**PATIENT NAME: _____ ID#: _____ DATE: _____**

**Description**: This survey is meant to help us obtain information from our patients regarding their current levels of discomfort and capability. **Please circle the answers below that best apply.**

**1. Please rate your pain level with activity:** NO PAIN = 0 1 2 3 4 5 6 7 8 9 10 = VERY SEVERE PAIN

## NECK DISABILITY INDEX – INITIAL VISIT

**1. Pain Intensity**
(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 worse imaginable at the moment.

**2. Personal Care (washing, dressing, etc)**
(0) I can look after myself normally without 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 cannot get dressed, wash with difficulty and stay in bed

**3. Lifting**
(0) I can lift heavy weights without extra pain.
(1) I can lift heavy weights but it gives me extra pain.
(2) Pain prevents me from lifting heavy weights off the floor but I can manage if they are on a table.
(3) Pain prevents me from lifting heavy weights but I can manage if they are conveniently placed.
(4) I can lift only very light weights.
(5) I cannot lift or carry anything at all.

**4. Headache**
(0) I have no headaches at all.
(1) I have slight headaches which come infrequently.
(2) I have moderate headaches which come infrequently.
(3) I have moderate headaches which come frequently.
(4) I have severe headaches which come infrequently.
(5) I have headaches almost all the time.

**5. Recreation**
(0) I am able engage in all my recreational activities without pain.
(1) I am able to engage in my recreational activities with some pain.
(2) I am able to engage in most but not all of my usual recreational activities because of my neck pain.
(3) I am able to engage in a few of my usual recreational activities with some neck pain.
(4) I can hardly do any recreational activities because of neck pain.
(5) I can't do any recreational activities at all.

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

**7. Work**
(0) I can do as much 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 usual work at all.
(5) I can't do any work at all.

**8. Sleeping**
(0) Pain does not prevent me from sleeping well.
(1) My sleep is slightly disturbed (<1 hr sleep loss).
(2) My sleep is mildly disturbed (1-2 hr sleep loss).
(3) My sleep is moderately disturbed (2-3 hr sleep loss).
(4) My sleep is greatly disturbed (3-4 hr sleep loss).
(5) My sleep is completely disturbed (5-7 hr sleep loss).

**9. Concentration**
(0) I can concentrate fully when I want with no difficulty.
(1) I can concentrate fully when I want with slight difficulty.
(2) I have a fair degree of difficulty concentrating when I want.
(3) I have a lot of difficulty concentrating when I want.
(4) I have great difficulty concentrating when I want.
(5) I cannot concentrate at all.

**10. Driving**
(0) I can drive my car without neck pain.
(1) I can drive my car as long as I want with slight neck pain.
(2) I can drive my car as long as I want with moderate neck pain.
(3) I can't drive my car as long as I want because of moderate pain.
(4) I can hardly drive my car at all because of severe neck pain.
(5) I can't drive my car at all.



**Therapist Use Only**

Comorbidities:
☐Cancer
☐Diabetes
☐Heart Condition
☐High Blood Pressure
☐Multiple Treatment Areas
☐Neurological Disorders (e.g., Parkinson's, Muscular Dystrophy, Huntington's, CVA, Alzheimer's, TBI)
☐Obesity
☐Surgery for this Problem
☐Systemic Disorders (e.g., Lupus, Rheumatoid Arthritis, Fibromyalgia)

ICD Code: _____

Initial Intake Questionnaire

Body part being seen for:_____

Weight:_____ Height:_____

Date of injury:____/____/_____ Date of Surgery:_____/_____/____

Did your symptoms come on as a:

- Gradual process
- New Injury
- Chronic problem

Occupation:

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Is the work load:

- Sedentary
- Light
- Medium
- Heavy

Primary concern/complaint:

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What is your goal to achieve from physical therapy?

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**Pain rating**: 0=No pain and 10=Severe, unrelenting pain that makes you unable to function at all

Worst (when you have the most pain): 0 1 2 3 4 5 6 7 8 9 10

Current (what it is now): 0 1 2 3 4 5 6 7 8 9 10

Best (when you have the least pain): 0 1 2 3 4 5 6 7 8 9 10

**Describe your pain** (Circle all that apply): Dull/Achy Sharp Throbbing Burning Shooting

Constant Intermittent

**Medications** (Please list or provide a list):

_____ _____
_____ _____
_____ _____
_____ _____
_____ _____

I have provided my medication list to the best of my knowledge and will notify my therapist of any changes as they occur.

Signature:_____ Date:____/_____/_____

Past Medical History: Check all that apply

| | |
|---|---|
| ○ Alzheimer's<br>○ Cardiovascular Disease<br>○ Stroke<br>○ Current Infection<br>○ Diabetes Mellitus Type 1<br>○ Diabetes Mellitus Type 2<br>○ Fibromyalgia<br>○ Fracture Or Suspected Fracture<br>○ High Blood Pressure<br>○ Pacemaker<br>○ Other (Please describe below) | ○ History Of Cancer (Describe below)<br>__In Remission __Active<br>○ Huntington's<br>○ Immunosuppression<br>○ Lupus<br>○ Muscular Dystrophy<br>○ Obesity<br>○ Osteoarthritis<br>○ Parkinson's<br>○ Rheumatoid Arthritis<br>○ Traumatic Brain Injury<br>○ Infectious Disease (Describe below) |

Other: _____

_____

_____

Only for patients being seen for **Low Back Pain**:
Have you experienced any of the following symptoms?

- ○ Saddle Numbness (numbness in the groin region)
- ○ Problems with urination: (circle all that apply) Incontinence Urgency Can't go
- ○ Problems with bowel: (circle all that apply) Can't control Can't go

Email: _____

(This is optional, however by providing your email it will allow us to communicate issues regarding your account, updates about our company and allow you an opportunity for online bill pay. We will not share your email with any outside agency except our contracted billing agency, LB Medical Billing, LLC)

**How did you hear about us**? _____