FOR PATIENT

Please bring the following documents with you on your next visit.

- ☐ Your **Auto Insurance Card** & **Coverage Declaration pages** (showing your policy details and limits)
- ☐ Any **Medical Records** relating to accident (ambulance, ER, hospital, urgent care, doctor, X-rays, CT/MRI scans, prescriptions for medications, physical therapy, etc..)
- ☐ **Police Report**
- ☐ **Auto Body Shop damage estimate**/report & any pictures taken of your vehicle
- ☐ **Insurance Claims Adjusters** info (claim #, company, address, tel#, fax#)
- ☐ **Insurance info of Other Person** that hit you (company, address, tel#, fax#)
- ☐ Any **Photos** taken (auto accident scene, vehicles, road conditions, bodily injury, auto body shop, etc.)

We can help you determine if an attorney referral is required or not.
We may also refer you to MRI centers, Medical Specialists & other professionals if medically necessary.
If you have any questions or concerns, please ask us to schedule your FREE CONSULTATION.

Personal Injury Questionnaire

PLEASE PRINT CLEARLY - All Information is required for your injury case.

Please provide us with your: Driver's License • Health Insurance cards
Auto Insurance info • All Police, Medical, Accident Reports

Who referred you to our Center?

☐Referred by* ☐Internet website* ☐Health Fair/Event* ☐Met Doctor* ☐Drove by

***Name**:_____

A. Patient Information

Patient's First & Last Name: _____
Email :_____
Home Phone #: ( )_____ Cell/Pager/Other #: ( )_____
Address: _____ Apt/Suite#:_____ City: _____ State: ___ Zip:_____
Date of Birth: _____ Gender: Male Female Marital Status: single / married / widowed/ divorced
Driver's License #: _____

Emergency Contact Name: _____ Tel #: ( ) _____
Relationship to Patient:_____
Address: _____ Apt/Suite#:_____ City: _____ State: ____ Zip:_____
Home Phone #: ( ) _____ Cell/Pager/Other #: ( )_____
Work Phone #: ( ) _____ Extension: _____ Email:_____

B. Patient Employment Information

☐Student → ☐ Full Time ☐Part Time School Name: _____

☐Not employed ☐Employed → ☐Full Time ☐Part Time ☐Self-employed →_____

Employer: _____ Job title: _____
Address: _____ Apt/Suite#:____ City: _____ State: ____ Zip:_____
Work Phone #: ( ) _____ Extension: _____ Work Email:_____

C. Patient Health Insurance Information

Do you currently have Health Insurance: ☐ No ☐ Yes→ Complete below

Name of Insured/Subscriber: _____
Relationship: ☐ Self ☐ Spouse ☐ Child ☐ Parent ☐ Legal Guardian ☐ Other: _____
Insurance Company: _____
Plan Type: ☐ PPO ☐ HMO ☐ Medicare ☐ Other: _____
ID #: _____ Policy #: _____ Group #: _____
Insurance Tel # (on back of card): ( ) _____
Name of Primary Care Doctor: _____ Tel #: ( ) _____

D. Patient's Attorney Information

Have you hired an attorney: ☐No ☐Yes→ Attorney First & Last Name:_____
Law Firm/Office Name:_____
Paralegal/Assistant's Name: _____
Address: _____ Suite#:_____ City: _____ State: ____ Zip: _____
Work Phone #: ( ) _____ Extension: _____
Fax: ( ) _____ Email address:_____

E. Incident Details

1) **Please check all boxes that relate to your type of injury case:**
☐ Automobile ☐ Motorcycle ☐ Bicycle ☐ Bus ☐ Metro Rail ☐ Boat ☐ Train
☐ Slip/Trip/Fall ☐ Amusement Park ☐ Work related/Driving for Employer
☐ Other:_____

2) **At the time of injury, were you a:** ☐ Driver ☐ Passenger ☐ Pedestrian ☐ Bicyclist
☐ Other: _____

3) **Incident Occurred on**: Date: _____ City & State: _____
Street/Freeway Intersection or Location:_____

4) **Describe the incident in your own words using specific details:**

_____

_____

_____

5) **Draw a diagram of the incident scene. Show positions of all parties involved**:
e.g.[V1]=Your vehicle [V2]=Other vehicle

6) **After the first collision, there was a**: ☐ second collision ☐ third collision ☐ more than 3 collisions

7) **What type(s) of collision/incident was involved: CHECK ALL THAT APPLY**:
☐ Two-vehicle crash ☐ Three or more vehicles ☐ Rear-end crash ☐ Head-on crash ☐ Rollover
☐ Tailbone/side crash ☐ Hit guardrail/tree ☐ Ran off road ☐ Not sure
☐ Other:_____

8) **Did police/authorities arrive on scene**: ☐No ☐Yes→Was a written report made: ☐No ☐Yes

F. Your Vehicle Information

1) Were you in a vehicle that belonged to your company of employment (e.g. company car) ☐No ☐Yes
2) Were you: ☐ Driver ☐ Front center passenger ☐ Front right passenger
☐ Rear right passenger ☐ Rear center passenger ☐ Rear left passenger ☐ Pedestrian
3) Seatbelt pain: ☐No ☐Yes Head hit headrest: ☐No ☐Yes Pain from deployed Airbags: ☐No ☐Yes
4) **Were you hit from**: ☐ BEHIND ☐ FRONT ☐ LEFT SIDE ☐ RIGHT SIDE
5) **Have you taken your vehicle to an auto body shop:** ☐No ☐Yes→Damage Estimate: $_____
☐total loss
6) **Was your car towed:** ☐No ☐Yes
7) **Was there any part inside OR outside your vehicle that broke, bent or was damaged** (eg: car seat back, mirrors, windows, doors, etc..): ☐No ☐Yes→_____
8) **Your Vehicle Make**: _____ **Model**: _____
☐small car ☐mid-size car ☐full-size car ☐pick up truck ☐SUV ☐van ☐large truck/bus/semi

G. Your Current Injuries & Symptoms due to Incident

1) **Please describe how you felt...[e.g. cuts, scrapes, bruises, pain, stiff, sore, emotions, etc..]**
IMMEDIATELY AFTER the incident: ☐unconscious ☐dizzy/dazed ☐disoriented
☐nervous ☐nauseous ☐upset ☐weak
☐other:_____
LATER that day: _____
The NEXT day: _____

2) CURRENT COMPLAINTS: Check **ALL** symptoms you have noticed since the incident:

*Note Your Current Intensity of Pain (0=no pain through 10=constant severe pain).
*CIRCLE R=right OR L=left OR BOTH

☐*Head pain=__/10	☐jaw/TMJ pain	☐impatient	☐face flushed	☐feet cold
☐*Neck pain=__/10	☐chest pain	☐shortness of breath	☐buzzing in ears	☐hands cold
☐*Upper back pain=__/10	☐eye pain	☐coughing	☐hiccups	☐fever
☐*Mid back pain=__/10	☐abdominal pain	☐tension	☐grinding teeth	☐vomiting
☐*Low back pain=__/10	☐jaw clenching	☐irritability	☐nervous	☐restless
☐*R/L Shoulder pain=__/10	☐dizziness	☐fatigue	☐loss of balance	☐stomach upsets
☐ *R/L Elbow pain=__/10	☐head is "heavy"	☐depression	☐fainting	☐constipation
☐ *R/L Wrist pain=__/10	☐mood swings	☐light sensitivity	☐loss of smell	☐cold sweats
☐ *R/L Hip pain=__/10	☐disoriented	☐loss of memory	☐loss of taste	☐hot sweats
☐ *R/L Knee pain=__/10	☐unconscious	☐ringing in ears	☐diarrhea	☐anxiety
☐ *R/L Ankle pain=__/10	☐headaches	☐blurred vision	☐confused	☐difficulty sleeping
☐ *R/L Foot pain=__/10	☐difficulty swallowing		☐fear of driving/entering a vehicle	
	☐ loss of concentration/difficult to focus on tasks			☐ nightmares

☐ **Broken bones**→regions:_____
☐ **Open cuts/Scrapes**→regions:_____
☐ **Bruising (blue/red discoloration)**→regions:_____
☐ **Muscle spasms**→regions:_____
☐ **Muscle Weakness**: →regions: _____
☐ **Numbness/Tingling/Pins & Needles**:→regions:_____
☐ **Head pain** that travels/radiates to: ☐ left side of head ☐ right side of head ☐ both sides of head
☐ front of head ☐ back of head ☐ top of head ☐ neck ☐ other:_____
☐ **Neck pain** that travels/radiates to: ☐ left shoulder ☐ left arm ☐ left forearm ☐ left hand
☐ right shoulder ☐ right arm ☐ right forearm ☐ right hand ☐ other:_____
☐ **Low Back pain** that travels/radiates to: ☐ left buttock ☐ left thigh ☐ left knee ☐ left foot
☐ right buttock ☐ right thigh ☐ right knee ☐ right foot ☐ other:_____
☐ **ANY OTHER SYMPTOMS**:_____

3) **List any part of your body that struck anything inside your vehicle** (eg: door, window, roof, dashboard, steering wheel, seatbelt harness, air bag, etc.): _____

4) **Were you knocked unconscious:** ☐No ☐Yes→For how long: ____ minutes/hours/days ☐ not sure

5) Where did you go RIGHT AFTER the accident?

→☐ HOSPITAL / URGENT CARE **OR** →☐ DOCTOR'S OFFICE

How did you get to the hospital/office: ☐ Ambulance ☐ Drove yourself ☐ Other:_____
Hospital/Clinic Name:_____ **Doctor's name**:_____
MRI scans taken: ☐ Head ☐ Neck ☐ Back ☐ None ☐ Other region:_____
CT scans taken: ☐ Head ☐ Neck ☐ Back ☐ None ☐ Other region:_____
X-rays taken: ☐ Head ☐ Neck ☐ Back ☐ None ☐ Other region:_____
All Diagnoses:_____
Treatment/Supports received: ☐ exam only ☐ stitches ☐ bandages ☐ neck collar ☐ crutches ☐ cane
☐ Other:_____
All medications prescribed: ☐ "Pain killer" ☐ "Muscle relaxer" ☐ "Anti-Inflammatory" ☐ None
☐ Other Medications: _____

6) As a result of this incident, have you seen any OTHER Doctor, Health Care Provider or Therapist:

☐ **URGENT CARE / AFTER HOURS CLINIC → Date(s):** _____

☐ **DOCTOR / PROVIDER OFFICE → Date(s):** _____

Clinic name:_____ **Doctor/Provider name:**_____

Area of Specialty/Type of Provider: ☐ Medical Doctor ☐ Primary Care Dr ☐ Orthopedic surgeon ☐ Pain Management Dr ☐ Chiropractor ☐ Acupuncturist ☐ Physical therapist ☐ Massage therapist ☐ Other: _____

All Diagnoses:_____

Treatment received: ☐ Exam only ☐ Surgery ☐ Stitches ☐ Bandages ☐ Injections

All medications prescribed:

7) Any other treatment received for this condition:

☐ No ☐Yes→Date(s) of treatment_____ Treatment Details: _____

_____

H. Your Daily Activities at Home/Work/School

1) **Since this injury, have you lost time from work/school:** ☐ No ☐Yes→List dates missed:

_____

2) **Are you currently working?**

☐**No** → Are you: ☐ looking for employment ☐ "stay at home" parent ☐ other:_____

☐**Yes** → Are you on: ☐ regular duty ☐ light duty ☐ part time ☐ other:_____

3) **Do you notice any activities that are difficult to do at WORK / SCHOOL as a result of this injury?** ☐No ☐Yes → Details: _____

_____

4) **Do you notice any activities that are difficult to do at HOME as a result of this injury?**

☐No ☐Yes → Details: _____

_____

5) **Since the incident, do you have more difficulty at home with raising children?** ☐N/A ☐No ☐Yes→# Kids_____ → List Ages:_____

6) **Do you require assistance from another family member/friend or hired help/nanny?**

☐No ☐Yes→Details: _____

7) **Since the incident, are there any activities that you are now no longer able to enjoy OR have difficulty doing due to incident** (e.g. hobbies, sports, domestic duties, household duties, etc....)?

☐No ☐Yes→Details: _____

I. Your Previous Medical History [NOT relating to current injury/incident]

1)Previous Results/Findings/Diagnoses:_____

2) Results of Previous Blood/Lab Tests: _____

3) Results of Previous X-rays/CT/MRI: _____

4) Other Tests: :_____

5) **For Women**: Is there any chance you may be pregnant: ☐ No ☐ Yes→# weeks:_____

_____

6) **All Prescribed Medications** (before incident):_____

7) **All Over-The-Counter Medications** (before incident):_____

8) **Do you have any congenital (from birth) factors which relate to your condition:**

☐ No ☐ Yes→details/dates: _____

9) **Do you have any <u>previous</u> illnesses/complications from previous injuries:**
☐ No ☐ Yes→details/dates: _____

10) **Have you ever been involved in any accident <u>in the last 10 years</u>:** ☐ No ☐ Yes→details/dates:

_____

Treatment Received for <u>previous</u> injuries: ☐ None ☐ Yes→details:_____

_____

Any residual pain/symptoms/complications from <u>previous</u> injuries: ☐ None ☐ Yes→details:

_____

11) **Did you have any physical complaints <u>before</u> this incident**: ☐ No ☐ Yes→_____

_____

12) **Have you <u>ever</u> been to the hospital for any reason (surgery, trauma, childhood, etc.):**
☐ No ☐ Yes→details/dates:_____

J. Your *<u>Previous</u>* Medical Concerns **[NOT related to current incident]**
Check ALL of the following that apply to you.

YES	*NO*		*YES*	*NO*	
☐	☐	Loss of consciousness/head injuries	☐	☐	Lupus
☐	☐	Seizures/Epilepsy/Convulsions	☐	☐	Diabetes
☐	☐	Dizziness/Fainting	☐	☐	Pacemaker
☐	☐	Visual disturbances/Eye problems	☐	☐	Hernia
☐	☐	Nose, throat, breathing problems	☐	☐	Osteoporosis
☐	☐	Asthma, allergies, allergic reactions	☐	☐	Sleep apnea/sleep conditions
☐	☐	Diarrhea, constipation	☐	☐	Menstrual problems
☐	☐	Numbness in groin/buttocks	☐	☐	Urinary problems
☐	☐	Abnormal/rapid weight gain/loss	☐	☐	Recent fever
☐	☐	High blood pressure	☐	☐	Corticosteroid – cortisone, prednisone
☐	☐	Artificial joints	☐	☐	Birth control pills
☐	☐	Pain at night	☐	☐	Alcohol/tobacco/drug abuse
☐	☐	Pain unrelieved by position/rest	☐	☐	Rheumatoid arthritis
☐	☐	Morning pain/stiffness	☐	☐	Blood disease: _____
☐	☐	Cancer/tumor/lumps: _____			
☐	☐	Stroke [date/complications]:_____			

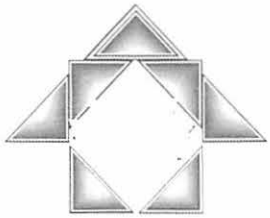
Previous Organ Problems/Diseases: ☐Heart ☐Liver ☐Kidney ☐Stomach ☐Pancreas ☐Lungs ☐Gall bladder ☐Intestines ☐Prostate ☐Uterus ☐Ovaries ☐Thyroid

☐Other:_____

_____

I certify that the above information is complete & accurate to the best of my knowledge.

PATIENT SIGNATURE:_____ **DATE**: _____



Patient Name: _____ Date: _____/_____/20___

Loss of Enjoyment/Duties Under Duress Summary

Complete the following questionnaire as it relates to how your injury(s) affect your performance of your living and work duties. Place a check in front of the day-to-day **living or work duties that are painful or difficult for you to perform as a result of the injuries** you sustained. Then check mark the appropriate box designating reason for difficulty. Include those duties/responsibilities, which require that you reduce the time you are capable of performing them.

Please Print Clearly in Black Ink

Job description: _____

N/A	**Work**	**Reason for the Difficulty/Limitation**			
_____	Lifting	☐ Increased Pain	☐ Restricted Movement	☐ Weakness	☐ Cannot Perform
_____	Bending	☐ Increased Pain	☐ Restricted Movement	☐ Weakness	☐ Cannot Perform
_____	Sitting	☐ Increased Pain	☐ Restricted Movement	☐ Weakness	☐ Cannot Perform
_____	Walking	☐ Increased Pain	☐ Restricted Movement	☐ Weakness	☐ Cannot Perform
_____	Computer Duties	☐ Increased Pain	☐ Restricted Movement	☐ Fatigue	☐ Cannot Perform
_____	Other: _____	☐ Increased Pain	☐ Restricted Movement	☐ Weakness	☐ Cannot Perform

N/A	**Studies/School**	**Reason for the Difficulty/Limitation**			
_____	Lifting	☐ Increased Pain	☐ Restricted Movement	☐ Weakness	☐ Cannot Perform
_____	Bending	☐ Increased Pain	☐ Restricted Movement	☐ Weakness	☐ Cannot Perform
_____	Sitting	☐ Increased Pain	☐ Restricted Movement	☐ Weakness	☐ Cannot Perform
_____	Walking	☐ Increased Pain	☐ Restricted Movement	☐ Weakness	☐ Cannot Perform
_____	Computer Duties	☐ Increased Pain	☐ Restricted Movement	☐ Fatigue	☐ Cannot Perform
_____	Studying	☐ Increased Pain	☐ Restricted Movement	☐ Fatigue	☐ Cannot Perform
_____	Other: _____	☐ Increased Pain	☐ Restricted Movement	☐ Weakness	☐ Cannot Perform

N/A	**Domestic Duties**	**Reason for the Difficulty/Limitation**			
_____	Vacuuming	☐ Increased Pain	☐ Restricted Movement	☐ Fatigue	☐ Cannot Perform
_____	Taking Care of Kids	☐ Increased Pain/Anxiety	☐ Restricted Movement	☐ Fatigue	☐ Cannot Perform
_____	Cleaning	☐ Increased Pain	☐ Restricted Movement	☐ Fatigue	☐ Cannot Perform
_____	Preparing Meals	☐ Increased Pain	☐ Restricted Movement	☐ Fatigue	☐ Cannot Perform
_____	Other: _____	☐ Increased Pain/Anxiety	☐ Restricted Movement	☐ Fatigue	☐ Cannot Perform

N/A	**Household Duties**	**Reason for the Difficulty/Limitation**			
_____	Yardwork	☐ Increased Pain	☐ Restricted Movement	☐ Fatigue	☐ Cannot Perform
_____	Transportation	☐ Increased Pain/Anxiety	☐ Restricted Movement	☐ Fatigue	☐ Cannot Perform
_____	Shopping	☐ Increased Pain/Anxiety	☐ Restricted Movement	☐ Fatigue	☐ Cannot Perform
_____	Taking Out Trash	☐ Increased Pain	☐ Restricted Movement	☐ Weakness	☐ Cannot Perform
_____	Other: _____	☐ Increased Pain	☐ Restricted Movement	☐ Weakness	☐ Cannot Perform

N/A **Sports**
Name Sport: _____
Pre-Accident Level of Participation:

Reason for the Difficulty/Limitation
☐ Increased Pain ☐ Restricted Movement ☐ Weakness ☐ Cannot Perform
☐ Socially ☐ Competitively ☐ Professional

Patient Name: _____

Date: _____

The Rivermead Post-Concussion Symptoms Questionnaire*

After a head injury or accident some people experience symptoms which can cause worry or nuisance. We would like to know if you now suffer from any of the symptoms given below. As many of these symptoms occur normally, we would like you to compare yourself now with before the accident. For each one, please circle the number closest to your answer.

0 = Not experienced at all
1 = No more of a problem
2 = A mild problem
3 = A moderate problem
4 = A severe problem

Compared with before the accident, do you now (i.e., over the last 24 hours) suffer from:

Headaches	0	1	2	3	4
Feelings of Dizziness	0	1	2	3	4
Nausea and/or Vomiting	0	1	2	3	4
Noise Sensitivity, easily upset by loud noise	0	1	2	3	4
Sleep Disturbance	0	1	2	3	4
Fatigue, tiring more easily	0	1	2	3	4
Being Irritable, easily angered	0	1	2	3	4
Feeling Depressed or Tearful	0	1	2	3	4
Feeling Frustrated or Impatient	0	1	2	3	4
Forgetfulness, poor memory	0	1	2	3	4
Poor Concentration	0	1	2	3	4
Taking Longer to Think	0	1	2	3	4
Blurred Vision	0	1	2	3	4
Light Sensitivity, Easily upset by bright light	0	1	2	3	4
Double Vision	0	1	2	3	4
Restlessness	0	1	2	3	4

Are you experiencing any other difficulties?

1. _____	0	1	2	3	4
2. _____	0	1	2	3	4

*King, N., Crawford, S., Wenden, F., Moss, N., and Wade, D. (1995) J. Neurology 242: 587-592

Name_____ Date_____

Sleep Quality Assessment (PSQI)

What is PSQI, and what is it measuring?

The Pittsburgh Sleep Quality Index (PSQI) is an effective instrument used to measure the quality and patterns of sleep in adults. It differentiates "poor" from "good" sleep quality by measuring seven areas (components): subjective sleep quality, sleep latency, sleep duration, habitual sleep efficiency, sleep disturbances, use of sleeping medications, and daytime dysfunction

INSTRUCTIONS:

The following questions relate to your usual sleep habits during the past month only. Your answers should indicate the most accurate reply for the majority of days and nights in the past month. Please answer all questions.

1. When have you usually gone to bed? _____
2. How long (in minutes) has it taken you to fall asleep each night? _____
3. What time have you usually gotten up in the morning? _____
4. A. How many hours of actual sleep did you get at night? _____
   B. How many hours were you in bed? _____

5. , how often have you had trouble sleeping because you	Not during the past month (0)	Less than once a week (1)	Once or twice a week (2)	Three or more times a week (3)
A. Cannot get to sleep within 30 minutes				
B. Wake up in the middle of the night or early morning				
C. Have to get up to use the bathroom				
D. Cannot breathe comfortably				
E. Cough or snore loudly				
F. Feel too cold				
G. Feel too hot				
H. Have bad dreams				
I. Have pain				
J. Other reason (s), please describe, including how often you have had trouble sleeping because of this reason (s):				
6. how often have you taken medicine (prescribed or "over the counter") to help you sleep?				
7. , how often have you had trouble staying awake while driving, eating meals, or engaging in social activity?				
8. how much of a problem has it been for you to keep up enthusiasm to get things done?				
9. how would you rate your sleep quality overall?	Very good (0)	Fairly good (1)	Fairly bad (2)	Very bad (3)

Scoring

Component 1	#9 Score	C1 _____
Component 2	#2 Score (<15min (0), 16-30min (1), 31-60 min (2), >60min (3)) + #5a Score (if sum is equal 0=0; 1-2=1; 3-4=2; 5-6=3)	C2 _____
Component 3	#4 Score (>7(0), 6-7 (1), 5-6 (2), <5 (3)	C3 _____
Component 4	(total # of hours asleep) / (total # of hours in bed) x 100 >85%=0, 75%-84%=!, 65%-74%=2, <65%=3	C4 _____
Component 5	# sum of scores 5b to 5j (0=0; 1-9=1; 10-18=2; 19-27=3)	C5 _____
Component 6	#6 Score	C6 _____
Component 7	#7 Score + #8 score (0=0; 1-2=1; 3-4=2; 5-6=3)	C7 _____

Add the seven component scores together _____ *Global PSQI* _____

A total score of "5" or greater is indicative of poor sleep quality.
If you scored "5" or more it is suggested that you discuss your sleep habits with a healthcare provider

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.***

SECTION 1 - Pain Intensity 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.	*SECTION 6 - Concentration/* 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.
SECTION 2 -Personal Care (Washing, Dressing, etc.) 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.	*SECTION 7 - Work* 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.
SECTION 3 - Lifting 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.	*SECTION 8 – Driving* 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.
SECTION 4 - Reading 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.	*SECTION 9 – Sleeping* 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)
SECTION 5 – Headaches 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.	*SECTION 10 – Recreation* 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.

COMMENTS: _____

_____

_____

Vernon H, Mior S. The Neck Disability Index: A study of reliability and validity. J Manipulative Physiol Ther 1991;14:409-415.

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***.

SECTION 1 - Pain Intensity
- 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.

SECTION 2 - Personal Care (washing, dressing, etc.)
- A ☐ I can look after myself normally without causing extra pain.
- B ☐ I can look after myself normally but it is very painful.
- 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, wash with difficulty and stay in bed.

SECTION 3 - Lifting
- A ☐ I can lift heavy weights without extra pain.
- B ☐ I can lift heavy weights, but it causes extra pain.
- C ☐ 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 ☐ Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
- E ☐ I can only lift very light weights, at the most.
- F ☐ I cannot lift or carry anything at all.

SECTION 4 - Walking
- A ☐ Pain does not prevent me from walking any distance.
- B ☐ Pain prevents me from walking more than one mile.
- C ☐ Pain prevents me from walking more than 1/4 mile.
- D ☐ Pain prevents me from walking more than 100 yards.
- E ☐ I can only walk while using a stick or crutches.
- F ☐ I am in bed most of the time and have to crawl to the toilet.

SECTION 5 - Sitting
- A ☐ I can sit in any chair as long as I like.
- B ☐ I can only sit in my favorite chair as long as I like.
- C ☐ Pain prevents me from sitting more than 1 hour.
- D ☐ Pain prevents me from sitting more than 1/2 hour.
- E ☐ Pain prevents me from sitting more than ten minutes.
- F ☐ Pain prevents me from sitting at all.

SECTION 6 - Standing
- A ☐ I can stand as long as I want without extra pain.
- B ☐ I can stand as long as I want but it gives me extra pain.
- C ☐ Pain prevents me from standing for more than 1 hour.
- D ☐ Pain prevents me from standing for more than 1/2 hour.
- E ☐ Pain prevents me from standing for more than 10 minutes.
- F ☐ Pain prevents me from standing at all.

SECTION 7 - Sleeping
- A ☐ My sleep is never disturbed by pain.
- B ☐ My sleep is occasionally disturbed by pain.
- C ☐ Because of pain I have less than 6 hours' sleep.
- D ☐ Because of pain I have less than 4 hours' sleep.
- E ☐ Because of pain I have less than 2 hours' sleep.
- F ☐ Pain prevents me from sleeping at all.

SECTION 8 - Sex Life (if applicable)
- A ☐ My sex life is normal and causes me no extra pain.
- B ☐ My sex life is normal, but causes some extra pain.
- C ☐ My sex life is nearly normal but is very painful.
- D ☐ My sex life is severely restricted by pain.
- E ☐ My sex life is nearly absent because of pain.
- F ☐ Pain prevents any sex life at all.

SECTION 9 - Social Life
- A ☐ My social life is normal and causes me no extra pain.
- B ☐ My social life is normal, but increases the degree of pain.
- C ☐ Pain has no significant effect on my social life apart from limiting my more energetic interests, e.g., sport, etc.
- D ☐ Pain has restricted my social life and I do not go out as often.
- E ☐ Pain has restricted my social life to my home.
- F ☐ I have no social life because of the pain.

SECTION 10 - Traveling
- A ☐ I can travel anywhere without pain.
- B ☐ I can travel anywhere but I gives extra pain.
- C ☐ Pain is bad but I manage journeys over 2 hours.
- D ☐ Pain restricts me to journeys of less than 1 hour.
- E ☐ Pain restricts me to short necessary journeys under 30 minutes.
- F ☐ Pain prevents me from traveling except to receive treatment.

COMMENTS: _____

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Roland, M. and J. Fairbank (2000). "The Roland-Morris Disability Questionnaire and the Oswestry Disability Questionnaire." Spine 25(24): 3115-24.

DISABILITIES OF THE ARM, SHOULDER AND HAND

Please rate your ability to do the following activities in the last week by circling the number below the appropriate response.

	NO DIFFICULTY	MILD DIFFICULTY	MODERATE DIFFICULTY	SEVERE DIFFICULTY	UNABLE
1. Open a tight or new jar.	1	2	3	4	5
2. Write.	1	2	3	4	5
3. Turn a key.	1	2	3	4	5
4. Prepare a meal.	1	2	3	4	5
5. Push open a heavy door.	1	2	3	4	5
6. Place an object on a shelf above your head.	1	2	3	4	5
7. Do heavy household chores (e.g., wash walls, wash floors).	1	2	3	4	5
8. Garden or do yard work.	1	2	3	4	5
9. Make a bed.	1	2	3	4	5
10. Carry a shopping bag or briefcase.	1	2	3	4	5
11. Carry a heavy object (over 10 lbs).	1	2	3	4	5
12. Change a lightbulb overhead.	1	2	3	4	5
13. Wash or blow dry your hair.	1	2	3	4	5
14. Wash your back.	1	2	3	4	5
15. Put on a pullover sweater.	1	2	3	4	5
16. Use a knife to cut food.	1	2	3	4	5
17. Recreational activities which require little effort (e.g., cardplaying, knitting, etc.).	1	2	3	4	5
18. Recreational activities in which you take some force or impact through your arm, shoulder or hand (e.g., golf, hammering, tennis, etc.).	1	2	3	4	5
19. Recreational activities in which you move your arm freely (e.g., playing frisbee, badminton, etc.).	1	2	3	4	5
20. Manage transportation needs (getting from one place to another).	1	2	3	4	5
21. Sexual activities.	1	2	3	4	5

DISABILITIES OF THE ARM, SHOULDER AND HAND

	NOT AT ALL	SLIGHTLY	MODERATELY	QUITE A BIT	EXTREMELY
22. During the past week, *to what extent* has your arm, shoulder or hand problem interfered with your normal social activities with family, friends, neighbours or groups? *(circle number)*	1	2	3	4	5

	NOT LIMITED AT ALL	SLIGHTLY LIMITED	MODERATELY LIMITED	VERY LIMITED	UNABLE
23. During the past week, were you limited in your work or other regular daily activities as a result of your arm, shoulder or hand problem? *(circle number)*	1	2	3	4	5

Please rate the severity of the following symptoms in the last week. *(circle number)*

	NONE	MILD	MODERATE	SEVERE	EXTREME
24. Arm, shoulder or hand pain.	1	2	3	4	5
25. Arm, shoulder or hand pain when you performed any specific activity.	1	2	3	4	5
26. Tingling (pins and needles) in your arm, shoulder or hand.	1	2	3	4	5
27. Weakness in your arm, shoulder or hand.	1	2	3	4	5
28. Stiffness in your arm, shoulder or hand.	1	2	3	4	5

	NO DIFFICULTY	MILD DIFFICULTY	MODERATE DIFFICULTY	SEVERE DIFFICULTY	SO MUCH DIFFICULTY THAT I CAN'T SLEEP
29. During the past week, how much difficulty have you had sleeping because of the pain in your arm, shoulder or hand? *(circle number)*	1	2	3	4	5

	STRONGLY DISAGREE	DISAGREE	NEITHER AGREE NOR DISAGREE	AGREE	STRONGLY AGREE
30. I feel less capable, less confident or less useful because of my arm, shoulder or hand problem. *(circle number)*	1	2	3	4	5

DASH DISABILITY/SYMPTOM SCORE = _____ ([(sum of n responses / n) - 1] x 25, where n is the number of completed responses.)

A DASH score may <u>not</u> be calculated if there are greater than 3 missing items.

THE LOWER EXTREMITY FUNCTIONAL SCALE

We are interested in knowing whether you are having any difficulty at all with the activities listed below because of your lower limb problem for which you are currently seeking attention. Please provide an answer for **each** activity.

Today, do you or would you have any difficulty at all with:

	Activities	Extreme Difficulty or Unable to Perform Activity	Quite a Bit of Difficulty	Moderate Difficulty	A Little Bit of Difficulty	No Difficulty
1	Any of your usual work, housework, or school activities.	0	1	2	3	4
2	Your usual hobbies, re creational or sporting activities.	0	1	2	3	4
3	Getting into or out of the bath.	0	1	2	3	4
4	Walking between rooms.	0	1	2	3	4
5	Putting on your shoes or socks.	0	1	2	3	4
6	Squatting.	0	1	2	3	4
7	Lifting an object, like a bag of groceries from the floor.	0	1	2	3	4
8	Performing light activities around your home.	0	1	2	3	4
9	Performing heavy activities around your home.	0	1	2	3	4
10	Getting into or out of a car.	0	1	2	3	4
11	Walking 2 blocks.	0	1	2	3	4
12	Walking a mile.	0	1	2	3	4
13	Going up or down 10 stairs (about 1 flight of stairs).	0	1	2	3	4
14	Standing for 1 hour.	0	1	2	3	4
15	Sitting for 1 hour.	0	1	2	3	4
16	Running on even ground.	0	1	2	3	4
17	Running on uneven ground.	0	1	2	3	4
18	Making sharp turns while running fast.	0	1	2	3	4
19	Hopping.	0	1	2	3	4
20	Rolling over in bed.	0	1	2	3	4
	Column Totals:					

Minimum Level of Detectable Change (90% Confidence): 9 points

SCORE: _____/ 80

Please submit the sum of responses to ASH

Reprinted from Binkley, J., Stratford, P., Lott, S., Riddle, D., & The North American Orthopaedic Rehabilitation Research Network, The Lower Extremity Functional Scale: Scale development, measurement properties, and clinical application, Physical Therapy, 1999, 79, 4371-383, with permission of the American Physical Therapy Association.