



Please complete this questionnaire. It is designed to give us information as to how your neck (or arm) trouble has affected your ability to manage in everyday life. Please answer **every section**. Mark **one box only** in each section that most closely describes you **today**.

**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

**2. Personal care (washing, dressing etc)**

- I can look after myself normally without causing extra pain
- I can look after myself normally but it is very painful
- 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, wash with difficulty and stay in bed

**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 weights off the floor but I can manage if they are conveniently positioned, eg on a table
- Pain prevents me from lifting weights off the floor but I can manage light to medium weights if they are conveniently positioned
- I can lift only very light weights
- I cannot lift or carry anything at all

**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 to with moderate pain in my neck
- I cannot 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

**5. Headaches**

- I have no headaches at all
- I have slight headaches which come infrequently
- I have moderate headaches which come infrequently
- I have moderate headaches which come frequently
- I have severe headaches which come frequently
- I have headaches almost all the time

**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 concentrating when I want to
- I have a great deal of difficulty concentrating when I want to
- I cannot concentrate at all

**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 cannot do any work at all

**8. Driving**

- I can 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 cannot drive my car as long as I want because of moderate pain in my neck
- I can hardly drive at all because of severe pain in my neck
- I cannot drive my car at all

**9. Sleeping**

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

**10. Recreation**

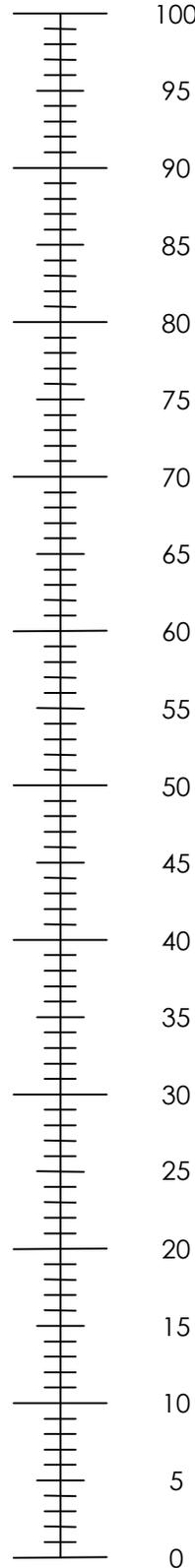
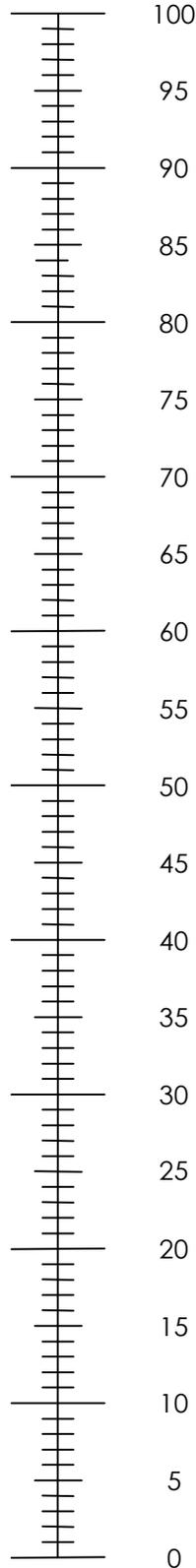
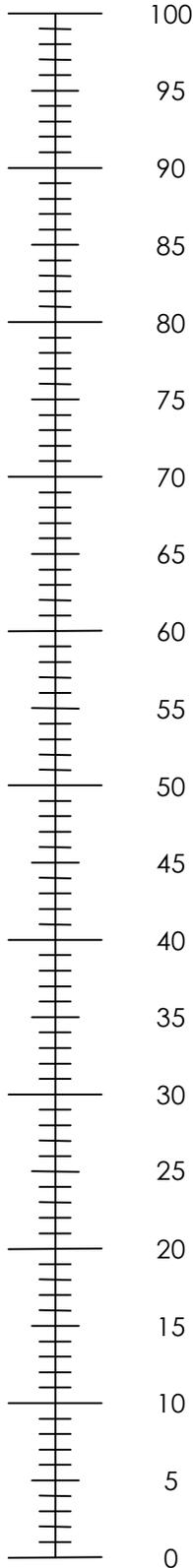
- I am able to engage in all of my recreational activities with no neck pain at all
- I am able to engage in all of my recreational activities with some pain in my neck
- I am able to engage in most, but not all of my recreational activities because of pain in my neck
- I am able to engage in a few of my recreational activities because of pain in my neck
- I can hardly do any recreational activities because of pain in my neck
- I cannot do any recreational activities at all



Worst **LEFT ARM** pain  
you can imagine

Worst **NECK** pain  
you can imagine

Worst **RIGHT ARM** pain  
you can imagine



### Visual Analogue Score: Neck and Arm Pain

Please mark on the  
lines to the left how  
much pain you have  
had from your **neck**  
and **arms**, on average,  
over the past week:

No **LEFT ARM** pain

No **NECK** pain

No **RIGHT ARM** pain

DATE \_\_\_\_\_



Under each heading, please tick the ONE box that best describes your health TODAY

**MOBILITY**

- I have no problems in walking about
- I have slight problems in walking about
- I have moderate problems in walking about
- I have severe problems in walking about
- I am unable to walk about

**SELF-CARE**

- I have no problems washing or dressing
- I have slight problems washing or dressing myself
- I have moderate problems washing or dressing myself
- I have severe problems washing or dressing myself
- I am unable to wash or dress myself

**USUAL ACTIVITIES** (e.g. work, study, housework, family or leisure activities)

- I have no problems doing my usual activities
- I have slight problems doing my usual activities
- I have moderate problems doing my usual activities
- I have severe problems doing my usual activities
- I am unable to do my usual activities

**PAIN / DISCOMFORT**

- I have no pain or discomfort
- I have slight pain or discomfort
- I have moderate pain or discomfort
- I have severe pain or discomfort
- I have extreme pain or discomfort

**ANXIETY / DEPRESSION**

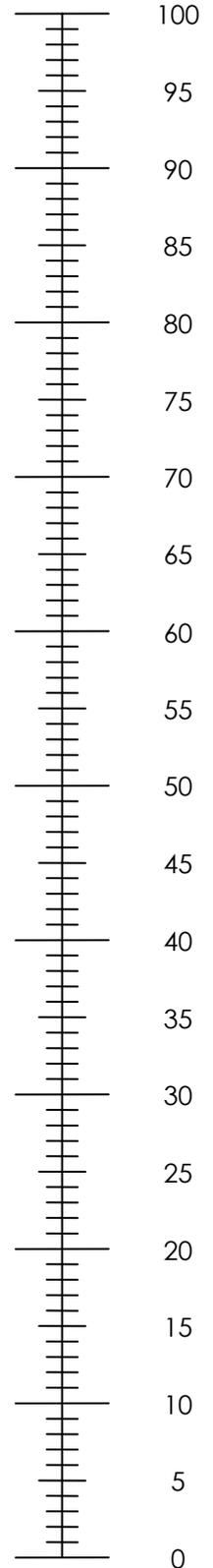
- I am not anxious or depressed
- I am slightly anxious or depressed
- I am moderately anxious or depressed
- I am severely anxious or depressed
- I am extremely anxious or depressed

We would like to know how good or bad your health is **TODAY**. This scale is numbered from 0 to 100. 100 means the best health you can imagine. 0 means the worst health you can imagine.

Mark an X on the scale to indicate how your health is **TODAY**. Now, please write the number you marked on the scale in the box below.

YOUR HEALTH TODAY =   
DATE \_\_\_\_\_

The best health you can imagine



The worst health you can imagine



Please complete this questionnaire. It is designed to give us information as to how your spinal trouble has affected your ability to manage in everyday life. Please answer **every section**. Mark **one box only** in each section that most closely describes you **today**.

**Rising** - Are you able to stand up from an armless straight chair?

- Without ANY difficulty
- With SOME difficulty
- With MUCH difficulty / assistance required
- Unable to do

**Rising** - Are you able to get in and out of bed?

- Without ANY difficulty
- With SOME difficulty
- With MUCH difficulty / assistance required
- Unable to do

**Eating** - Are you able to cut your meat?

- Without ANY difficulty
- With SOME difficulty
- With MUCH difficulty / assistance required
- Unable to do

**Eating** - Are you able to lift a full cup or glass to your mouth?

- Without ANY difficulty
- With SOME difficulty
- With MUCH difficulty / assistance required
- Unable to do

**Walking** - Are you able to walk outdoors on flat ground?

- Without ANY difficulty
- With SOME difficulty
- With MUCH difficulty / assistance required
- Unable to do

**Walking** - Are you able to climb up five steps?

- Without ANY difficulty
- With SOME difficulty
- With MUCH difficulty / assistance required
- Unable to do

**Hygiene** - Are you able to wash and dry your entire body?

- Without ANY difficulty
- With SOME difficulty
- With MUCH difficulty / assistance required
- Unable to do

**Hygiene** - Are you able to get on and off the toilet?

- Without ANY difficulty
- With SOME difficulty
- With MUCH difficulty / assistance required
- Unable to do

**Grip** - Are you able to open jars which have been previously opened?

- Without ANY difficulty
- With SOME difficulty
- With MUCH difficulty / assistance required
- Unable to do

**Activities** - Are you able to get in and out of a car?

- Without ANY difficulty
- With SOME difficulty
- With MUCH difficulty / assistance required
- Unable to do