

Neck Disability Index

Please Read: This questionnaire is designed to enable us to understand how much your neck pain has affected your everyday activities. In the event that two or more of the statements in a category may relate to you, please mark the one answer that most accurately describes your problem. Please answer based upon your average pain over the past two weeks **without pain medication**.

SECTION 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 and comes and goes.
- 3 The pain is moderate and does not vary much.
- 4 The pain is severe but comes and goes.
- 5 The pain is severe and does not vary much.

SECTION 2 – Personal Care (Washing, Dressing etc.)

- 0 I can look after myself without extra neck pain.
- 1 I can look after myself 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 help every day in most aspect of self-care.
- 5 I do not get dressed, wash with difficulty, and stay in bed.

SECTION 3 – Lifting

- 0 I can lift heavy weights without extra pain.
- 1 I can lift heavy weights, but it causes extra neck pain.
- 2 Pain prevents me from lifting heavy weights off the floor but I can if they are conveniently placed for example, on a table.
- 3 Pain prevents me from lifting heavy weights but I can lift light to medium weights if they are conveniently placed.
- 4 I can lift very light weights.
- 5 I cannot lift or carry anything at all due to neck pain.

SECTION 4 – Work

- 0 I can do as much work as I want to.
- 1 I can 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 work at all.
- 5 I cannot do any work.

SECTION 5 – Headache

- 0 I have no headaches at all.
- 1 I have slight headaches that come infrequently.
- 2 I have moderate headaches that come infrequently.
- 3 I have moderate headaches that come frequently.
- 4 I have severe headaches that come frequently.
- 5 I have headaches almost all of the time.

SECTION 6 – Concentration

- 0 I can concentrate fully with no difficulty.
- 1 I can concentrate fully with slight difficulty.
- 2 I have a fair degree of difficulty in concentrating
- 3 I have a lot of difficulty in concentrating.
- 4 I have a great deal of difficulty in concentrating.
- 5 I cannot fully concentrate at all.

SECTION 7 – Sleeping

- 0 I have no trouble sleeping.
- 1 My sleep is slightly disturbed (less than 1 hour sleepless).
- 2 My sleep is mildly disturbed (1-2 hours sleepless).
- 3 My sleep is moderately disturbed (2-3 hours sleepless).
- 4 My sleep is greatly disturbed (3-5 hours sleepless).
- 5 My sleep is completely disturbed (5-7 hours sleepless).

SECTION 8 – Driving

- 0 I can drive my car without neck pain.
- 1 I can drive my car as long as I want with slight neck pain.
- 2 I can drive my car as long as I want with moderate neck pain.
- 3 I cannot drive my car as long as I want because of moderate neck pain.
- 4 I can hardly drive my car at all because of severe neck pain.
- 5 I cannot drive my car at all.

SECTION 9- Reading

- 0 I can read as much as I want with no neck pain.
- 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't read as much as I want because of severe neck pain.
- 5 I can't read at all due to neck pain.

SECTION 10 – Recreation

- 0 I am able to engage in all recreational activities with no pain.
- 1 I am able to engage in all recreational activities with slight pain.
- 2 I am able to engage in most, but not all, recreational activities because of pain.
- 3 I am unable to engage in a few of my usual recreational activities because of pain.
- 4 I can hardly do any recreational activities because of neck pain.
- 5 I cannot do any recreational activities due to neck pain.

Print Name: _____
By entering my name above, I affirm all of this information is correct.

Date: _____
DOB: _____
Cervical Disability Score %: _____



NECK PAIN _____ ARM (LEFT) _____ SHOULDER (LEFT) _____
 HEADACHE _____ ARM (RIGHT) _____ SHOULDER (RIGHT) _____

IF YOU ARE POST OP: (Please Check boxes)

- 1. Overall were you satisfied with your surgery? YES NO
 - 2. Returned to work after surgery? YES NO
 - 3. If given the chance would you repeat the same surgery for the same outcome? YES NO
 - 4. Retired? YES NO
- Pre-Op 6 Wks 3 Mon 6 Mon 1 Year 2 Year 3 Year 4 Year 5 Year