Description: This survey is meant to help us obtain information from our patients regarding their current levels of discomfort and capability. **Please circle the answers below that best apply.**

NECK DISABILITY INDEX- INITIAL VISIT

1. Pain Intensity
- (0) I have no pain at the moment.
- (1) The pain is very mild at the moment.
- (2) The pain is moderate at the moment.
- (3) The pain is fairly severe at the moment.
- (4) The pain is very severe at the moment.
- (5) The pain is the worst imaginable at the moment.

2. Personal Care (washing, dressing, etc.)
- (0) I can look after myself normally without extra pain.
- (1) I can look after myself normally but it causes extra pain.
- (2) It is painful to look after myself, and I am slow and careful.
- (3) I need some help but manage most of my personal care.
- (4) I need some help every day in most aspects of self care.
- (5) I cannot get dressed, wash with difficulty and stay in bed.

3. Lifting
- (0) I can lift heavy weights without extra pain.
- (1) I can lift heavy weights but it gives me extra pain.
- (2) Pain prevents me from lifting heavy weights off the floor but I can manage if they are on a table.
- (3) Pain prevents me from lifting heavy weights but I can manage if they are conveniently placed.
- (4) I can lift only very light weights.
- (5) I cannot lift or carry anything at all.

4. Headache
- (0) I have no headaches at all.
- (1) I have slight headaches which come infrequently.
- (2) I have moderate headaches which come infrequently.
- (3) I have moderate headaches which come frequently.
- (4) I have severe headaches which come infrequently.
- (5) I have headaches almost all the time.

5. Recreation
- (0) I am able to engage in all my recreational activities without pain
- (1) I am able to engage in recreational activities with some pain.
- (2) I am able to engage in most but not all of my usual recreational activities because of my neck pain.
- (3) I am able to engage in a few of my usual recreational activities with some neck pain.
- (4) I can hardly do any recreational activities because of neck pain.
- (5) I can't do any recreational activities at all.

6. Reading
- (0) I can read as much as I want with no pain in my neck.
- (1) I can read as much as I want with slight neck pain.
- (2) I can read as much as I want with moderate neck pain.
- (3) I can't read as much as I want because of moderate neck pain.
- (4) I can hardly read at all because of severe neck pain.
- (5)I cannot read at all because of neck pain.

7. Work
- (0) I can do as much as I want to.
- (1) I can only do my usual work but no more.
- (2) I can do most of my usual work but no more.
- (3) I cannot do my usual work.
- (4) I can hardly do any usual work at all.
- (5) I can't do any work at all.

8. Sleeping
- (0) Pain does not prevent me from sleeping well.
- (1) My sleep is slightly disturbed (<1hr sleep loss).
- (2) My sleep is mildly disturbed (1-2 hr sleep loss).
- (3) My sleep is moderately disturbed (2-3 hr sleep loss).
- (4) My sleep is greatly disturbed (3-4 hr sleep loss).
- (5) My sleep is completely disturbed (5-7 hr sleep loss).

9. Concentration
- (0) I can concentrate fully when I want with no difficulty.
- (1) I can concentrate fully when I want with slight difficulty
- (2) I have a fair degree of difficulty concentrating when I want.
- (3) I have a lot of difficulty concentrating when I want.
- (4) I have great difficulty concentrating when I want.
- (5) I cannot concentrate at all.

10. Driving
- (0) I can drive my car without neck pain.
- (1) I can drive my car as long as I want with some slight neck pain.
- (2) I can drive my car as long as I want with moderate neck
- (3) I can't drive my car as long as I want because of moderate pain.
- (4) I can hardly drive my car at all because of severe neck pain.
- (5) I can't drive my car at all.

Olympic Physical Therapy, LLC

Patient Name:_____ **Date:**_____

Age:_____ **Height:**_____ **Weight:**_____

How much pain do you have <u>today?</u> Please circle a number (0= no pain, 10= worst pain)

0 1 2 3 4 5 6 7 8 9 10

Please list below any medications you are currently taking. Please include prescription meds, over the counter meds, and/or supplements with names, dosage, and frequency.

Drug Name	Dosage	Frequency	Drug name	Dosage	Frequency
1.			4.		
2.			5.		
3.			6.		

Have you had an injury as a result of a fall in the past year? (Please circle one): **Yes** **No**

Have you had two or more falls in the past year? **Yes** **No**

Who is your primary care physician?_____

When is the next time you are seeing a physician?_____

Have you had any diagnostic tests for this problem? **Yes** **No** (If Yes, please list below):

_____

Have you had a specific injury or surgery for this problem? **Yes** **No** (If Yes, please list below):

_____

Please list any other medical problems you have, or any other surgeries you have had?

_____

_____

Are you currently employed? **Yes** **No** **Job Title?**_____

Has your work schedule been modified because of this problem? **Yes** **No**

Are you living alone at this time? **Yes** **No**

What goal(s) would you like to accomplish with PT? _____

Please turn page over ⟶