



NAME \_\_\_\_\_ Primary Complaint: \_\_\_\_\_

Preferred Pronoun: *He/Him/His*    *She/Her/Hers*    *They/Them/Theirs*    *Other*

1. Please indicate your usual level of pain during the past week:  
***No pain* 0 1 2 3 4 5 6 7 8 9 10 *Worst possible pain***
2. Does pain, numbness, tingling or weakness extend into your leg (from low back) and/or arm (from neck)?  
***None of the time* 0 1 2 3 4 5 6 7 8 9 10 *All of the time***
3. How would you rate your general health? (10-x)  
***Poor* 0 1 2 3 4 5 6 7 8 9 10 *Excellent***
4. If you had to spend the rest of your life with your condition as it is right now, how would you feel?  
***Delighted* 0 1 2 3 4 5 6 7 8 9 10 *Terrible***
5. How anxious (i.e., tense, uptight, irritable, fearful, difficulty in concentrating/relaxing) have you been feeling during the past week?  
***Not at all* 0 1 2 3 4 5 6 7 8 9 10 *Extremely anxious***
6. How much have you been able to control (i.e., reduce/help) your pain/complaint on your own during the past week?  
***I can reduce it* 0 1 2 3 4 5 6 7 8 9 10 *I can't reduce it all***
7. Please indicate how depressed (e.g., blue, downhearted, sad, in low spirits, pessimistic, hopeless feeling) you have been feeling in the past week  
***Not depressed at all* 0 1 2 3 4 5 6 7 8 9 10 *Extremely depressed***
8. On a scale of 0 to 10, how certain are you that you will be doing normal activities or working within six months?  
***Very certain* 0 1 2 3 4 5 6 7 8 9 10 *Not certain at all***
9. I can do light work for an hour:  
***Completely agree* 0 1 2 3 4 5 6 7 8 9 10 *Completely disagree***
10. I can sleep at night:  
***Completely agree* 0 1 2 3 4 5 6 7 8 9 10 *Completely disagree***
11. An increase in pain is an indication that I should stop what I am doing until the pain decreases:  
***Completely agree* 0 1 2 3 4 5 6 7 8 9 10 *Completely disagree***
12. Physical activity makes my pain worse:  
***Completely disagree* 0 1 2 3 4 5 6 7 8 9 10 *Completely agree***
13. I should not do my normal activities, including work, with my present pain:  
***Completely disagree* 0 1 2 3 4 5 6 7 8 9 10 *Completely agree***

Patient Signature \_\_\_\_\_

Date: \_\_\_\_\_



**Patient Specific Functional Scale (PSFS):**

Identify 2-3 activities that you are not able to do or have difficulty with as a result of your chief complaint.

*Write the activity that you are having trouble with in the space provided below (e.g., running, sitting, standing, etc.), then circle the number that corresponds to that activity.*

1. How difficult is \_\_\_\_\_ for you?  
*Unable to perform   0   1   2   3   4   5   6   7   8   9   10   Able to perform fully*

2. How difficult is \_\_\_\_\_ for you?  
*Unable to perform   0   1   2   3   4   5   6   7   8   9   10   Able to perform fully*

3. How difficult is \_\_\_\_\_ for you?  
*Unable to perform   0   1   2   3   4   5   6   7   8   9   10   Able to perform fully*

**Pain Limitation:** Over the past 24 hours, how much has your pain limited you from performing any of your normal, daily activities?

*Activities severely limited   0   1   2   3   4   5   6   7   8   9   10   Activities not limited*

**Pain Intensity:** Over the past 24 hours, how bad has your pain been?

*No Pain   0   1   2   3   4   5   6   7   8   9   10   Pain as bad as it can be*

## NECK PAIN DISABILITY INDEX QUESTIONNAIRE

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 CIRCLE THE ONE CHOICE WHICH MOST CLOSELY DESCRIBES YOUR CURRENT PROBLEM.

<p><b>SECTION 1 - Pain Intensity</b></p> <p>A I have no pain at the moment.            B The pain is 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.</p>	<p><b>SECTION 6 - Concentration</b></p> <p>A I can stand as long as I want without pain.            B I have some pain on standing but it does not increase with time.            C I cannot stand for longer than 1 hour without increasing pain.            D I cannot stand for longer than 1/2 hour without increasing pain.            E I cannot stand for longer than 10 minutes without increasing pain.            F I avoid standing because it increases the pain immediately.</p>
<p><b>SECTION 2 - Personal Care (washing, dressing, etc.)</b></p> <p>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.</p>	<p><b>SECTION 7 - Work</b></p> <p>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.</p>
<p><b>SECTION 3 - Lifting</b></p> <p>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, 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.</p>	<p><b>SECTION 8 - Driving</b></p> <p>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.</p>
<p><b>SECTION 4 - Reading</b></p> <p>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.</p>	<p><b>SECTION 9 - Sleeping</b></p> <p>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).</p>
<p><b>SECTION 5 - Headaches</b></p> <p>A I have no headache 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.</p>	<p><b>SECTION 10 - Recreation</b></p> <p>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.</p>

## CERVICAL POSITIONAL TOLERANCE QUESTIONNAIRE (CPTQ)

1. **Do you avoid looking up as if into a high cabinet shelf because do so causes:**

a) Visual Problems or Dizziness	YES / NO / SOMETIMES
b) Sudden Drop to the Floor	YES / NO / SOMETIMES
c) Unsteadiness	YES / NO / SOMETIMES
d) Extremity Weakness	YES / NO / SOMETIMES
e) Confusion	YES / NO / SOMETIMES
f) Headaches	YES / NO / SOMETIMES
g) Hearing Loss	YES / NO / SOMETIMES
h) Loss of Consciousness	YES / NO / SOMETIMES
i) Arm or Leg Numbness	YES / NO / SOMETIMES
j) Problems with Speech	YES / NO / SOMETIMES
k) Ringing in the Ear	YES / NO / SOMETIMES
l) Numbness around Mouth	YES / NO / SOMETIMES
  
2. **Do you avoid looking over your LEFT shoulder as if backing up to your car because of:**

a) Visual Problems or Dizziness	YES / NO / SOMETIMES
b) Sudden Drop to the Floor	YES / NO / SOMETIMES
c) Unsteadiness	YES / NO / SOMETIMES
d) Extremity Weakness	YES / NO / SOMETIMES
e) Confusion	YES / NO / SOMETIMES
f) Headaches	YES / NO / SOMETIMES
g) Hearing Loss	YES / NO / SOMETIMES
h) Loss of Consciousness	YES / NO / SOMETIMES
i) Arm or Leg Numbness	YES / NO / SOMETIMES
j) Problems with Speech	YES / NO / SOMETIMES
k) Ringing in the Ear	YES / NO / SOMETIMES
l) Numbness around Mouth	YES / NO / SOMETIMES
  
3. **Do you avoid looking over your RIGHT shoulder as if backing up to your car because of:**

a) Visual Problems or Dizziness	YES / NO / SOMETIMES
b) Sudden Drop to the Floor	YES / NO / SOMETIMES
c) Unsteadiness	YES / NO / SOMETIMES
d) Extremity Weakness	YES / NO / SOMETIMES
e) Confusion	YES / NO / SOMETIMES
f) Headaches	YES / NO / SOMETIMES
g) Hearing Loss	YES / NO / SOMETIMES
h) Loss of Consciousness	YES / NO / SOMETIMES
i) Arm or Leg Numbness	YES / NO / SOMETIMES
j) Problems with Speech	YES / NO / SOMETIMES
k) Ringing in the Ear	YES / NO / SOMETIMES
l) Numbness around Mouth	YES / NO / SOMETIMES

\_\_\_\_\_ *TOTAL SCORE* = "YES" Responses + "Sometimes" Responses.  
*Scores ≥ 1 constitute a positive CPTQ.*