SIERRA
PACIFIC
ORTHOPAEDIC
CENTER
MEDICAL GROUP, INC.

Henry E. Aryan, M.D.
Jonathan Grossman, M.D.
Jerry N. Smith, M.D.
Timothy C. Watson, M.D.
Jeryl J. Wiens, M.D.

Dear:_____,

YOUR APPOINTMENT HAS BEEN SCHEDULED FOR:

DATE:_____/_____/_____ (MON. TUES. WED. THURS. FRI.)

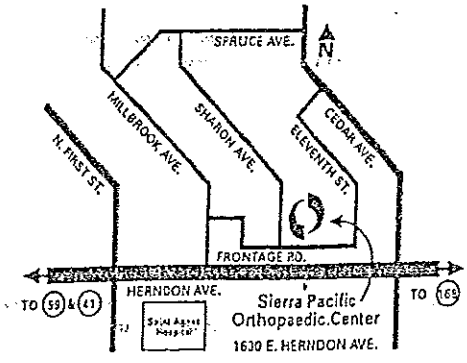
TIME:_____:_____ AM/PM

PLEASE COMPLETE THE ENCLOSED FORMS AND BRING THEM WITH YOU TO YOUR APPOINTMENT.

PLEASE BRING ANY XRAYS, MRI'S, CT'S OR NUCLEAR BONE SCAN FILMS, DOCTOR WILL NEED TO VIEW THEM AT THE TIME OF YOUR VISIT. YOU MAY ALSO CONTACT THE IMAGING CENTER WHERE THE FILMS WERE TAKEN AND HAVE THEM DELIEVERED TO THIS OFFICE PRIOR TO YOUR APPOINTMENT DATE. PLEASE BE SURE TO CHECK WITH OUR OFFICE FOR YOUR FILMS, SO THAT WE DO NOT HAVE TO RESCHEDULE YOUR APPOINTMENT.

IF YOU SHOULD HAVE ANY QUESTIONS PLEASE FEEL FREE TO CONTACT OUR OFFICE AT (559) 256-5200. THANK YOU AND WE LOOK FORWARD TO SEEING YOU SOON.

Sierra Pacific Orthopaedic and Spine Center
1630 E. Herndon Ave.
Fresno, CA 93720
Phone # (559) 256-5200



NAME:_____ DATE:_____

Welcome. Please take your time and read this questionnaire carefully. Please answer all of the questions that pertain to you the best you can. If you feel that more explanation is necessary in any section, feel free to write on the back of the questionnaire. DO NOT USE OTHER MARKS OR COLORS. Thank you.

Mark these drawings according to where you hurt. (If the back of your neck hurts, mar the drawing on the back of the neck, etc.) If you feel any of the following symptoms please indicate where you feel them by placing the marks shown here on the diagram.

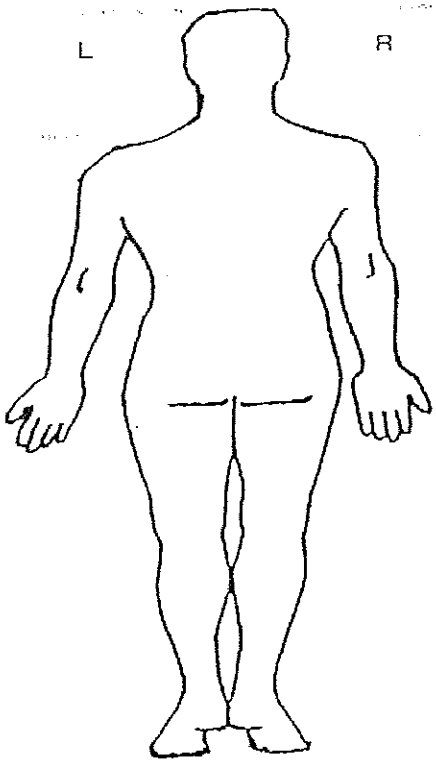
Numbness

Pins and needles oooooooooo oooooooooo

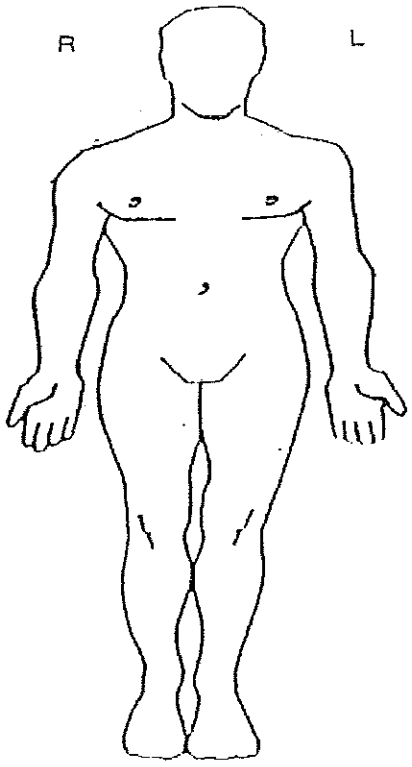
Burning xxxxxxxxxxx xxxxxxxxxxx

Stabbing

Aches



BACK VIEW



FRONT VIEW

BACK AND NECK HISTORY FORM

Instructions: This form has been designed to help the doctor focus in on the pertinent facts regarding your problem and initial visit to his office. Please complete sections II and III only if you had an on the job injury or were involved in a motor vehicle accident. All patients need to complete sections I and IV through VI.

SECTION I General Information (For all patients)

Name: _____ Date: _____

Date of Birth: _____ Age: _____ Sex: M F

Who referred you to our office? _____

Who is your family doctor? _____

In your own words, please describe what your problem is and what you hope to get from this visit. You may use the back of this sheet if necessary.

_____

_____

When did your problem begin or how long have you had it? _____

How did your problem begin? _____

_____

_____

What is, or was, your occupation? _____ Retired ☐

Have you ever had a disability rating before, and if so, why and how much? _____

_____

Are there any other family members with disability or compensation injuries?_____

What is the name of the attorney involved with your present medical problem? _____

Have you ever had back or neck surgery before? If so, describe below.

Date	Type of Surgery and Doctor	Result		
		Helped	Made Worse	No Change
_____	_____	☐	☐	☐
_____	_____	☐	☐	☐
_____	_____	☐	☐	☐

Name _____ **Date of Birth** _____

SECTION II Work Injury (Fill out this section only if your problem is work related (on the job injury).

Date of first injury: _____ Other dates of injury (if any):_____

Employer: _____

Name of Primary Treating Physician_____

What functions does your job require you to do? _____

_____

Are you working now? If not, what was the last date that you worked?_____

How long have you been at this job?_____

Have you had an industrial claim before? If so, please explain._____

_____

_____

Please list previous employers, dates of employment, and job descriptions.

_____

_____

_____

_____

If you were to get better in the next few weeks, would your employer let you return to work?

☐ Yes ☐ No

SECTION III Motor **Vehicle Accident** (Fill out this section only if your problem relates to a motor vehicle accident).

Please describe the accident and note whether you were the driver, passenger, wearing a seat belt, speed of vehicles involved, and other information you think is important.

_____

_____

_____

_____

Name _____ Date of Birth _____

SECTION IV (For all patients)

Are you having problems with your bowels or bladder; for example, loss of control? If so, please describe. _____

Have you ever had problems with your neck or back in the past? If so, please explain. _____

_____

Check ☑ how the following activities affect your discomfort.

	Increase	Decrease	No Effect
Driving	☐	☐	☐
Turning your head	☐	☐	☐
Lying down	☐	☐	☐
Coughing/Sneezing	☐	☐	☐
Getting upset or tension	☐	☐	☐
Straining at a bowel movement	☐	☐	☐
Medications, such as aspirin or Tylenol	☐	☐	☐

Check the joint areas below in which you have weakness. (☑R = Right; ☑L = Left)

Shoulder	☐R☐	☐L☐	Hip	☐R☐	☐L☐	Knee	☐R☐	☐L☐
Ankle	☐R☐	☐L☐	Elbow	☐R☐	☐L☐	Big Toe	☐R☐	☐L☐
Wrist	☐R☐	☐L☐	Thumb	☐R☐	☐L☐	Other Toes	☐R☐	☐L☐
Fingers	☐R☐	☐L☐						

Describe this weakness, if any: _____

Which of the following describes the reason for the weakness?

☐ Pain ☐ Actual loss of a muscle, or muscles ability to move a joint

What has been your most significant life stressor(s)? _____

_____

Name **Date of Birth**

With a total of all of your pain adding up to 100%, what percentage of your pain is:

Neck _____%
Arm _____%
Mid Back _____%
Low Back _____%
Leg _____%
Total ___100___ % (can not add up to more than 100%)

Are you right or left handed? ☐R ☐L

Please use the Pain Guidelines in the box below to express, by number, the amount of pain you are feeling in the areas listed below (back, neck, etc.) (Circle number; ☑R = Right; ☑L = Left)

Pain Guideline:
0 = No pain
1 = Nuisance pain
2 = Mild to moderate pain – Can live with the pain
3 = Moderate pain – Having difficulty dealing with the pain
4 = Severe pain - I cannot function anymore

Neck	0 1 2 3 4	☐R	☐L	Upper Back	0 1 2 3 4	☐R	☐L
Shoulders	0 1 2 3 4	☐R	☐L	Upper Arms	0 1 2 3 4	☐R	☐L
Forearms	0 1 2 3 4	☐R	☐L	Hands	0 1 2 3 4	☐R	☐L
Lower Back	0 1 2 3 4	☐R	☐L	Buttocks	0 1 2 3 4	☐R	☐L
Thighs	0 1 2 3 4	☐R	☐L	Calves	0 1 2 3 4	☐R	☐L
Feet	0 1 2 3 4	☐R	☐L				

Name _____ **Date of Birth** _____

What tests have been performed?

Regular spine x-rays	Date_____	Nuclear Bone Scan	Date_____
CT Scan	Date_____	MRI Scan	Date_____
Discogram	Date_____	Myelogram	Date_____
EMG/Nerve Conduction	Date_____	Nerve Blocks	Date_____
Bone Density	Date_____	PET scan	Date_____

What treatments have you had so far for your problem?

	Not Tried	Helped	Made Worse	No change
Muscle relaxants	☐	☐	☐	☐
Strong pain medications (narcotics)	☐	☐	☐	☐
Aspirin type medications	☐	☐	☐	☐
Anti-depression medications	☐	☐	☐	☐
Electrical stimulation	☐	☐	☐	☐
Physical therapy	☐	☐	☐	☐
Chiropractic treatment	☐	☐	☐	☐
Massage therapy	☐	☐	☐	☐
Acupuncture	☐	☐	☐	☐
Surgery	☐	☐	☐	☐
☐Back exercises	☐	☐	☐	☐
Hot packs	☐	☐	☐	☐
Ultrasound	☐	☐	☐	☐
Ice	☐	☐	☐	☐
TENS unit for home use	☐	☐	☐	☐
Traction	☐	☐	☐	☐
Bedrest	☐	☐	☐	☐
Biofeedback	☐	☐	☐	☐
Local (trigger point) injections	☐	☐	☐	☐
Epidural injections	☐	☐	☐	☐
Facet injections	☐	☐	☐	☐
Percutaneous rhizotomy	☐	☐	☐	☐
Osteopathic treatment	☐	☐	☐	☐
Gravity inversion	☐	☐	☐	☐
Manipulation	☐	☐	☐	☐
Vertebroplasty/Kyphoplasty	☐	☐	☐	☐

Other (please describe)_____

Name_____Date of Birth_____

SECTION V Past Medical History (For all patients)

Please list all unusual childhood illnesses you have had?

_____

Do you have a history of the following medical problems? (Please check all that apply)

- ☐ high blood pressure
- ☐ sugar diabetes
- ☐ thyroid (low/high)
- ☐ heart problems
- ☐ stomach ulcers
- ☐ blood problems
- ☐ vein problems
- ☐ liver problems
- ☐ kidney problems
- ☐ lung problems
- ☐ eye problems
- ☐ gout
- ☐ arthritis
- ☐ bladder problems
- ☐ prostate problems
- ☐ blood clot problems
- ☐ asthma
- ☐ stroke/TIA
- ☐ nerve problems
- ☐ skin problems
- ☐ recurrent infections
- ☐ chronic pain
- ☐ headaches
- ☐ anxiety
- ☐ cancer
- ☐ Other_____

Name **Date of Birth**

If you have been hospitalized in the last five years, please explain._____

_____

Are you, or have you ever been, under the care of a psychiatrist/psychologist? ☐Yes ☐No

If yes, please explain and name of treater._____

Please check all that apply:

☐ Depression ☐ Bipolar disorder ☐ Schizophrenia

☐ Dysthymia ☐ Anxiety ☐ Suicidal

List all previous non back surgeries and dates._____

_____

Are you allergic to anything? If so, please list, and describe your reactive symptoms.

_____

_____

Please list all of your current medications. Please include the strength and dosage. You may use the back of this paper, if necessary.

_____

_____

_____

_____

_____

_____

What illnesses, including psychiatric, do your parents have, if any, or what illnesses tend to run in your family? _____

What are your ethnic background / religion? _____

How much alcohol do you drink on average in a day? ☐ None

Beer_____bottles Wine_____glasses Liquor_____drinks

Do you smoke? ☐ Yes ☐ No If yes, _____ packs per day for _____ years.

Do you use other nicotine products? ☐ Yes ☐ No

If yes, please explain_____

Do you use any recreational drugs? Please list them_____

Are you: ☐ Married ☐ Single ☐ Divorced ☐ Widowed # of children_____

Name _____ **Date of Birth** _____

How much school did you complete?

Grade school _____ year's High school _____ years
Technical school _____ years College _____ years

Present means of support (financial) _____

SECTION VI Review of Systems (For all patients)

Constitutional

1. Yes☐ No ☐ Have you lost weight this last year? How many pounds? _____
2. Yes☐ No ☐ Have you gained weight this year? How many pounds? _____
3. Yes☐ No ☐ Have you had unexplained chills or fevers in the past month?
4. Yes☐ No ☐ Do you have trouble sleeping?
5. Yes☐ No ☐ Are you tired most of the time?

HEENT

6. Yes ☐ No ☐ Are you having vision problems, aside from wearing corrective glasses?
7. Yes ☐ No ☐ Are you having hearing problems?
8. Yes ☐ No ☐ Are you frequently bothered with nosebleeds?
9. Yes ☐ No ☐ Has your voice been persistently hoarse in the past year?
10. Yes ☐ No ☐ Have you had bleeding gums often in the past year?

Neurological

11. Yes ☐ No ☐ Do you have problems with dizziness?
12. Yes ☐ No ☐ Do you frequently feel nervous or upset?
13. Yes ☐ No ☐ Do you often feel discouraged or depressed?
14. Yes ☐ No ☐ Are you subject to fainting or blackout spells?
15. Yes ☐ No ☐ Do you have seizures?
16. Yes ☐ No ☐ Are you often bothered with bad headaches?

Musculoskeletal

17. Yes ☐ No ☐ Do you have frequent swelling, inflammation, or stiffness in any joints?

Immunological

18. Yes ☐ No ☐ Do you have frequent skin rashes?

Respiratory

19. Yes ☐ No ☐ Are you troubled with a chronic cough?
20. Yes ☐ No ☐ Do you regularly cough up much sputum?
21. Yes ☐ No ☐ Have you coughed up blood in the past year?
22. Yes ☐ No ☐ Do you have problems with shortness of breath?

SIERRA PACIFIC ORTHOPAEDIC & SPINE CENTER MEDICAL GROUP INC.

NEW PATIENT REGISTRATION

PLEASE PRINT

Date _____

Patient _____
Last Name First Name Middle Initial

Birthdate _____ Age _____ ____ Male ____ Female Home Phone _____
Address _____ Cell Phone _____
City _____ County _____ State _____ Zip _____
Marital Status ___ Married ____ Single ____ Divorced ____ Widowed Social Security# _____
Driver's License # _____ Email Address _____
Patient Employed By _____ Occupation _____
Business Address _____
City _____ State _____ Zip _____ Business Phone _____
Emergency Contact _____ Relationship _____ Phone Number _____

Responsible Party (if different from above) _____ Relationship _____
Address _____ Birthdate _____
City _____ State _____ Zip _____ Home Phone _____
Social Security # _____ Driver's License # _____
Employer _____
Business Address _____
City _____ State _____ Zip _____ Business Phone _____

Spouse or Other Parent/Guardian Information (Please circle one)
Name _____ Home Phone _____
Employer _____ Business Phone _____

PAYMENT: All charges are due at the time of services, all professional services rendered are charged to the patient. The patient is responsible for all fees, regardless of insurance coverage.
WORKER'S COMP? YES NO MOTOR VEHICLE ACCIDENT? YES NO LITIGATION PENDING? YES NO

Insurance Information (Please present insurance cards to front desk)
Name of Insurance Company _____ Policy Holder's Name _____
Policy Holder's DOB _____ Employer _____
Billing Address _____
Policy Number _____ Group Number _____
Name of Secondary Insurance _____ Policy Holder _____ DOB _____
Billing Address _____ Employer _____
Policy Number _____ Group Number _____
Worker's Comp Carrier _____ Claim Number _____
Date of Injury _____ Adjuster's Name _____ Phone Number _____

Referring Physician or Person _____
Business Address _____
City _____ State _____ Zip _____ Business Phone _____
Family Phyician _____
Business Address _____
City _____ State _____ Zip _____ Business Phone _____

SIERRA PACIFIC ORTHOPAEDIC CENTER
MEDICAL GROUP, INC.

ACCIDENT/INJURY INFORMATION

Patient Name: _____ **Date:** _____

Reason for today's appointment _____
Affected body area(s) _____ ☐ Left ☐ Right ☐ Both
Is the problem related to an accident or injury of any kind? ☐ Yes ☐ No
If yes, please complete the following information:

What is the date of injury? _____ When did symptoms occur? _____
(Please give approximate date)

How did the injury occur? _____
_____

Where did the injury occur? _____

Have you been treated for this condition before? ☐ Yes ☐ No
Name of treating physician _____ Is this a second opinion? ☐ Yes ☐ No
Did you have x-rays taken? ☐ Yes ☐ No If yes, where? _____
Are you presently taking medications? ☐ Yes ☐ No If yes, please list _____

Is this injury work related? ☐ Yes ☐ No If yes, has it been reported to your employer? ☐ Yes ☐ No
Employer contact _____ Phone _____
Is this an accepted worker's compensation case? ☐ Yes ☐ No
Has a first report of injury been done? ☐ Yes ☐ No If yes, by which physician? _____
Insurance Name _____ Claim Number _____
Address _____

Is this injury related to an auto accident? ☐ Yes ☐ No
If yes, is there auto insurance with medical coverage (med pay)? ☐ Yes ☐ No
Insurance Name _____ Claim Number _____
Address _____
Contact person _____ Phone _____

Is there a third party responsible for payment? ☐ Yes ☐ No
Is there litigation involved? ☐ Yes ☐ No
Attorney Name _____ Phone Number _____

SIERRA PACIFIC ORTHOPAEDIC & SPINE CENTER MEDICAL GROUP, INC.

Financial Policy

Welcome to Sierra Pacific Orthopaedic & Spine Center Medical Group, Inc. We would like to take this time to acquaint you with the financial policies of our group. Our goal is to provide you with the highest quality care possible. In order to maintain our goal, we have highly trained staff available to help answer questions you may have regarding your treatment, insurance or billing issues. Please do not hesitate to ask for assistance.

Our office contracts with certain Preferred Provider Organizations (PPOs). If your health care expenses are covered by one of these plans, we require that you pay all deductible, co-pay and co-insurance amounts at the time of service. We will bill your plan for the remaining balance. If we do not contract with your plan, we require payment in full at the time of service. Please remember medical services are rendered directly to each patient at their request, therefore, each patient is responsible to us for payment.

A copy of your insurance card is required at each visit. It is your responsibility to notify Sierra Pacific Orthopaedic & Spine Center Medical Group, Inc. of any changes. This information will be kept in your medical file.

You will receive a monthly statement whenever a balance is due. Charges billed to your insurance plan will be noted on your statement until payment and/or an explanation of benefits (EOB) is received from the insurance company. We will bill your plan directly as a service to you, but not in substitute of your primary responsibility for payment. Charges which have not been paid by the insurance are the patient's responsibility. All patient due balances are expected to be paid within thirty (30) days of receipt of a statement. There will be a $20 service charge on all returned checks.

Request for alternate methods of payment will be reviewed on an individual basis. Every effort will be made to come to an agreed upon methods of payment.

Some of the physicians in Sierra Pacific Orthopaedic & Spine Center Medical Group, Inc., have a financial interest in the following facilities:

Fresno Surgical Hospital
Summit Surgical

I have read the above policy and agree to comply with its provisions. I understand that I am responsible for payment for all medical services rendered. I understand that if I am covered by a third party payment service such as an insurance plan, your office may bill them directly as a convenience to me, but that I am personally responsible for such charges until they are paid in full.

Assignment and Release: *I hereby authorize my insurance benefits to be paid directly to SIERRA PACIFIC ORTHOPAEDIC & SPINE CENTER MEDICAL GROUP, INC., and that I am financially responsible for services that the insurance considers to be non-covered. I authorize SIERRA PACIFIC ORTHOPAEDIC & SPINE CENTER MEDICAL GROUP, INC., to release any information required to process my claim.*

Responsible Party Signature: _____ Date: _____

Acknowledgement of Receipt of Notice of Privacy Practices

Sierra Pacific Orthopaedic Center Medical Group, Inc.
1630 E. Herndon Avenue
Fresno, CA 93720
Chief Privacy Officer 559-256-5398

I hereby acknowledge that I received a copy of Sierra Pacific Orthopaedic Center Medical Group, Inc.'s Notice of Privacy Practices. I have been informed that a copy of the current notice will be posted in the reception area, and on the website.

Signed: _____ Date: _____

Print Name: _____ Telephone: _____

If not signed by the patient, please indicate:

Relationship:

- ☐ parent or guardian of minor patient
- ☐ guardian or conservator of an incompetent patient
- ☐ beneficiary or personal representative of deceased patient

Name of Patient: _____

Name **Date of Birth**

Cardiovascular

23. Yes ☐ No ☐ Do you have problems with chest pain?
24. Yes ☐ No ☐ Do you have chest pressure or tightness when excited?
25. Yes ☐ No ☐ Do you have chest pressure or tightness when walking or working?
26. Yes ☐ No ☐ Does your heart often pound or race?
27. Yes ☐ No ☐ Are your feet or legs unusually swollen by the end of the day?

Gastrointestinal

28. Yes ☐ No ☐ Are you often troubled by stomach discomfort, indigestion, or heartburn?
29. Yes ☐ No ☐ Have you recently noted blood in your stool?
30. Yes ☐ No ☐ Have you had a recent change in bowel habits?
31. Yes ☐ No ☐ Are you bothered by itching around the rectum?

Genitourinary

32. Yes ☐ No ☐ Have you had a recent change in bladder habits?
33. Yes ☐ No ☐ How many times do you get up at night and empty your bladder?____times.
34. Yes ☐ No ☐ Do you have burning or pain when emptying your bladder?
35. Yes ☐ No ☐ Do you have problems starting to empty your bladder?
36. Yes ☐ No ☐ Have you seen blood in your urine?
37. Yes ☐ No ☐ Have you noted any stones in your urine?
38. Yes ☐ No ☐ Do you have problems emptying your bladder completely?

Hematological

39. Yes ☐ No ☐ Do you bleed excessively when cut?

Reproductive

40. Yes ☐ No ☐ Do you have difficulties in your sex life?
41. Yes ☐ No ☐ Women Only: Is your menstrual cycle regular?
42. Yes ☐ No ☐ Women Only: If you have reached menopause, do you still have any bleeding?
43. Yes ☐ No ☐ Women Only: Are you pregnant? Date of last menstrual period? _____
44. Yes ☐ No ☐ Women Only: Have you taken birth control pills in the last 2 weeks?
45. Yes ☐ No ☐ Women Only: Do you notice a change in back discomfort with your menstrual cycle?

Metabolic/Endocrine

46. Yes ☐ No ☐ Do you have generalized weakness?

Please explain any "yes" answers. _____

_____

_____

_____

_____

_____

Name_____ Date_____

DOB_____

Back Disability Questionnaire

This questionnaire has been designed to give us information as to how your back or leg pain is affecting your ability to manage in everyday life. Please answer by checking **one box in each section** for the statement which best applies to you. We realize you may consider that two or more statements in any one section apply but please just shade out the spot that indicates the statement **which most clearly describes your problem.**

Section 1: Pain Intensity

☐ I have no pain at the moment
☐ The pain is very mild at the moment
☐ The pain is moderate at the moment
☐ The pain is fairly severe at the moment
☐ The pain is very severe at the moment
☐ The pain is the worst imaginable at the moment

Section 2: Personal Care (eg. washing, dressing)

☐ I can look after myself normally without causing extra pain
☐ I can look after myself normally but it causes extra pain
☐ It is painful to look after myself and I am slow and careful
☐ I need some help but can manage most of my personal care
☐ I need help every day in most aspects of self-care
☐ I do not get dressed, wash with difficulty and stay in bed

Section 3: Lifting

☐ I can lift heavy weights without extra pain
☐ I can lift heavy weights but it gives me extra pain
☐ Pain prevents me lifting heavy weights off the floor but I can manage if they are conveniently placed eg. on a table
☐ Pain prevents me lifting heavy weights but I can manage light to medium weights if they are conveniently positioned
☐ I can only lift very light weights
☐ I cannot lift or carry anything

Section 4: Walking

☐ Pain does not prevent me walking any distance
☐ Pain prevents me from walking more than 1 mile
☐ Pain prevents me from walking more than ½ mile
☐ Pain prevents me from walking more than ¼ mile
☐ I can only walk using a stick or crutches
☐ I am in bed most of the time

Section 5: Sitting

☐ I can sit in any chair as long as I like
☐ I can only sit in my favorite chair as long as I like
☐ Pain prevents me sitting more than one hour
☐ Pain prevents me from sitting more than 30 minutes
☐ Pain prevents me from sitting more than 10 minutes
☐ Pain prevents me from sitting at all

Section 6: Standing

☐ I can stand as long as I want without extra pain
☐ I can stand as long as I want but it gives me extra pain
☐ Pain prevents me from standing for more than 1 hour
☐ Pain prevents me from standing for more than 30 minutes
☐ Pain prevents me from standing for more than 10 minutes
☐ Pain prevents me from standing at all

Name_____
Date_____

Section 7: Sleeping

☐ My sleep is never disturbed by pain
☐ My sleep is occasionally disturbed by pain
☐ Because of pain I have less than 6 hours sleep
☐ Because of pain I have less than 4 hours sleep
☐ Because of pain I have less than 2 hours sleep
☐ Pain prevents me from sleeping at all

Section 8: Sex Life

☐ My sex life is normal and causes no extra pain
☐ My sex life is normal but causes some extra pain
☐ My sex life is nearly normal but is very painful
☐ My sex life is severely restricted by pain
☐ My sex life is nearly absent because of pain
☐ Pain prevents any sex life at all

Section 9: Social Life

☐ My social life is normal and gives me no extra pain
☐ My social life is normal but increases the degree of pain
☐ Pain has no significant effect on my social life apart from
limiting my more energetic interests e.g. sport
☐ Pain has restricted my social life and I do not go out as
often
☐ Pain has restricted my social life to my home
☐ I have no social life because of pain

Section 10: Traveling

☐ I can travel anywhere without pain
☐ I can travel anywhere but it gives me extra pain
☐ Pain is bad but I manage journeys over two hours
☐ Pain restricts me to journeys of less than one hour
☐ Pain restricts me to short necessary journeys under 30
minutes
☐ Pain prevents me from traveling except to receive treatment

Name:_____ Date_____
DOB:_____

Neck Disability Index
This questionnaire has been designed to give us information as to how your neck pain has affected your ability to manage in everyday life. Please answer every section and **mark in each section only the one box that applies to you.** We realize you may consider that two or more statements in any one section relate to you, but please just mark the box that most closely describes your problem.

Section 1: Pain Intensity
☐ I have no pain at the moment
☐ The pain is very mild at the moment
☐ The pain is moderate at the moment
☐ The pain is fairly severe at the moment
☐ The pain is very severe at the moment
☐ The pain is the worst imaginable at the moment

Section 2: Personal Care (Washing, Dressing, etc.)
☐ I can look after myself normally without causing extra pain
☐ I can look after myself normally but it causes extra pain
☐ It is painful to look after myself and I am slow and careful
☐ I need some help but can manage most of my personal care
☐ I need help every day in most aspects of self care
☐ I do not get dressed, I wash with difficulty and stay in bed

Section 3: Lifting
☐ I can lift heavy weights without extra pain
☐ I can lift heavy weights but it gives extra pain
☐ Pain prevents me lifting heavy weights off the floor, but I can manage if they are conveniently placed, for example on a table
☐ Pain prevents me from lifting heavy weights but I can manage light to medium weights if they are conveniently positioned
☐ I can only lift very light weights
☐ I cannot lift or carry anything

Section 4: Reading
☐ I can read as much as I want to with no pain in my neck
☐ I can read as much as I want to with slight pain in my neck
☐ I can read as much as I want with moderate pain in my neck
☐ I can't read as much as I want because of moderate pain in my neck
☐ I can hardly read at all because of severe pain in my neck
☐ I cannot read at all

Section 5: Headaches
☐ I have no headaches at all
☐ I have slight headaches, which come infrequently
☐ I have moderate headaches, which come infrequently
☐ I have moderate headaches, which come frequently
☐ I have severe headaches, which come frequently
☐ I have headaches almost all the time

Section 6: Concentration
☐ I can concentrate fully when I want to with no difficulty
☐ I can concentrate fully when I want to with slight difficulty
☐ I have a fair degree of difficulty in concentrating when I want to
☐ I have a lot of difficulty in concentrating when I want to
☐ I have a great deal of difficulty in concentrating when I want to
☐ I cannot concentrate at all

Section 7: Work
☐ I can do as much work as I want to
☐ I can only do my usual work, but no more
☐ I can do most of my usual work, but no more
☐ I cannot do my usual work
☐ I can hardly do any work at all
☐ I can't do any work at all

Section 8: Driving
☐ I can drive my car without any neck pain
☐ I can drive my car as long as I want with slight pain in my neck
☐ I can drive my car as long as I want with moderate pain in my neck
☐ I can't drive my car as long as I want because of moderate pain in my neck
☐ I can hardly drive at all because of severe pain in my neck
☐ I can't drive my car at all

Name_____
Date_____
DOB_____

Section 9: Sleeping

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

Section 10: Recreation

☐ I am able to engage in all my recreation activities with no neck pain at all
☐ I am able to engage in all my recreation activities, with some pain in my neck
☐ I am able to engage in most, but not all of my usual recreation activities because of pain in my neck
☐ I am able to engage in a few of my usual recreation activities because of pain in my neck
☐ I can hardly do any recreation activities because of pain in my neck
☐ I can't do any recreation activities at all