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.)?					