Intensity</b></p> <p>A <input type="checkbox"/> I have no pain at the moment.          B <input type="checkbox"/> The pain is very mild at the moment.          C <input type="checkbox"/> The pain is moderate at the moment.          D <input type="checkbox"/> The pain is fairly severe at the moment.          E <input type="checkbox"/> The pain is very severe at the moment.          F <input type="checkbox"/> The pain is the worst imaginable at the moment.</p>	<p><b>SECTION 6 - Standing</b></p> <p>A <input type="checkbox"/> I can stand as long as I want without extra pain.          B <input type="checkbox"/> I can stand as long as I want but it gives me extra pain.          C <input type="checkbox"/> Pain prevents me from standing for more than 1 hour.          D <input type="checkbox"/> Pain prevents me from standing for more than 1/2 hour.          E <input type="checkbox"/> Pain prevents me from standing for more than 10 minutes.          F <input type="checkbox"/> Pain prevents me from standing at all.</p>
<p><b>SECTION 2 - Personal Care (washing, dressing, etc.)</b></p> <p>A <input type="checkbox"/> I can look after myself normally without causing extra pain.          B <input type="checkbox"/> I can look after myself normally but it is very painful.          C <input type="checkbox"/> It is painful to look after myself and I am slow and careful.          D <input type="checkbox"/> I need some help but manage most of my personal care.          E <input type="checkbox"/> I need help every day in most aspects of self care.          F <input type="checkbox"/> I do not get dressed, wash with difficulty and stay in bed.</p>	<p><b>SECTION 7 - Sleeping</b></p> <p>A <input type="checkbox"/> My sleep is never disturbed by pain.          B <input type="checkbox"/> My sleep is occasionally disturbed by pain.          C <input type="checkbox"/> Because of pain I have less than 6 hours' sleep.          D <input type="checkbox"/> Because of pain I have less than 4 hours' sleep.          E <input type="checkbox"/> Because of pain I have less than 2 hours' sleep.          F <input type="checkbox"/> Pain prevents me from sleeping at all.</p>
<p><b>SECTION 3 - Lifting</b></p> <p>A <input type="checkbox"/> I can lift heavy weights without extra pain.          B <input type="checkbox"/> I can lift heavy weights, but it causes extra pain.          C <input type="checkbox"/> Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned, e.g. on a table.          D <input type="checkbox"/> Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.          E <input type="checkbox"/> I can only lift very light weights, at the most.          F <input type="checkbox"/> I cannot lift or carry anything at all.</p>	<p><b>SECTION 8 - Sex Life (if applicable)</b></p> <p>A <input type="checkbox"/> My sex life is normal and causes me no extra pain.          B <input type="checkbox"/> My sex life is normal, but causes some extra pain.          C <input type="checkbox"/> My sex life is nearly normal but is very painful.          D <input type="checkbox"/> My sex life is severely restricted by pain.          E <input type="checkbox"/> My sex life is nearly absent because of pain.          F <input type="checkbox"/> Pain prevents any sex life at all.</p>
<p><b>SECTION 4 - Walking</b></p> <p>A <input type="checkbox"/> Pain does not prevent me from walking any distance.          B <input type="checkbox"/> Pain prevents me from walking more than one mile.          C <input type="checkbox"/> Pain prevents me from walking more than 1/4 mile.          D <input type="checkbox"/> Pain prevents me from walking more than 100 yards.          E <input type="checkbox"/> I can only walk while using a stick or crutches.          F <input type="checkbox"/> I am in bed most of the time and have to crawl to the toilet.</p>	<p><b>SECTION 9 - Social Life</b></p> <p>A <input type="checkbox"/> My social life is normal and causes me no extra pain.          B <input type="checkbox"/> My social life is normal, but increases the degree of pain.          C <input type="checkbox"/> Pain has no significant effect on my social life apart from limiting my more energetic interests, e.g., sport, etc.          D <input type="checkbox"/> Pain has restricted my social life and I do not go out as often.          E <input type="checkbox"/> Pain has restricted my social life to my home.          F <input type="checkbox"/> I have no social life because of the pain.</p>
<p><b>SECTION 5 - Sitting</b></p> <p>A <input type="checkbox"/> I can sit in any chair as long as I like.          B <input type="checkbox"/> I can only sit in my favorite chair as long as I like.          C <input type="checkbox"/> Pain prevents me from sitting more than 1 hour.          D <input type="checkbox"/> Pain prevents me from sitting more than 1/2 hour.          E <input type="checkbox"/> Pain prevents me from sitting more than ten minutes.          F <input type="checkbox"/> Pain prevents me from sitting at all.</p>	<p><b>SECTION 10 - Traveling</b></p> <p>A <input type="checkbox"/> I can travel anywhere without pain.          B <input type="checkbox"/> I can travel anywhere but I gives extra pain.          C <input type="checkbox"/> Pain is bad but I manage journeys over 2 hours.          D <input type="checkbox"/> Pain restricts me to journeys of less than 1 hour.          E <input type="checkbox"/> Pain restricts me to short necessary journeys under 30 minutes.          F <input type="checkbox"/> Pain prevents me from traveling except to receive treatment.</p>

**COMMENTS:** \_\_\_\_\_

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