Oswestry Disability Index for Neck pain

Name:_____ **Today's Date**:_____

Please Read Carefully: This questionnaire is designed to enable us to understand how much your neck pain has affected your ability to manage your everyday activities. Please circle the NUMBER that most closely describes your situation.

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 worst imaginable at the moment.

2 Personal Care (Washing, Dressing, etc.)

0. I can look after myself normally without causing 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 my personal care.
5. I do not get dressed, I wash with difficulty and stay in bed.

3 Lifting

0. I can lift heavy weights without causing 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 items are conveniently positioned, i.e. on a table.
3. Pain prevents me from lifting heavy weights, but I can manage light weights if they are conveniently positioned.
4. I can lift only very light weights.
5. I cannot lift or carry anything at all.

4 Work/ Home making

0. I can do as much job activities/ homemaking as I want.
1. I can only do my usual job activities/ home making, but no more.
2. I can do most of my usual job activities/ homemaking, but no more.
3. I can't do my usual job activities/ homemaking.
4. I can hardly do any job activities/ homemaking at all.
5. I can't do any job activities/ homemaking at all.

5 Headaches

0. I have no headaches at all.
1. I have slight headaches that come infrequently.
2. I have moderate headaches that come infrequently.
3. I have moderate headaches that come frequently.
4. I have severe headaches that come frequently.
5. I have headaches almost all the time.

6 Concentration

0. I can concentrate fully without difficulty.
1. I can concentrate fully with slight difficulty.
2. I have a fair degree of difficulty concentrating.
3. I have a lot of difficulty concentrating.
4. I have a great deal of difficulty concentrating.
5. I can't concentrate at all.

7 Sleeping

0. I have no trouble sleeping.
1. My sleep is slightly disturbed (less than 1 hour sleepless).
2. My sleep is mildly disturbed (1-2 hours sleepless).
3. My sleep is moderately disturbed (2-3 hours sleepless).
4. My sleep is greatly disturbed (3-5 hours sleepless).
5. My sleep is greatly disturbed (5-7 hours sleepless).

8 Driving

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

9 Reading

0. I can read as much as I want with no neck pain.
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't read as much as I want because of severe neck pain.
5. I can't read at all.

10 Recreation

0. I have no neck pain during all recreational activities.
1. I have some neck pain with a few recreational activities.
2. I have some neck pain with all recreational activities.
3. I have neck pain with most recreational activities.
4. I can hardly do recreational activities due to neck pain.
5. I can't do any recreational activities due to neck pain.

FOTO Patient Intake Neck Survey

Name: Date:

Please Read Carefully: Answer each question based on the **problem for which you are receiving treatment**. Mark which column best describes how you are able to do each activity. Please answer each question even if you do not do or have not done this activity. Make your best guess as to which response is most accurate.

Today, does or would your health problem limit:	Extreme difficulty/ Unable to do	Quite a bit of difficulty	Moderate Difficulty	A little bit of difficulty	No Difficutly
1. Looking up to see a bird?					
2. Performing personal care activities like washing, dressing, bathing?					
3. Moving your head quickly, such a following a loud noise?					
4. Performing recreational activities that require little effort (eg. card playing, knitting, etc.)?					
5. Turning to look behind you to drive a car?					
6. Turning over in bed?					
7. Sitting and reading a book for 1 hour?					
8. Changing a light bulb overhead?					
9. Sitting, performing light desk work for 8 hours?					
10. Performing recreational acitivities in which you take some force or impact (eg. golf, hammering, tennis, etc.)?					