CORNERSTONE HEALTH
CHIROPRACTIC · ACUPUNCTURE · NUTRITION

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: _____

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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***

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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.

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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.

SECTION 1 - Pain Intensity
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.

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 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, 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 - 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 5 – Headaches
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.

SECTION 6 - Concentration
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.

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 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 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 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.

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HEADACHE DISABILITY INDEX

INSTRUCTIONS. Please CIRCLE the correct response:

1. I have headache: (1) 1 per month (2) more than 1 but less than 4 per month (3) more than one per week
2. My headache is: (1) mild (2) moderate (3) severe

Please read carefully: The purpose of the scale is to identify difficulties that you may be experiencing because of your headache. Please check off "YES", "SOMETIMES", or "NO" to each item. Answer each question as it pertains to your headache only.

Yes	Sometimes	No	
_____	_____	_____	F1. Because of my headaches I feel handicapped.
_____	_____	_____	F2. Because of my headaches I feel restricted in performing my routine daily activities.
_____	_____	_____	E3. No one understands the effect my headaches have on my life.
_____	_____	_____	F4. I restrict my recreational activities (e.g., sports, hobbies) because of my headaches.
_____	_____	_____	E5. My headaches make me angry.
_____	_____	_____	E6. Sometimes I feel that I am going to lose control because of my headaches.
_____	_____	_____	F7. Because of my headaches I am less likely to socialize.
_____	_____	_____	E8. My family/friends have no idea what I am going through because of my headaches.
_____	_____	_____	E9. My headaches are so bad that I feel that I am going to go insane.
_____	_____	_____	E10. My outlook on the world is affected by my headaches.
_____	_____	_____	E11. I am afraid to go outside when I feel that a headache is starting.
_____	_____	_____	E12. I feel desperate because of my headaches.
_____	_____	_____	F13. I am concerned that I am paying penalties at work/ home because of my headaches.
_____	_____	_____	E14. My headaches place stress on my relationships with family or friends.
_____	_____	_____	F15. I avoid being around people when I have a headache.
_____	_____	_____	F16. I believe my headaches are making it difficult for me to achieve my goals in life.
_____	_____	_____	F17. I am unable to think clearly because of my headaches.
_____	_____	_____	F18. I get tense (e.g., muscle tension) because of my headaches.
_____	_____	_____	F19. I do not enjoy social gatherings because of my headaches.
_____	_____	_____	E20. I feel irritable because of my headaches.
_____	_____	_____	F21. I avoid traveling because of my headaches.
_____	_____	_____	E22. My headaches make me feel confused.
_____	_____	_____	E23. My headaches make me feel frustrated.
_____	_____	_____	F24. I find it difficult to read because of my headaches.
_____	_____	_____	F25. I find it difficult to focus my attention away from my headaches and on other things.

OTHER COMMENTS:

_____

_____

I understand that the information I have provided above is current and complete to the best of my knowledge.
Signature _____ Date _____

With permission from: Jacobson GP, Ramadan NM, et al. The Henry Ford Hospital headache disability inventory (HDI). Neurology 1994;44:837-842.