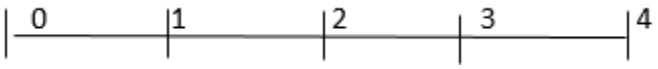
Functional Rating Index

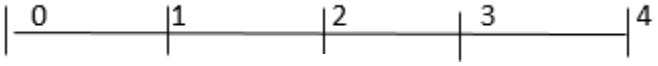
In order to properly assess your condition, we must understand how much your **neck and/or back problems** has affected your ability to manage everyday activities. For each item below, **please circle the number which most closely describes your condition right now.**

1. Pain Intensity



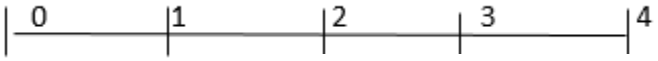
No pain | Mild pain | Moderate pain | Severe pain | Worst possible pain

2. Sleeping



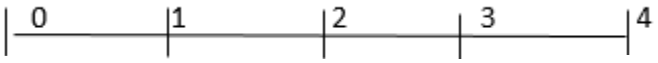
Perfect sleep | Mildly disturbed sleep | Moderately disturbed sleep | Greatly disturbed sleep | Totally disturbed sleep

3. Personal Care (washing, dressing, etc.)



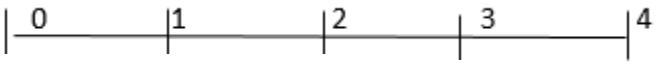
No pain; no restrictions | Mild pain; no restrictions | Moderate pain; need to go slowly | Moderate pain; need some | Severe pain; need 100% assistance

4. Travel (driving, etc.)



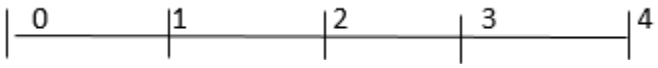
No pain on long trips | Mild pain on long trips | Moderate pain on long trips | Moderate pain on short trips | Severe pain on short trips

5. Work



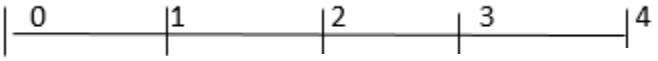
Can do usual work +unlimited extra work | Can do usual work; no extra work | Can do 50% of usual work | Can do 25% of usual work | Cannot work

6. Recreation



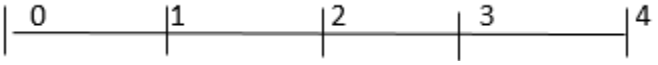
Can do all activities | Can do most activities | Can do some activities | Can do few activities | Cannot do any activities

7. Frequency of Pain



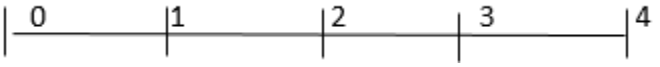
No pain | Occasional pain; 25% of day | Intermitten pain; 50% o day | Frequent pain; 75% of day | Constant pain; 100% of day

8. Lifting



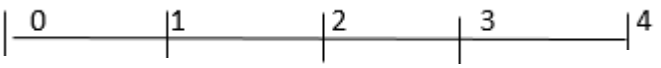
No pain with heavy weight | Increased pain with heavy weight | Increased pain with moderate weight | Increased pain with light weight | Increased pain with any weight

9. Walking



No pain; any distance | Increased pain after 1mile | Increased pain after 1/2mile | Increased pain after 1/4mile | Increased pain with all walking

10. Standing



No pain after several hours | Increased pain after several hours | Increased pain after 1 hour | Increased pain after 1/2 hour | Increased pain with any standing

_____ _____ _____

Patient/Guardian's Signature **Date** **Total**

Patient #:_____

General Pain Disability Index Questionnaire

Name (please print): _____ **Date:** _____

Age:_____ **Date of Birth:**_____ **Occupation:** _____

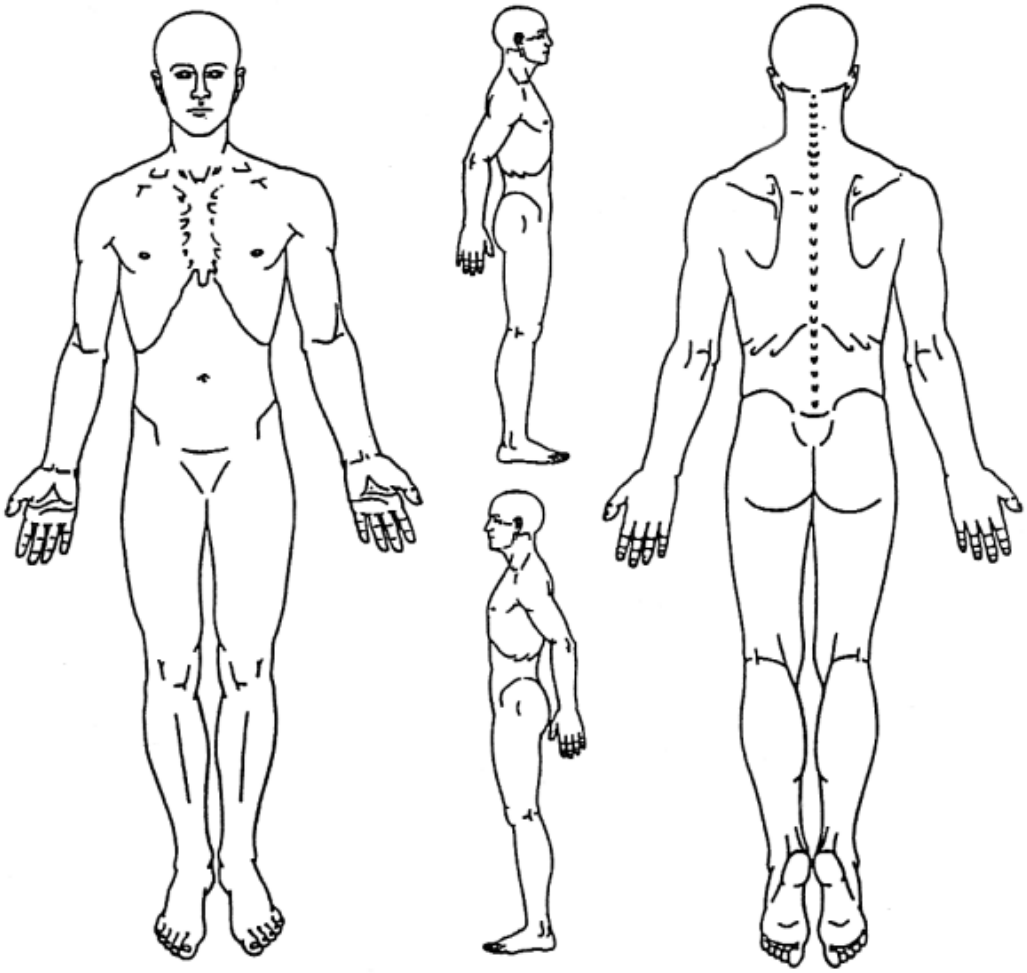
How long have you had this pain? _____**Years** _____**Months** _____**Weeks**

Is this your first episode of this pain? _____**Yes** _____**No**

Use the letters below to indicate the type and location of your sensations right now. Please write the letter **ON** the body.

Key:

A = Ache	B = Burning	N = Numbness
P = Pins & Needles	S = Stabbing	O = Others



For Doctor's Use:

Chief complaint (other than neck or low back pain):_____

_____