Patient's Name_____ Number_____ Date_____

LOW BACK DISABILITY QUESTIONNAIRE (REVISED OSWESTRY)

This questionnaire has been designed to give the doctor information as to how your back pain has affected your ability to manage in everyday life. **Please answer every section and mark in each section only ONE box** which applies to you. We realize you may consider that two of the statements in any one section relate to you, but **please just mark the box which MOST CLOSELY describes your problem.**

Section 1 - Pain Intensity

☐ I can tolerate the pain without having to use painkillers.
☐ The pain is bad but I can manage without taking painkillers.
☐ Painkillers give complete relief from pain.
☐ Painkillers give moderate relief from pain.
☐ Painkillers give very little relief from pain.
☐ Painkillers have no effect on the pain and I do not use them.

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 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 from lifting heavy weights off the floor, but I can manage if they are conveniently positioned, 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 lift very light weights.
☐ I cannot lift or carry anything at all.

Section 4 – Walking

☐ Pain does not prevent me from walking any distance.
☐ Pain prevents me from walking more than one mile.
☐ Pain prevents me from walking more than one-half mile.
☐ Pain prevents me from walking more than one-quarter mile
☐ I can only walk using a stick or crutches.
☐ I am in bed most of the time and have to crawl to the toilet.

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 from 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 almost all the time.

Scoring: Questions are scored on a vertical scale of 0-5. Total scores and multiply by 2. Divide by number of sections answered multiplied by 10. A score of 22% or more is considered significant activities of daily living disability.
(Score___ x 2) / (____Sections x 10) = _____ %ADL

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 extra pain.
☐ Pain prevents me from standing more than 1 hour.
☐ Pain prevents me from standing more than 30 minutes.
☐ Pain prevents me from standing more than 10 minutes.
☐ Pain prevents me from standing at all.

Section 7 -- Sleeping

☐ Pain does not prevent me from sleeping well.
☐ I can sleep well only by using tablets.
☐ Even when I take tablets I have less than 6 hours sleep.
☐ Even when I take tablets I have less than 4 hours sleep.
☐ Even when I take tablets I have less than 2 hours sleep.
☐ Pain prevents me from sleeping at all.

Section 8 – 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. dancing.
☐ 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 9 – Traveling

☐ I can travel anywhere without extra pain.
☐ I can travel anywhere but it gives me extra pain.
☐ Pain is bad but I manage journeys over 2 hours.
☐ Pain is bad but I manage journeys less than 1 hour.
☐ Pain restricts me to short necessary journeys under 30 minutes.
☐ Pain prevents me from traveling except to the doctor or hospital.

Section 10 – Changing Degree of Pain

☐ My pain is rapidly getting better.
☐ My pain fluctuates but overall is definitely getting better.
☐ My pain seems to be getting better but improvement is slow at the present.
☐ My pain is neither getting better nor worse.
☐ My pain is gradually worsening.
☐ My pain is rapidly worsening.

Comments_____

Reference: Fairbank, Physiotherapy 1981; 66(8): 271-3, Hudson-Cook. In Roland, Jenner (eds.), Back Pain New Approaches To Rehabilitation & Education. Manchester Univ Press, Manchester 1989: 187-204

Patient's Name_____ Number_____ Date_____

NECK DISABILITY INDEX

This questionnaire has been designed to give the doctor 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 ONE box** which applies to you. We realize you may consider that two of the statements in any one section relate to you, but **please just mark the box which 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 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 from lifting heavy weights off the floor, but I can manage if they are conveniently positioned, 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 lift very light weights.
☐ I cannot lift or carry anything at all.

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.
☐ 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 slight headaches which come frequently.
☐ I have moderate headaches which come infrequently.
☐ I have severe headaches which come frequently.
☐ I have headaches almost all the time.

Scoring: Questions are scored on a vertical scale of 0-5. Total scores and multiply by 2. Divide by number of sections answered multiplied by 10. A score of 22% or more is considered a significant activities of daily living disability.
(Score___ x 2) / (____Sections x 10) = _____ %ADL_____

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 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 my car at all because of severe pain in my neck.
☐ I can't drive my car at all.

Section 9 – Sleeping

☐ I have no trouble sleeping.
☐ My sleep is slightly disturbed (less than 1 hr. sleepless).
☐ My sleep is moderately disturbed (1-2 hrs. sleepless).
☐ My sleep is moderately disturbed (2-3 hrs. sleepless).
☐ My sleep is greatly disturbed (3-4 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.

Comments_____
%ADL

Reference: Vernon, Mior. JMPT 1991; 14(7): 409-15

HEADACHE DISABILITY INDEX

NAME: _____ DATE: _____ AGE: ____ SCORES TOTAL: ____; E____; F____
(100) (52) (48)

INSTRUCTIONS: Please CIRCLE the correct response:

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

INSTRUCTIONS: ***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 item as it pertains to your headache only.

	YES	SOMETIMES	NO
E1. 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 spouse/significant other, or family and friends have no idea what I am going through because of my headaches.	☐	☐	☐
E9. My headaches are so bad that I feel 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 a headache is starting.	☐	☐	☐
E12. I feel desperate because of my headaches.	☐	☐	☐
F13. I am concerned that I am paying penalties at work or at 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.	☐	☐	☐

Reference: Jacobson Gary P., Ramadan NM, et al., The Henry Ford Hospital Headache Disability Inventory (HDI). Neurology 1994; 44:837-842

LOW BACK PAIN DISABILITY QUESTIONNAIRE
(ROLAND-MORRIS)

Name _____ Number _____ Date _____

SCORE: _____

When your back hurts, you may find it difficult to do some of the things you normally do.
Mark only the sentences that describe you today.

- ☐ **I stay at home most of the time because of my back.**
- ☐ **I change position frequently to try and get my back comfortable.**
- ☐ **I walk more slowly than usual because of my back.**
- ☐ **Because of my back, I am not doing any jobs that I usually do around the house.**
- ☐ **Because of my back, I use a handrail to get upstairs.**
- ☐ **Because of my back, I lie down to rest more often.**
- ☐ **Because of my back, I have to hold on to something to get out of an easy chair.**
- ☐ **Because of my back, I try to get other people to do things for me.**
- ☐ **I get dressed more slowly than usual because of my back.**
- ☐ **I stand up only for short periods of time because of my back.**
- ☐ **Because of my back, I try not to bend or kneel down.**
- ☐ **I find it difficult to get out of a chair because of my back.**
- ☐ **My back is painful almost all of the time.**
- ☐ **I find it difficult to turn over in bed because of my back.**
- ☐ **My appetite is not very good because of my back pain.**
- ☐ **I have trouble putting on my socks (or stockings) because of pain in my back.**
- ☐ **I sleep less well because of my back.**
- ☐ **Because of back pain, I get dressed with help from someone else.**
- ☐ **I sit down for most of the day because of my back.**
- ☐ **I avoid heavy jobs around the house because of my back.**
- ☐ **Because of back pain, I am more irritable and bad tempered with people than usual.**
- ☐ **Because of my back pain, I go upstairs more slowly than usual.**
- ☐ **I stay in bed most of the time because of my back.**

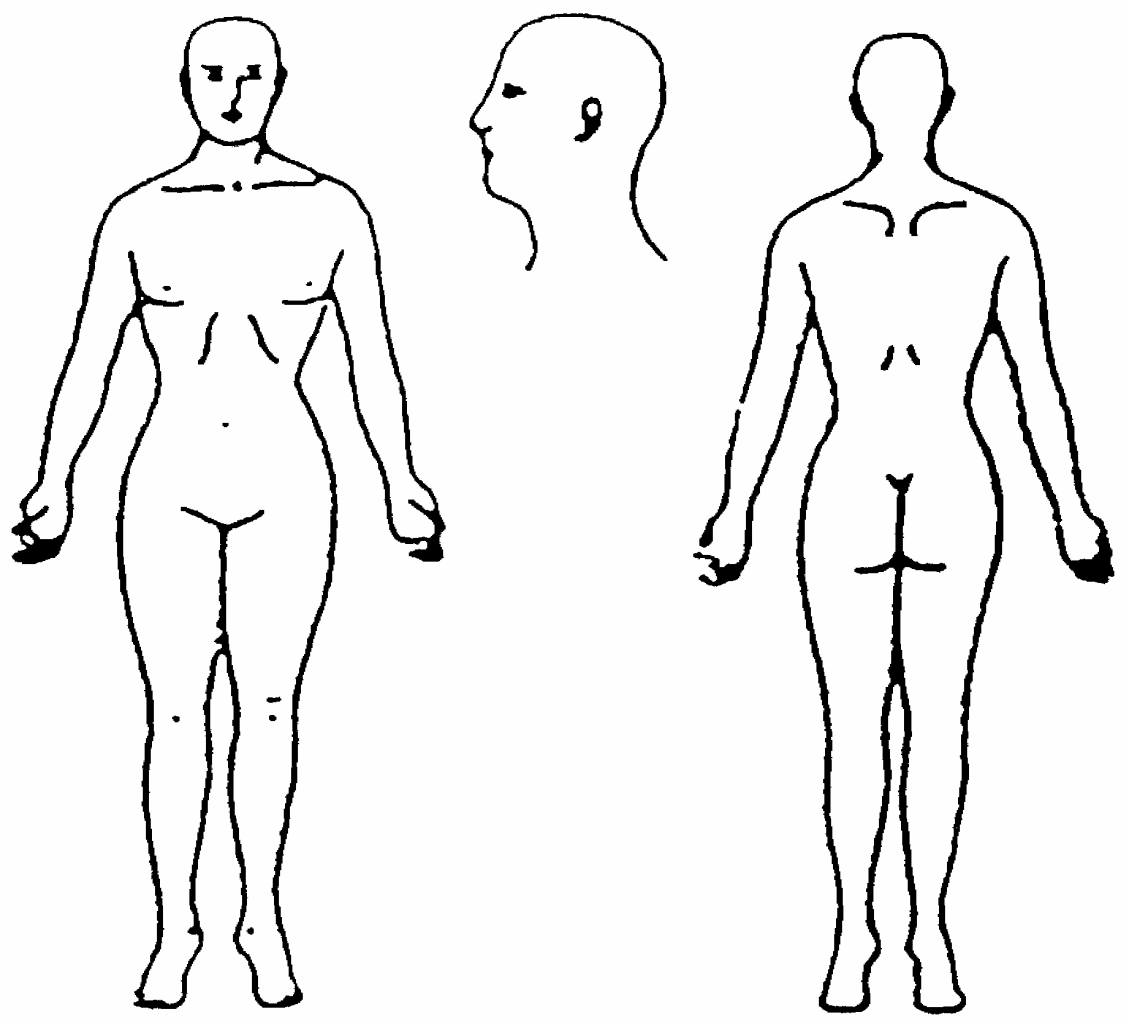
Reference: Roland, Morris. A Study of the Natural History of Back Pain Part 1: Development of a Reliable and Sensitive Measure of Disability in Low-Back Pain. Spine 1983; 8(2): 141-144

SYMPTOM DIAGRAM

Name _____ Number _____ Date _____

Please be sure to fill this form out extremely accurately. Mark the area(s) on your body where you feel the described sensation(s). Use the appropriate symbol(s). Mark areas of radiating pain, and include all affected areas. You may draw on the face as well.

Aches ΛΛΛΛ Numbness oooo Pins/Needles ●●●● Burning xxxx Stabbing ////



Reference: Randsford. Spine, Vol. 1, No 2, June 1976

QUADRUPLE VISUAL ANALOGUE SCALE

Name _____ Number _____ Date _____

INSTRUCTIONS: Please circle the number that best describes the question being asked.

NOTE: If you have more than one complaint, please answer each question for each Individual complaint and indicate which score is for which complaint.

EXAMPLE:

HEADACHE NECK LOW BACK

0 1 (2) 3 (4) 5 6 7 8 (9) 10

---

1. What is your pain RIGHT NOW?

0 1 2 3 4 5 6 7 8 9 10

2. What is your TYPICAL or AVERAGE pain?

0 1 2 3 4 5 6 7 8 9 10

3. What is your pain AT ITS BEST (How close to "0" does your pain get at its best)?

0 1 2 3 4 5 6 7 8 9 10

What percentage of your awake hours is your pain at its best? _____%

4. What is your pain AT ITS WORST (How close to "10" does your pain get at its worst)?

0 1 2 3 4 5 6 7 8 9 10

What percentage of your awake hours is your pain at its worst? _____%

Reference: Thomeé R., Grimby G., Wright B.D., Linacre J.M. (1995) Rasch analysis of Visual Analog Scale. *Scandinavian Journal of Rehabilitation Medicine* 27, 145-151.

CARPAL TUNNEL QUESTIONNAIRE

Name _____ Number _____ Date _____

How severe is the hand or wrist pain that you have at night?
☐ I do not have hand or wrist pain at night
☐ Mild pain
☐ Moderate pain
☐ Severe pain
☐ Very severe pain

How often did hand or wrist pain wake you up during a typical night in the past two weeks?
☐ Never
☐ Once
☐ Two or three times
☐ Four or five times
☐ More than five times

Do you typically have pain in your hand or wrist during the daytime?
☐ I never have pain during the day
☐ I have mild pain during the day
☐ I have moderate pain during the day
☐ I have severe pain during the day
☐ I have very severe pain during the day

How often do you have hand or wrist pain during the daytime?
☐ Never
☐ Once or twice a day
☐ Three to five times a day
☐ More than five times a day
☐ The pain is constant

How long on average does an episode of pain last during the daytime?
☐ I never get pain during the day
☐ Less than 10 minutes
☐ 10 to 60 minutes
☐ Greater than 60 minutes
☐ The pain is constant throughout the day

Do you have numbness (loss of sensation) in your hand?
☐ No
☐ I have mild numbness
☐ I have moderate numbness
☐ I have severe numbness
☐ I have very severe numbness

Do you have weakness in your hand or wrist?
☐ No weakness
☐ Mild weakness
☐ Moderate weakness
☐ Severe weakness
☐ Very severe weakness

Do you have tingling sensations in your hand?
☐ No tingling
☐ Mild tingling
☐ Moderate tingling
☐ Severe tingling
☐ Very severe tingling

How severe is the numbness (loss of sensation) or tingling at night?
☐ I have no numbness or tingling at night
☐ Mild
☐ Moderate
☐ Severe
☐ Very severe

How often did hand numbness or tingling wake you up during a typical night during the past two weeks?
☐ Never
☐ Once
☐ Two or three times
☐ Four or five times
☐ More than five times

Do you have difficulty with the grasping and use of small objects such as keys or pencils?
☐ No difficulty
☐ Mild difficulty
☐ Moderate difficulty
☐ Severe difficulty
☐ Very severe difficulty

Reference: Levine et al. A Self- Administered Questionnaire for the Assessment of Severity of Symptoms and Functional Status in Carpal Tunnel Syndrome. The Journal of Bone and Joint Surgery 1993; 75-A(11):1585-1592.

SHOULDER PAIN SCORE

Name _____ Number _____ Date _____

	None	Light	Average	Severe
Pain at rest	☐	☐	☐	☐
Pain in motion	☐	☐	☐	☐
Nightly pain	☐	☐	☐	☐
Sleeping problems caused by pain	☐	☐	☐	☐
Incapability of lying on the painful side	☐	☐	☐	☐

	None	Till halfway the upper arm	Till the elbow	Past the elbow
Degree of radiation	☐	☐	☐	☐

Pain Scale:

Indicate on the line below the number between 0 and 100 that best describes your pain.

No pain is 0 ⟶ Unbearable pain is 100

Reference: Winters J. C., Sobel J. S., Gronier K. H., Arendxen J.H., Meyboorn-De Jong B. A Shoulder Pain Score: A Comprehensive Questionnaire for Assessing Pain n Patients with Shoulder Complaints. Scand J Rehab Med 28:163-167. 1996

THE MCGILL PAIN QUESTIONNAIRE (MPQ) – ABBREVIATED

Name _____ Number _____ Date _____

PRI: S _____ A _____ E _____ M(S) _____ M(AE) _____ M(T) _____ PRI(T) _____
(1-10) (11-15) (16) (17-19) (20) (17-20) (1-20)

1. Flickering ☐
   Quivering ☐
   Pulsing ☐
   Throbbing ☐
   Beating ☐
   Pounding ☐

2. Jumping ☐
   Flashing ☐
   Shooting ☐

3. Pricking ☐
   Boring ☐
   Drilling ☐
   Stabbing ☐
   Lancinating ☐

4. Sharp ☐
   Cutting ☐
   Lacerating ☐

5. Pinching ☐
   Pressing ☐
   Gnawing ☐
   Cramping ☐
   Crushing ☐

6. Tugging ☐
   Pulling ☐
   Wrenching ☐

7. Hot ☐
   Burning ☐
   Scalding ☐
   Searing ☐

8. Tingling ☐
   Itchy ☐
   Smarting ☐
   Stinging ☐

9. Dull ☐
   Sore ☐
   Hurting ☐
   Aching ☐
   Heavy ☐

10. Tender ☐
    Taut ☐
    Rasping ☐
    Splitting ☐

11. Tiring ☐
    Exhausting ☐

12. Sickening ☐
    Suffocating ☐

13. Fearful ☐
    Frightful ☐
    Terrifying ☐

14. Punishing ☐
    Grueling ☐
    Cruel ☐
    Vicious ☐
    Killing ☐

15. Wretched ☐
    Blinding ☐

16. Annoying ☐
    Troublesome ☐
    Miserable ☐
    Intense ☐
    Unbearable ☐

17. Spreading ☐
    Radiating ☐
    Penetrating ☐
    Piercing ☐

18. Tight ☐
    Numb ☐
    Drawing ☐
    Squeezing ☐
    Tearing ☐

19. Cool ☐
    Cold ☐
    Freezing ☐

20. Nagging ☐
    Nauseating ☐
    Agonizing ☐
    Dreadful ☐
    Torturing ☐

PPI
0 No Pain ☐
1 Mild ☐
2 Discomforting ☐
3 Distressing ☐
4 Horrible ☐
5 Excruciating ☐

Accompanying Symptoms:
Nausea ☐
Headache ☐
Dizziness ☐
Drowsiness ☐
Constipation ☐
Diarrhea ☐

Comments

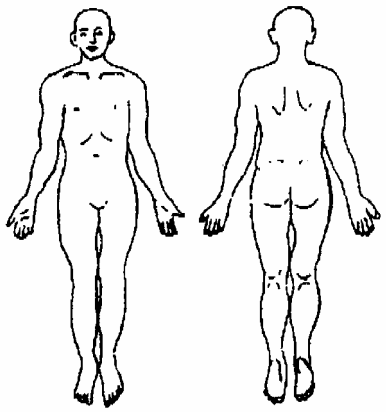
Sleep:
Good ☐
Fitful ☐
Can't Sleep ☐

Comments

Food Intake:
Good ☐
Some ☐
Little ☐

Comments

Activity:
Good ☐
Some ☐
Little ☐
None ☐



Comments

PPI _____

Comments

Good ☐
Some ☐
Little ☐

Reference: Melzack, Ronald. Psychological Aspects of Pain, Pain, 1980;8;145

FORM 508

THE CHIROPRACTIC SATISFACTION QUESTIONNAIRE

NAME (OPTIONAL) _____ **DATE** _____

The following questions are in reference to the treatment you have had in the past. Please circle the number which best reflects your satisfaction for each of the following. (CIRCLE 1 NUMBER ON EACH LINE):

	Very Poor	Poor	Fair	Good	Very Good	Excel	The Best
1. The amount of privacy you were given	1	2	3	4	5	6	7
2. Interest shown in you as a person	1	2	3	4	5	6	7
3. Friendliness, warmth, and personal manner of the chiropractor who treated you	1	2	3	4	5	6	7
4. Explanations of treatment	1	2	3	4	5	6	7
5. Willingness to listen	1	2	3	4	5	6	7
6. Understanding your health problem	1	2	3	4	5	6	7
7. Answers given to your questions	1	2	3	4	5	6	7
8. Amount of time spent with you	1	2	3	4	5	6	7
9. Cost of care to you	1	2	3	4	5	6	7
10. Skill and ability of the chiropractor	1	2	3	4	5	6	7
11. Advice about ways to avoid illness and stay healthy	1	2	3	4	5	6	7
12. Ability of the chiropractor to put you at ease	1	2	3	4	5	6	7
13. Courtesy, politeness, and respect shown by the chiropractor	1	2	3	4	5	6	7
14. Quality of overall care received	1	2	3	4	5	6	7

Other Comments??

Note:
To score, first average responses to each item to obtain a score ranging between 1 and 7. Second, subtract 1 from the average. Then divide the result by 6 and multiply by 100.

SCORE _____

Reference: Coulter, I. D., R. D. Hays, and C. D, Danielson, The Chiropractic Satisfaction Questionnaire, Topics in Clinical Chiropractic, Vol. 1, Issue 4, 1994, pp. 40-43.