For Office Use Only
Chart Number:_____
Reviewed by:_____

SPECTRUM MEDICAL PHYSICAL THERAPY
PAIN & SYMPTOMS QUESTIONNAIRE

Name: _____ Age:___ Date:_____ Email:_____

What is your present condition and/or mechanism of injury? _____
_____

What is your primary concern or chief complaint? _____
_____

How would you describe your pain? _____

What makes the pain worse? _____
_____

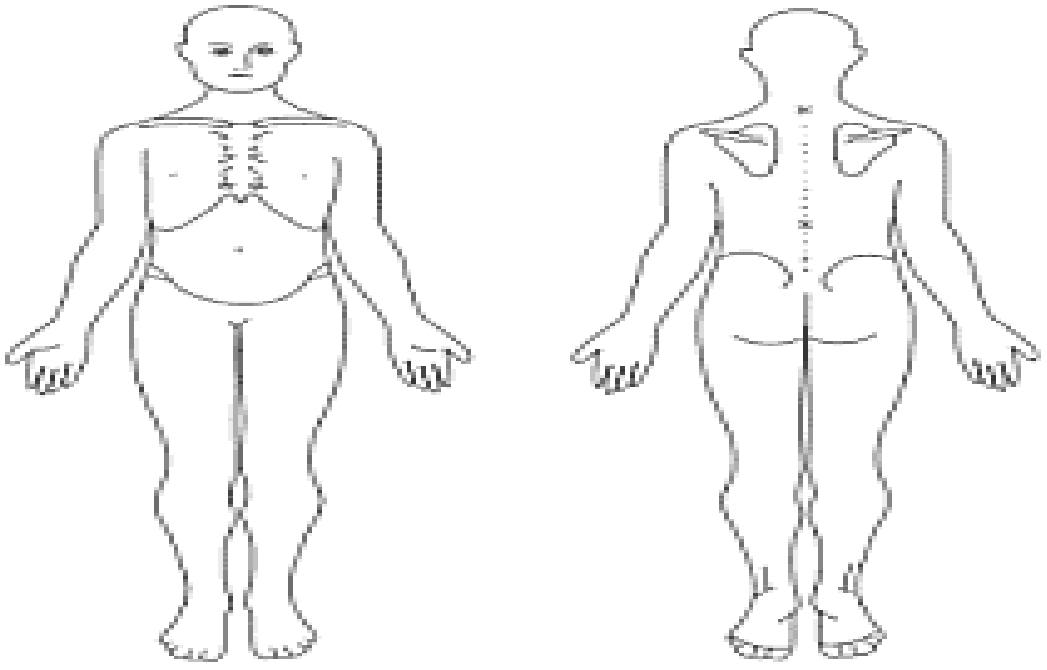
What eases your pain? _____
_____

Rate the pain of your primary concern on the following scale by circling the number that best corresponds.

0 = None 5 = Moderate 10 = Extreme

Current Pain:	0	1	2	3	4	5	6	7	8	9	10
Best:	0	1	2	3	4	5	6	7	8	9	10
Worst:	0	1	2	3	4	5	6	7	8	9	10

Indicate where your pain is located and what type of pain you feel at the present time.



Please check **all** that apply to your medical history:

- ❑ Osteoarthritis
- ❑ Cardiovascular Disease
- ❑ Diabetes Mellitus Type 1
- ❑ Diabetes Mellitus Type 2
- ❑ Allergies
- ❑ Complication Factors
- ❑ Surgical History
- ❑ Previous Physical Therapy for this concern
- ❑ Psycho-Social
- ❑ History of Cancer
- ❑ Current Infection
- ❑ Immunosuppression
- ❑ Fracture or Suspected Fracture
- ❑ Cauda Equina Syndrome
- ❑ Diagnostic Testing (MRI, X-Ray, etc)
- ❑

If you checked any of the above boxes, please explain. _____
_____
_____
_____

How would you rate your overall general health? (Circle the **one** that applies best.)

Good Fair Poor

Please state your goal of physical therapy: _____
_____

By signing below, I consent to a physical therapy evaluation and treatment.

Patient Signature: _____ Date: _____

SPECTRUM MEDICAL

PATIENT NAME:_____ ___ CHART#:_____ DATE:_____

NECK DISABILITY INDEX

Please Read: This questionnaire is designed to enable us to understand how much your neck pain has affected your ability to manage every day activities. Please answer each section by circling the **ONE CHOICE** that most applies to you. We realize that you may feel that more than one statement may relate to you, but please **just circle the one choice which closely describes your problem *right now*.**

	SECTION 1 – Pain Intensity
A	I have no pain at the moment.
B	The pain is mild at the moment.
C	The pain comes and goes and is moderate.
D	The pain is moderate and does not vary much.
E	The pain is severe and comes and goes.
F	The pain is severe and does not vary much.

	SECTION 2 – Personal Care (Washing, Dressing etc.)
A	I can look after myself without causing extra pain.
B	I can look after myself normally but it causes pain.
C	It is painful to look after myself and I am slow and careful.
D	I need some help, but manage most of my personal care.
E	I need help every day in most aspects of self-care.
F	I do not get dressed, I wash with difficulty and stay in bed.

	SECTION 3 - Lifting
A	I can lift heavy weights without extra pain.
B	I can lift heavy weights, but it causes extra pain.
C	Pain prevents me from lifting heavy weights off the floor but I can if they are conveniently positioned, for example on a table.
D	Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
E	I can lift very light weights.
F	I cannot lift or carry anything at all.

	SECTION 4 - Reading
A	I can read as much as I want to with no pain in my neck.
B	I can read as much as I want to with only slight pain in my neck.
C	I can read as much as I want with moderate pain in my neck.
D	I cannot read as much as I want because of moderate pain in my neck.
E	I cannot read as much as I want because of severe pain in my neck.
F	I cannot read at all.

	SECTION 5 – Headache
A	I have no headaches at all.
B	I have slight headaches which come infrequently.
C	I have moderate headaches which come infrequently.
D	I have moderate headaches which come frequently.
E	I have severe headaches which come frequently.
F	I have headaches almost all the time.

	SECTION 6 – Concentration
A	I can concentrate fully when I want to with no difficulty.
B	I can concentrate fully when I want to with slight difficulty.
C	I have a fair degree of difficulty concentrating when I want to.
D	I have a lot of difficulty in concentrating when I want to.
E	I have a great deal of difficulty concentrating when I want to.
F	I cannot concentrate at all.

	SECTION 7 – Work
A	I can do as much work as I want to.
B	I can only do my usual work, but no more.
C	I can do most of my usual work, but no more.
D	I cannot do my usual work.
E	I can hardly do any work at all.
F	I cannot do any work at all.

	SECTION 8 – Driving
A	I can drive my car without neck pain.
B	I can drive my car as long as I want with slight pain in my neck.
C	I can drive my car as long as I want with moderate pain in my neck.
D	I cannot drive my car as long as I want because of moderate pain in my neck.
E	I can hardly drive my car at all because of severe pain in my neck.
F	I cannot drive my car at all.

	SECTION 9 – Sleeping
A	I have no trouble sleeping.
B	My sleep is slightly disturbed (less than 1 hour sleepless).
C	My sleep is mildly disturbed (1-2 hours sleepless).
D	My sleep is moderately disturbed (2-3 hours sleepless).
E	My sleep is greatly disturbed (3-5 hours sleepless).
F	My sleep is completely disturbed (5-7 hours sleepless).

	SECTION 10 – Recreation
A	I am able to engage in all recreational activities with no pain my neck at all.
B	I am able to engage in all recreational activities with some pain my neck.
C	I am able to engage in most, but not all recreational activities because of pain in my neck.
D	I am able to engage in a few of my usual recreational activities because of pain in my neck.
E	I can hardly do any recreational activities because of pain in my neck.
F	I cannot do any recreational activities at all.

Patient Initials:_____

SPECTRUM MEDICAL

PATIENT NAME:_____ **CHART#:**_____ **DATE:**_____

HEADACHE DISABILITY INDEX

INSTRUCTIONS: Please CIRCLE the correct response:

1. I have headaches: (1) 1 per month (2) more than 1 but less than 4 per month (3) more than one per week

2. My headache is: (1) mild (2) moderate (3) severe

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 question as it pertains to your headache only.

	YES	SOMETIMES	NO
(El) 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 1 feel that I am going to lose control because of my headaches			
(F7) Because of my headaches 1 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 that I am going to go insane			
(El0) My outlook on the world is affected by my headaches			
(E11) I am afraid to go outside when I feel that a headache is starting			
(E12) I feel desperate because of my headaches			
(Fl3) 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 headache			
(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			

Patient Initials: _____

FUNCTIONAL INDEX SCORE: _____%: E (52):_____ F(48):_____