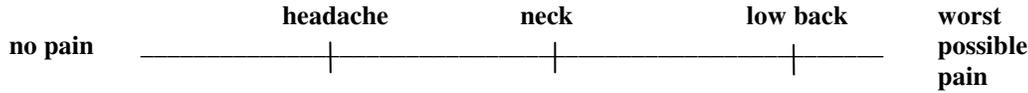


QUADRUPLE VISUAL ANALOGUE SCALE

INSTRUCTIONS: Please put a mark on the line that best describes the question being asked.

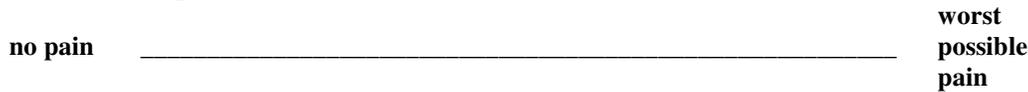
NOTE: If you have more than one complaint, please answer each question for each individual complaint and indicate the score for each complaint. Please indicate your average pain levels and pain at minimum / maximum using the last 3 months as your reference. If you have completed this form before, indicate you average pain level since the last time you completed this form.

EXAMPLE:



#####

1. What is your pain RIGHT NOW?



2. What is your TYPICAL or AVERAGE pain?

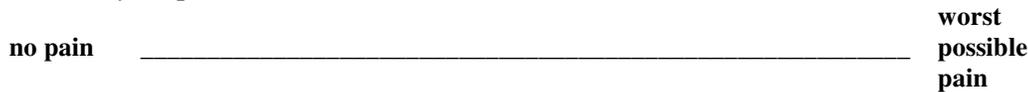


3. What is your pain level AT ITS BEST?



What percentage of your awake hours is your pain at its best? _____ %

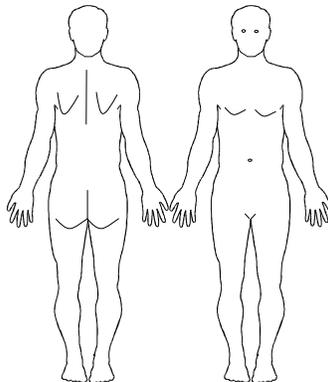
4. What is your pain level AT ITS WORST?



What percentage of your awake hours is your pain at its worst? _____ %

Mark the diagram as follows:

- A - Ache
- B - Burning
- N - Numbness
- P - Pins & Needles
- S - Stabbing
- O - Other - Describe



NAME _____ AGE _____ DATE _____ SCORE _____

SCORE: #1 _____ + #2 _____ + #4 _____ = _____ / 3 x 10 = _____ (Low intensity = <50; High intensity = >50)

NAME _____ AGE _____ DATE _____ DATE OF INJURY _____

HEALTH STATUS QUESTIONNAIRE

1. In general, would you say your health is:

(circle one number)

- Excellent..... 1
- Very Good..... 2
- Good..... 3
- Fair..... 4
- Poor..... 5

2. Compared to one year ago, how would you rate your health in general now?

(circle one number)

- Much better now than one year ago..... 1
- Somewhat better now than one year ago..... 2
- About the same..... 3
- Somewhat worse now than one year ago..... 4
- Much worse now than one year ago..... 5

The following items are about activities you might do during a typical day. Does your health now limit you in these activities? If so, how much?

(circle one number on each line)

	Yes, limited a lot	Yes, limited a little	No, not at all
3. Vigorous activities, such as running, lifting heavy objects, participating in strenuous sports.....	1	2	3
4. Moderate activities, such as moving a table, pushing a vacuum cleaner, bowling, or playing golf.....	1	2	3
5. Lifting or carrying groceries.....	1	2	3
6. Climbing several flights of stairs..	1	2	3
7. Climbing one flight of stairs.....	1	2	3
8. Bending, kneeling or stooping.....	1	2	3
9. Walking more than a mile.....	1	2	3
10. Walking several blocks.....	1	2	3
11. Walking one block.....	1	2	3
12. Bathing or dressing yourself.....	1	2	3

During the past 4 weeks, have you had any of the following problems with your work or other regular daily activities as a result of your physical health?

(circle one number on each line)

	<u>Yes</u>	<u>No</u>
13. Cut down the amount of time you spent on work or other activities.....	1	2
14. Accomplished less than you would like.	1	2
15. Were limited in the kind of work or other activities.....	1	2
16. Had difficulty performing the work or other activities (for example, it took extra effort).....	1	2

During the past 4 weeks, have you had any of the following problems with your work or other regular daily activities as a result of any emotional problems (such as feeling depressed or anxious)?

(Circle one number on each line)

	Yes	No
17. Cut down the amount of time you spent on work or other activities.....	1	2
18. Accomplished less than you would like	1	2
19. Didn't do work or other activities as carefully as usual.....	1	2

20. During the past 4 weeks, to what extent has your physical health or emotional problems interfered with your normal social activities with family, friends, neighbors, or groups?

(circle one number)

- Not at all..... 1
- Slightly..... 2
- Moderately..... 3
- Quite a bit..... 4
- Extremely..... 5

21. How much bodily pain have you had during the past 4 weeks?

(circle one number)

- None..... 1
- Very mild..... 2
- Mild..... 3
- Moderate..... 4
- Severe..... 5
- Very severe..... 6

22. During the past 4 weeks how much did pain interfere with your normal work (including both work outside the home and housework)?

(circle one number)

- None at all..... 1
- A little bit..... 2
- Moderately..... 3
- Quite a bit..... 4
- Extremely..... 5

These questions are about how you feel and how things have been with you during the past 4 weeks. For each question, please give the one answer that comes closest to the way you have been feeling.

How much of the time during the past 4 weeks...

(circle one number on each line)

	All of the time	Most of the time	A good bit of time	Some of the time	Little of the time	None of the time
23. Did you feel full of pep?	1	2	3	4	5	6
24. Have you been a very nervous person?	1	2	3	4	5	6
25. Have you felt so down in the dumps that nothing could cheer you up?	1	2	3	4	5	6
26. Have you felt calm and peaceful?	1	2	3	4	5	6
27. Did you have a lot of energy?	1	2	3	4	5	6
28. Have you felt downhearted and blue?	1	2	3	4	5	6
29. Did you feel worn out?	1	2	3	4	5	6
30. Have you been a happy person?	1	2	3	4	5	6
31. Did you feel tired?	1	2	3	4	5	6

32. During the past 4 weeks, how much of the time has your physical health or emotional health problems interfered with your social activities (like visiting with friends, relatives, etc.)?

(circle one number)

- All of the time..... 1
- Most of the time..... 2
- Some of the time..... 3
- A little of the time..... 4
- None of the time..... 5

How TRUE or FALSE is each of the following statements for you?

		Definitely true	Mostly true	Don't know	Mostly false	Definitely false
33.	I seem to get sick a little easier than other people...	1	2	3	4	5
34.	I am as health as anybody I know.....	1	2	3	4	5
35.	I expect my health to get worse.....	1	2	3	4	5
36.	My health is excellent....	1	2	3	4	5

Please answer YES or NO for each question by circling "1" or "2" on each line.

		<u>Yes</u>	<u>No</u>
37.	In the past year, have you had 2 weeks or more during which you felt sad, blue or depressed; or when you lost all interest or pleasure in things that you usually cared about of enjoyed?..	1	2
38.	Have you had 2 years or more in your life when you felt depressed or sad most days, even if you felt okay sometimes?.....	1	2
39.	Have you felt depressed or sad much of the time in the past year?.....	1	2

Oswestry Low Back Pain Scale

Please rate the severity of your pain by circling a number below:

No pain

0	1	2	3	4	5	6	7	8	9	10
---	---	---	---	---	---	---	---	---	---	----

Unbearable pain

Name _____ 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 mark the **ONE NUMBER** in each section, which most closely describes your problem. We realize you may consider that two of the statements in any one section relate to you, but only mark the box, which most closely describes your problem.

Section 1 – Pain Intensity Section

0. The pain comes and goes and is very mild.
1. The pain is mild and does not vary much.
2. The pain comes and goes and is moderate.
3. The pain is moderate and does not vary much.
4. The pain comes and goes and is severe.
5. The pain is severe and does not vary much.

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

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

Section 3 – Lifting

0. I can lift heavy weights without extra pain.
1. I can lift heavy weights but it gives extra pain.
2. Pain prevents me lifting heavy weights off the floor.
3. Pain prevents me lifting heavy weights off the floor, but I can manage if they are conveniently positioned, e.g., on a table.
4. Pain prevents me lifting heavy weights but I can manage light to medium weights if they are conveniently positioned.
5. I can only lift very light weights at most.

Section 4 – Walking

0. I have no pain on walking.
1. I have some pain on walking but it does not increase with distance.
2. I cannot walk more than 1 mile without increasing pain.
3. I cannot walk more than ½ mile without increasing pain.
4. I cannot walk more than ¼ mile without increasing pain.
5. I cannot walk at all without increasing pain.

Section 5 – Sitting Section

0. I can sit in any chair as long as I like.
1. I can sit only in my favorite chair as long as I like.
2. Pain prevents me from sitting more than 1 hour.
3. Pain prevents me from sitting more than ½ hour.
4. Pain prevents me from sitting more than 10 minutes.
5. I avoid sitting because it increases pain immediately.

6 – Standing

0. I can stand as long as I want without pain.
1. I have some pain on standing but it does not increase with time.
2. I cannot stand for longer than 1 hour without increasing pain.
3. I cannot stand for longer than ½ hour without increasing pain.
4. I cannot stand for longer than 10 minutes without increasing pain.
5. I avoid standing because it increases the pain immediately.

Section 7 – Sleeping

0. I get no pain in bed.
1. I get pain in bed but it does not prevent me from sleeping well.
2. Because of pain my normal nights sleep is reduced by less than one-quarter.
3. Because of pain my normal nights sleep is reduced by less than one-half.
4. Because of pain my normal nights sleep is reduced by less than three-quarters.
5. Pain prevents me from sleeping at all.

Section 8 – Social Life

0. My social life is normal and gives me no pain.
1. My social life is normal but it increases the degree of pain.
2. Pain has no significant effect on my social life apart from limiting my more energetic interests, e.g., dancing, etc.
3. Pain has restricted my social life and I do not go out very often.
4. Pain has restricted my social life to my home.
5. I have hardly any social life because of the pain.

Section 9 – Traveling

0. I get no pain when traveling.
1. I get some pain when traveling but none of my usual forms of travel make it any worse.
2. I get extra pain while traveling but it does not compel me to seek alternate forms of travel.
3. I get extra pain while traveling which compels to seek alternative forms of travel.
4. Pain restricts me to short necessary journeys under ½ hour.
5. Pain restricts all forms of travel.

10 – Changing Degree of Pain

0. My pain is rapidly getting better.
1. My pain fluctuates but is definitely getting better.
2. My pain seems to be getting better but improvement is slow.
3. My pain is neither getting better nor worse.
4. My pain is gradually worsening.
5. My pain is rapidly worsening.

TOTAL _____

Neck Pain Disability Index

Please rate the severity of your pain by circling a number below:

No pain

0	1	2	3	4	5	6	7	8	9	10
---	---	---	---	---	---	---	---	---	---	----

Unbearable pain

Name _____ 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 mark the **ONE NUMBER** in each section, which most closely describes your problem. We realize you may consider that two of the statements in any one section relate to you, but only mark the box, which most closely describes your problem.

Section 1 – Pain Intensity Section

- 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.

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

- 0. I can look after myself normally without causing 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 help every day in most aspects of self-care.
- 5. I do not get dressed; I 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 gives extra pain.
- 2. Pain prevents me lifting heavy weights off the floor, but I can manage if they are conveniently positioned, e.g., on a table
- 3. Pain prevents me lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
- 4. I can lift very light weights.
- 5. I cannot lift or carry anything at all.

Section 4 – Reading

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

Section 5 – Headaches

- 0. I have no headaches at all.
- 1. I have slight headaches, which come in-frequently.
- 2. I have moderate headaches, which come in-frequently.
- 3. I have moderate headaches, which come frequently.
- 4. I have severe headaches, which come frequently.
- 5. I have headaches almost all the time.

6 – Concentration

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

Section 7 – Work

- 0. I can do as much work 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 work at all.
- 5. I can't do any work at all.

Section 8 – Driving

- 0. I can drive my car without any neck pain.
- 1. I can drive my car as long as I want with slight pain in my neck.
- 2. I can drive my car as long as I want with moderate pain in my neck.
- 3. I can't drive my car as long as I want because of moderate pain in my neck.
- 4. I can't drive my car as long as I want because of moderate pain in my neck.
- 5. I can't drive my car at all because of the pain.

Section 9 – Sleeping

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

Section 10 – Recreation

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

TOTAL _____