

# Functional Rating Index

For use with Neck and/or Back Problems

In order to properly assess your condition, we must understand how much your neck and/or back problems have affected your ability to manage everyday activities. For each item, please **circle** the number which most closely describes your condition right now.

## 1. Pain Intensity

0-----1-----2-----3-----4  
No Mild Moderate Severe Worst  
pain pain pain pain possible  
pain

## 2. Sleeping

0-----1-----2-----3-----4  
Perfect Mildly Moderately Greatly Totally  
sleep disturbed disturbed disturbed disturbed  
sleep sleep sleep sleep sleep

## 3. Personal Care (washing, dressing, etc.)

0-----1-----2-----3-----4  
No Mild Moderate Moderate Severe  
pain; pain; pain; need pain; need pain; need  
no no to go slowly some 100%  
restrictions restrictions assistance assistance

## 4. Travel (driving, etc.)

0-----1-----2-----3-----4  
No Mild Moderate Moderate Severe  
pain on pain on pain on pain on pain on  
long trips long trips long trips short trips short trips

## 5. Work

0-----1-----2-----3-----4  
Can do Can do Can do Can do Cannot  
usual work usual work 50% of 25% of work  
plus unlimited no extra usual usual  
extra work work work work

## 6. Recreation

0-----1-----2-----3-----4  
Can do Can do Can do Can do Cannot  
all most some a few do any  
activities activities activities activities activities

## 7. Frequency of pain

0-----1-----2-----3-----4  
No Occasional Intermittent Frequent Constant  
pain pain; 25% pain; 50% pain; 75% pain; 100%  
of the day of the day of the day of the day

## 8. Lifting

0-----1-----2-----3-----4  
No Increased Increased Increased Increased  
pain with pain with pain with pain with pain with  
heavy heavy moderate light any  
weight weight weight weight weight

## 9. Walking

0-----1-----2-----3-----4  
No pain; Increased Increased Increased Increased  
any pain after pain after pain after pain after  
distance 1 mile ½ mile ¼ mile all walking

## 10. Standing

0-----1-----2-----3-----4  
No pain Increased Increased Increased Increased  
after pain pain pain pain  
several after several after after  
hours hours 1 hour ½ hour standing

Signature **X** \_\_\_\_\_

Date \_\_\_\_\_

Name \_\_\_\_\_

Account \_\_\_\_\_

Total Score: \_\_\_\_\_